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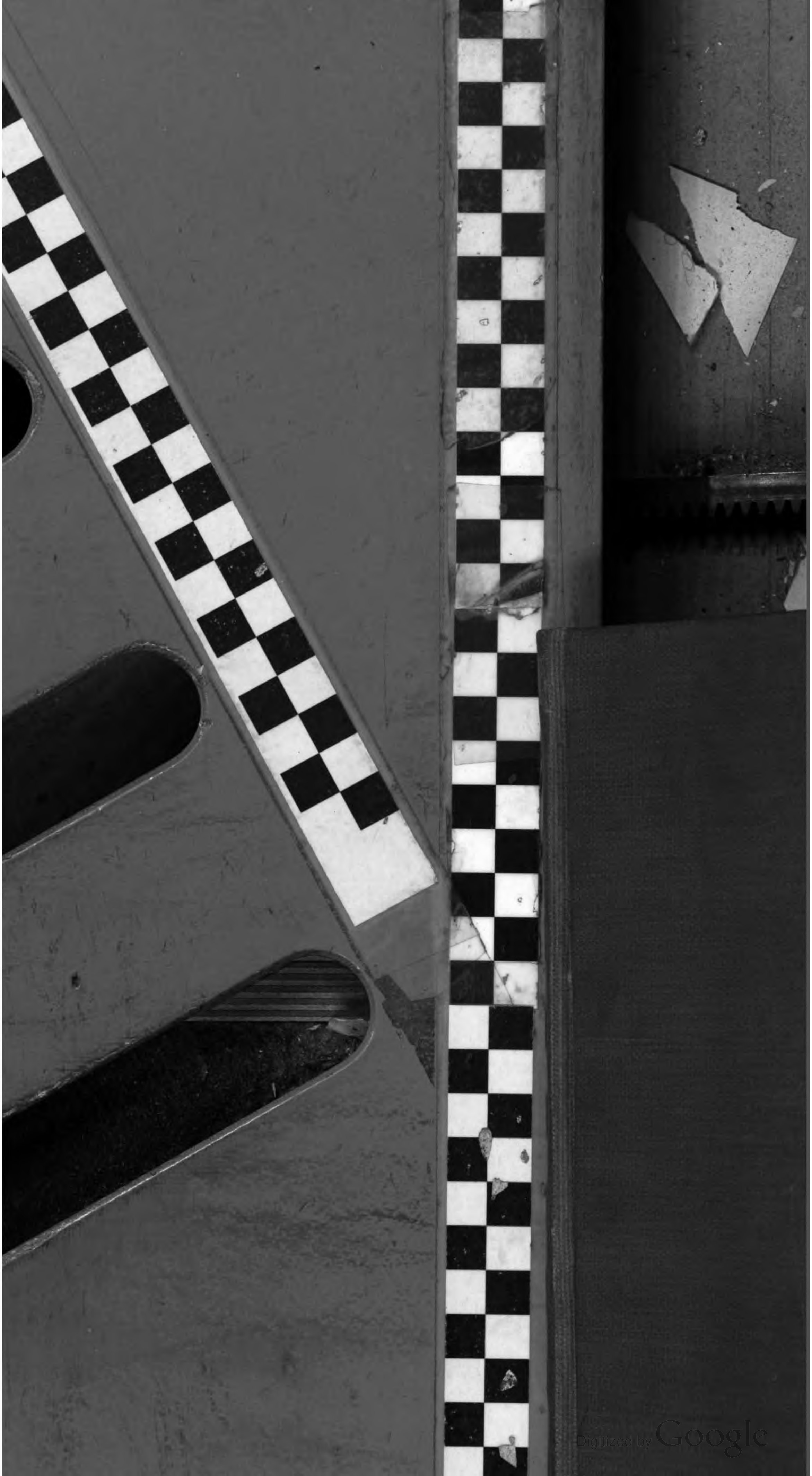

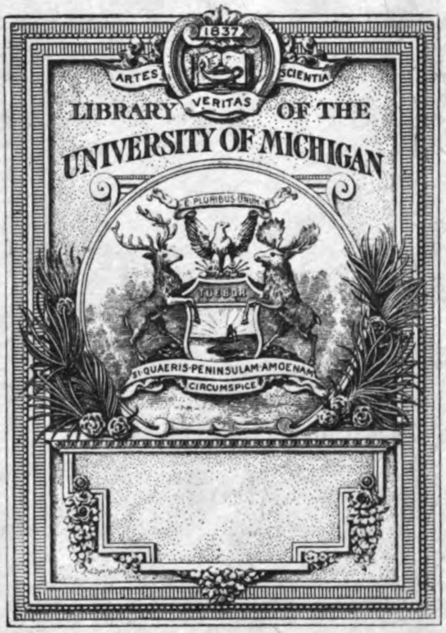

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INDEX.

VOL. LXXXIII NEW SERIES. (VOL. CXXXIV OLD SERIES.)

JANUARY TO JUNE 1907.

CLINICAL LECTURES.

TITLES.
Acroparæsthesia, Dr. Whiting, 388
Adolescence, mental risks of, Dr. Clouston, 86
Antrum, maxillary empyema of, Mr. Dempsey, 250
Arterial plethora and Bright's disease, Dr. O'Carroll, 6
Arthritis, Dr. Poynton, 360
Diabetes, Dr. Monro, 304
Diseases peculiar to children, Dr. Ormsby, 414
Ear, non-suppurative diseases of, Mr. Yearsley, 114-142
Floodings, climacteric, Prof. Smith, 528
Foods and feeding in certain conditions, Dr. West, 644
Fractures and dislocations and skiagraphy, Mr. Poland, 500
Glaucoma, Mr. Benson, 472
Hydronephrosis, Dr. Alexander, 196
Micturition in women, disorders of, Dr. Horrocks, 670, 698
Nervous disease, some cases of, Dr. Carter, 444
Pneumococcal affections, surgical treatment, Mr. Carmichael, 278,
Pneumonia, treatment of, Sir James Barr, 558, 586
Pneumonia, caseous, Prof. Debove, 34
Pregnancy, extra-uterine, developments and dangers of, Dr. Giles, 612
Optic neuritis and intra-cranial tumours, Dr. Fleming, 58
Sanitation, tropical, Mr. Ross, 332
Strabismus, treatment of, Dr. Story, 222
Ulcer gastric Sir Charles Ball, 170

AUTHORS.
Alexander, Dr., Hydronephrosis, 196
Ball, Sir C., Ulcer, gastric non-malignant, 170
Barr, Sir James, Pneumonia, treatment of, 558, 586
Benson, Mr., Glaucoma, 472
Carmichael, Mr., Pneumococcal affections, surgical treatment, 278
Carter, Dr., Nervous disease, some cases of, 444
Clouston, Dr., Adolescence, mental risks of, 86
Debove, Prof., Pneumonia, caseous, 34
Dempsey, Mr., Antrum, maxillary, empyema of, 250
Fleming, Dr., Optic neuritis, and intra-cranial tumours, 58
Giles, Dr., Pregnancy, extra-uterine, developments and dangers, 612
Horrocks, Dr., Micturition in Women, disorders of, 670, 698
O'Carroll, Dr., Arterial plethora and Bright's disease, 6
Ormsby, Dr., Diseases peculiar to children, 414
Poland, Mr., Fractures and dislocations and skiagraphy, 500
Poynton, Dr., Arthritis, 360
Monro, Dr., Diabetes, 304
Ross, Mr., Sanitation, tropical, 332
Smith, Prof., Floodings, climacteric, 528
Story, Dr., Strabismus, treatment of, 222
West, Dr., Foods and feeding in certain conditions, 644
Whiting, Dr., Acroparæsthesia, 388
Yearsley, Mr., Ear, non-suppurative diseases of, 114, 142

CORRESPONDENCE—FOREIGN

AUSTRIA—
Aniridia congenita, 655
Aorta and syphilis, atheromatosis of, 17
Asthma, isolated, 184
Asymmetry, facial, 345
Autan, 572
Bier's congestion treatment, 46
Bronchus, foreign body in, 71
Cranium, neoplasm of, 98
Cardiac anomaly, congenital, 99
Cardiac defect, 99
Carcinoma, serum, diagnosis of, 153
Cerebro-spinal fluid, 459
Children, protection of, congress for, 682
Cholecystitis, post typhoid, 373
Chondroma and Exostosis, 709
Chromaffine system, 486
Cirrhosis, hepatic, 400
Diabetes, 572
Digital malformation, 291
Disinfection, 709
Diuretic medicines, 46
Dysenteric toxin, 235
Dyspnœa, high tension, 152
Eclampsia, ætiology of, 317
Eczema universale, 683
Endocarditis, ulcerative, 127
Epididymitis, gonorrhoic, 515
Epilepsy autopsy, findings in, 572
Epiphysal multiple separation, 400
Exostosis cartilagenous, 540
Extremities, gangrene of, 127
French visit, 682
Fungoid multiple swellings, 345
Gall bladder and cholesterin, 18
Gangrene from ice-bag, 373
Gangrene, pulmonary, 600
Giant, infantile, 71
Glycosuria, 263
Hæmolysis, 629
Hair quills, 572
Hermaphrodites, pseudo, 399
Huhnerpest, 18
Idiocy, myxo-, 171
Intestinal infection, 46
Invagination, intestinal, 426
Leprosy, 235
Leucocystosis, serum treatment, 459
Ligaments, peritoneal pseudo, 600
Lupus-pernio, 540
Lupus vulgaris, exulcerans, 514
Lymphates, infection by, 427
Mammæ carcinoma, 655
Mammæ cystadenoma, 46
Metabolism and Rontgen rays, 18
Mongolism, 572
Necrosis phosphoric, 540
Neuritis, optic, 317
Ostetis fibrosa, 235
Otetus, temporal abscess from, 513
Ozone in surgery, 600
Paralysis of lower extremities, 514
Parotitis, recurring, 127
Percussion, Marzonus' theory of, 184
Pericardium, heart surgery, 513
Perstasis papulosis, 210
Pertusses and bacillus, 629
Petyriasis lichenoides, pruniens 17
Puerperal diseases, therapy of, 600, 709
Puerperal fever, surgical therapy of, 683
Rheumatism, chronic, and fibrolysin, 514
Rhinolith, 514
Right hand, contractions in, 486
Rontgen apparatus, 235
Sarcoma, and morbus basedowii, 373
Sarcoma, removed by torsion 373
Scoliosis, 540
Stenosis, broncho-, 127
Stomach, perforation healed, 17
Syphilis, maligna præcox, 709
Syphilitica osteitis, 71
Tæmia cucumerina, 290
Tetany, 263
Tetany, and adrenal bodies, 71
Tetany, infantile, 427
Teeth, artificial, accident, 210
Thorax, funnel-shaped, 263
Thyroid epithilial corpuscles, 655
Tick fever, 427
Trichonodosis, 46
Ulcers, Rontgen ray, 400
Uria, indigo, 71
Urine and body temperature, 184
Valgus and pes-varus, functional treatment of, 291
Vara crura, 571
Variola, theory of exanthum in 317

FRANCE—
Alopecia, in women, 151
Appendicitis, treatment of, 261
Asthma, cardio-sclerosis, 343
Biliary cirrhus, 45
Boils, treatment of, 97
Cardiac disease, digitalin in, 681
Colitis, entero-, 344
Collargol, injection of, 315
Death, sudden causes, 290
Digestive tract, hæmorrhage of, 261
Erections nocturnal, 426
Febrik diseases, ice over the heart in, 654
Grippe, treatment of, 654
Hæmorrhage in disease, 398
Heart disease, treatment of, 125
Infants, crying of, 512
Influenza epidemic, 69
Ions, treatment by, 315
Laryngitis, tuberculous, 151
Lymphadenoma of neck, 70
Neurasthenia, 16
Nipples, sore, 571
Paralysis, diphtheritic, treatment of, 681
Paralysis, General, treatment of, 538
Paraphimosis, 571
Peritonitis, tuberculous, 70
Phthisis, first signs of, 289
Phthisis, treatment of, 599
Pleurisy, treatment of, 484
Pulse, slow, 97
Sciatica, 261
Smoking, 261
Suppuration, abortive, treatment of, 539
Sweating, treatment of, 208
Tinea capitas, 457
Tuberculosis, external treatment of, 512
Tuberculosis, pulmonary, sure sign of, 654
Typhoid fever, treatment of, 233
Uræmia, treatment of, 425
Veins, varicose 570
Vomiting, treatment of, 627
Warts, treatment of, 425
Writer's cramp, 485
Zona, treatment of, 16

GERMANY—
Abdomen, retention of foreign body in, 262
Abscesses, splenic surgery of, 571
Addison's disease, 654
Albuminuria, orthostatic, 98, 152
Anæsthesia, lumbar, 628
Aneurysm, arterio-venous and arterial, 571
Appendix, vermiform, primary cinoma of, 708
Bergmann, Prof. von, death of, 708
Berlin, infectious disease in, 234
Bladder, paraffin, calculus of, 599
Brain, blastomycosis of, 654
Cancer inoculation, 539
Cardiac diseases and accidents, 316
Chest diseases in children, 152
Chloroform, cases of late death from, 426
Diphtheria, 459
Diseases communicable, campaign against, 262
Disease, psycho-reflex symptoms of, 426
Ear diseases and life insurance, 372
Epilepsy, opium-bromine treatment of, 183
Exophthalmus, pulsating, 571
Gall-bladder, true and false diverticula of, 628
Goitre and its treatment, 16
Hæmatomyelia, 152
Heart, surgery of, 222
Hepatic duct, rupture of, 71
Infants, natural feeding of, 234
Influenza, encephalitis, 183
Kidney, horseshoe calculus of, 708
Labium, tuberculous ulcer of, 426
Lipoma, intestinal, spontaneous expulsion of, 126
Liver, resection of, 628
Liver, syphilis of, 98
Lysol, antidotes to, 459
Lysol, poisoning by, 209
Menstrual blood, antiseptic action of, 262
Neuralgias, their treatment, 682
Œsophagus, dilatation of, 458
Œsophagus, hæmorrhage from varices of, 708
Optic nerve, atrophy of, 459
Pancreas, fistula in, 126
Pancreas, subcutaneous injurie of, 262
Pharyngitis, meningococcus, 210
Pneumonia contusional, 290, 344
Poisoning by lysol and greosol, pathology of, 485
Puncture, exploratory death after,
Puncture, exploratory, death after, 426
Renal surgery, 70
Schwam-Theodor, monument to, 372
Scoliotica, ischias, 344
Sepsis following pyonephrosis, 210
Skull, sarcoma of, 344,
Speech, loss of, 98
Spleneotomy, successful, 571
Spirochæte, transmission of, 399
Stomach, cancer of, and surgery, 485
Stomach, ulcerated, 210
Tetanus, treatment of, 628
Tuberculosis, 94 nephrectomies for, 399
Tumours, nature of, 599
Typhoid bacilli carriers, 45
Typhoid and milk, 46
Ulcer, Peptic, 98
Ureter, rupture of, 71
Vocal organs, functional changes in 682
Whooping cough, results of, 152

259524

HUNGARY—
  Abdominal section, 18
  Acne, treatment of, 153
  Aorta, ætiology of aneurisms, 263
  Basedowi, Rontgen rays in, 263
  Budapest, milk dispensaries in, 572
  Diphtheria, chronic, 572
  Epilepsy, 572
  Gastric juice, titration, of 263
  Gastro-enteritis, acid, creamless milk in, 263
  Hyperemesis gravidarum, 514
  Lead poisoning, 153,
  Narcosis, morphine scopolamine, 374
  Neuralgia trigeminal, 373
  Night sweats, treatment of, 153
  Nitro-glycerin, therapeutical value of, 153
  Palsy, obstetrical, 572
  Tuberculosis, pamphlet on, 573
  Tuberculosis, pulmonary, early diagnosis of 373,
  Typhoid fever, 18

CORRESPONDENCE—HOME.

Adams, Dr., action against, 128
Advertisements, fraudulent, suppression of, 402
Alcohol manifesto, 541, 601, 630
Alcohol question, 401
Alcohol untaxed, 129
Anti-vivisection and sport, 48
Anti-vaccination champion, 401
Anti-vaccination oration, 211
Anti-vivisectionists and falsehood, 319
Antrim infirmary, 601
Arsenical poisoning, 47
Apothecaries Bill, 684
Appendix and sauce-pan, 20
Bangor Asylum, 154
Beattie, Prof., dinner to, 683
Belfast, health of, 630
Belfast hospital for children, 154
Belfast public health, 47
Belfast sewage purification, 656
British Medical Association, Scottish branch, 128
Birth-rate, the falling, 211
Breath pictures or spirographs, 100
Bronchitis, infective, 155
Cancer problem, 20, 685
Carnegie trust, report of, 317
Carsewell, Dr., shooting assault, 460
Cerebro-spinal fever, Belfast, 429
Cerebro-spinal meningitis, 264, 487, 656, 684, 709
Children's hospitals and milk, 574
Clima-therapy and hygiene, 129
Compensation Act, Workmen's, and hospitals, 631
Consumption, compulsory notification of, 18
Consumption, treatment of, 709
Dairy cases, 541
Deaths in the profession, 211
Derry borough and county infirmary 128
Diplomates, Scottish, and London Hospitals, 684
Doctrina, 656
Dowie's mental condition, 347
Dowie, death of, 346
Down County Infirmary, 375
Edalji case, 100, 128, 601
Edinburgh and Glasgow medical club, 655
Edinburgh, health of, 1906, 47, 655
Edinburgh hospital for women, 19
Edinburgh infirmary and Lord Lister, 428
Edinburgh medical lecturers and Dublin University, 428
Edinburgh Royal Asylum, 264
Edinburgh Royal infirmary, annual report, 72
Edinburgh school board medical officers, 47
Edinburgh University annual report, 99
Epilepsy, homicidal impulses, 19
Eye, ear, and throat hospital, Ulster, 346
Finlayson, Dr. proposed memorial to, 128
Forster Green hospital, 154, 683
Fraser, Prof., 683
Free or sober, 72
Galashiels sanatorium, 601
General practitioners and London hospitals, 542
Girgenti home for inebriates, closing of, 318
Glasgow Royal visit to, 486
Glasgow University, death of Principal, 100
Glasgow University, medical school appointments, 683
Graduation ceremonial, Aberdeen, 428
Graduation ceremonial Edinburgh university, 428
Great quack, birthplace of, 318
Guardians, doctors action against, 100
Health commission, Belfast, 482, 461, 489, 515, 573
Health congresses, multiplication of, 264
Hebert, Dr. 684
Hollywood Water supply, 460
Homœpathy serums and vaccine, 73
Horn, perineal, 630, 656
Insanity, alleged increase of, 400
Insanity, "Pall Mall Gazette" on, 319
Irish university question, 128, 154
Keratoses, pharyngo-, 515
Lawyer and doctors, law for, 601
Littlejohn, Sir H., presentation to, 292
Law, tinkering with, 543
London hospitals and general practitioners, 574, 602
London and milk supply, 402
Lunacy and the law, 600
Lurgan, health of, 683
Maternity hospital, Belfast, 265
Mater Infirmorum Hospital, Belfast, 656
McCleery, Dr., death of, 128
Medical Benevolent fund, Belfast, 573
Medical clubs, 19
Medical defence union, its work, 573
Medical etiquette, 265
Medical law reform, 318
Meningitis, cerebro-spinal, Scotland, 153, 629
Meningitis, cerebro-spinal, Belfast, 100, 128, 154, 375, 460, 573, 601
Merrich, death of, 19
Milk question, Dr. Matthew Hay, of Aberdeen, on, 19
Morison lectures on insanity, 154
Nursing conference, international. 630
Nursing homes and medical men, 650
Ophthalmic hospital, Belfast, 345
Our climate, 488
Peddie, Dr., the late, 100
Phthisis, compulsory notification of, 127
Physiology and practice, 710
Poisoning case, 345
Politicians and anti-scientific fanaticism, 346
Poor law medical relief, organisation of, 266
Post-graduate work in Edinburgh, 487
Practitioner, the oldest, in Scotland, 127
Public health prosecutions, Belfast, 487
Public health, Belfast, 265, 401, 541
Quackery and practice by companies, 710
Quack medicine trade, 265, 293, 429
Queen's College, Belfast, 629
Railway carriages, insanitary, 155
Railway dust and darkness, 488
Ramsey, Dr., 541,
Rayner's reprieve, 347, 401
Rectorial addresses, Glasgow and Edinburgh Universities, 72
Rideal-Walker, Co-efficient, 373
Royal College of Physicians, laboratory, 211
Royal Infirmary, Glasgow, 486
Royal Victoria Hospital, 375
Samaritan Hospital Belfast,, 292
Scottish Asylums, cost of, 47
Sick poor, society for providing nurses for, 265
Sleeping sickness, 20
Smoking, juvenile, 265
Temperance question, science, 155
Tooth-brush in schools, 488
Tuberculosis and milk, 429, 461, 487, 515, 542
Tuberculosis in pigs, 72
Typhoid and water supply, 211
Typhus fever in Newry, 709
Tyrone County Hospital, 100
Ulster hospital for women and children, 318
Ulster Medical Society, 709
Unfit, elimination of, 402
University question, Belfast, 318
University question, Dublin, 211
Vagrant Act, 212
Vivisection and stag-hunting, 20
Vivisection, anti-, 48
Voluntary and State hospitals, 318
Walker, Dr. Norman, dinner to, 47
Water supply, Belfast, 630

CLINICAL RECORDS

Abortion missed, 422
Calculus renal simulating appendicitis, 284
Cancer, recurrent and inoperable, treatment of 535
Clinical cases, interesting, 310
Cyst, ovarian, ruptured, 478
Dropsy, fœtal, 203
Hydrothorax, suffocative, 120
Hysterectomy, large myoma, 337
Leontiasis ossea, 147
Pancreatitis, acute hæmorrhage of, 12
Parovarium, sarcoma of, 337
Pneumonia, acute, three cases of, 704
Pregnancy, extra-uterine, 450
Ureter, ulceration of, 256
Uterus, large fibromyoma, 228

SPECIAL ARTICLES.

Barnes, Dr., the late, 711
British Pharmacopœia, proposed changes in, 574
Consumptives' national sanatorium, 516
Droitwich, 631
General Medical Council, 621
Health of Dublin, 266
Infants' hospitals, 516
International surgical society, second congress of, 320
London County asylum, 685
Lunacy in Ireland, 44
Plague in New South Wales, 430
Prehistoric inhabitants of England, 544
Qualification of midwives, 462
R.C.S. of England, 685
Royal Commission on Trinity College, 130
Scotch poisoning case, plea of insanity, 574
University education in Ireland, 186, 212, 238, 657
University question in Ireland, 294, 404, 461

LEADING ARTICLES

Alcohol and doctors, 693
Alcohol manifesto, 468
Alcohol, use of, 384
Annus medicus, 1906, 2
Anthropometric survey, national, 274
Army medical reform, 410
Bread, a standard for, 524
Cerebro-spinal fever epidemics, 166
Coroners' fees and hospital medical witnesses, 246
Dublin, health of, 246
Dublin University, changes in, 110
Drug trade, fraudulent, 385
Edalji case, 54
Edalji committee's report, 554
Fraudulent drug trade, 385
Hospital appointments, monopoly of, 666
Indian Government and Mr. Haffkine, 496
King Edward's fund, bill to incorporate, 608
Law courts, professional misconduct, 138
Legislation and the conscientious objector, 192
London and its milk supply, 356
Meat (tuberculous), 641
Medical Council, General, 609
Medical man as citizen, 640
National anthropometric survey, 274
Nostrum vendor, bitter cry of, 300
Public charity and unqualified medical practice, 664
School children, medical inspection of, 218, 694
School boards and medical certificates, 111
Small-pox, disappearance of, 555
Trades unionism, an alternative, 583
Tuberculosis, Royal commission, 328
Tuberculosis commission, 139
Quackery, commission on, 30

NOTES AND COMMENTS.

Alcohol, a medical counter-manifesto, 468
Act, a kindly, 29
Advertising professional, and the sphinx club, 607
Ambulance accident, 581
An "O" too much, 82
Anthrax report, 1
Anti-vivisectionists and honesty, 299
Army, a way they have in, 192
Asylums, American, scandals in, 608
Bailey, New and old, 245
Beecham, Thomas, 409
Bill, unpaid, 29
Bipolar version, 137
Bone-setter's ethics, 217
Boston culture, 299
Cape medical libel, 640
Cerebro-spinal fever and secrecy, 495
Certificates and education committees, 1
C.M.B., caprice of the, 439
College of Surgeons and members, 553
Commissions, legitimate, 166
Co-operation, advantage of, 581
Coroner, legal, or medical, 191
Coventry dispute, 409
Cripple children, 639
Crocker v. Doyen, 245
Curative human radiations, 468
Death investigation, 355
Dentists, unregistered, and anæsthetics, 273
Doctor's crime, 327
Doctor's dilemma, 1
"Doctors," confusion of, 666
Dowie, exit, 299
Drunkenness, tests for, 496
Education pitfalls, 218
Eggs, tonic, 165
Epsom, croaking at, 383
Evolution, social, 2
Expert fees in India, 608
Eye-glasses for schools, 440
Failure to notify, 356
Faith healing, 245
Fluid fees, 274
Fowler's solution, 166
Free calls and Medical men, 2
General hospital, Prince of Wales', 523
Guardians and luxuries, 29
Hair and the dog, 138
Harems once more, 410
Health visiting, and medical treatment, 300
Health visitors, 273
"Help," 218
Highfield Infirmary, doctor and matron, 582
Humanitarianism and discretion 300
Imperialism and medicine, 495
In my opinion, 356
Innocents, protection of, 581
Inquests, behind the, 191
Iron-ox decision, 553
Isolation dances, 440
Journalism, medical, 30
L.C.C., deaf by order of, 217
L.C.C. election, 217
Lead poisoning, 30
Livingstone College, 666
"Liza" and students, 54
Lord Howard de Walden and Mr. Eastes, 665
Magic boots, 81
Meat, "Slink," 138
"Medical Press" and "Beacon Light," 639
Medicine and marriage, 54
Medicine and sex, 53
Microscopical tests and microscopical prejudice, 665
Midwives, barber, 439
Midwives, beware, 1
Midwifery fees at Rotherham, 439
Milk, ærated, 138
Motherhood, movement against, 640
No drugs, no doctors, 110
Non-professional attendance, 137
"Nourishment," 109
Novelist, recreation of, 484
Nurses, naval, 191
Objectors, unconscious, 246
One stroke, one orange, 137
Osler's, Mrs., death, 327

Ox-runners, 554
Paralysis, general, 299
Paying the substitute, 495
Plague and cats and rats, 524
Practitioner, a nervous, 165
Prescription, family, fine for, 524
Provident medical associations, principles of, 693
Quack, M.B., 523
Ranji as sanitarian, 409
Rank and "gowd," 274
Rayner, reprieve of, 355
Red lung balsam, 523
Sanitation and surcharge, 192
Sanatoria, English and German, 607
Sanitary jaunts, 245
Sanatorium afloat, 192
Sausage, raw, for delicate children, 581
Scholarship, Theodore Williams, 607
School for invalids, 410
Science and Indian Government, 694
Seamen's protest, 409
Secretly or corruptly, 109
Self-help or agents, 166
Semper paratus, 554
Shaving without razors, 467
Sic itur ad astra, 245
Simplest life, 110
Sleeping sickness, 639
Specialists' fees, 553
"Specialists" and immorality, 467
Strychnine and faith, 53
Surgical resurrection, 53
Telephones and infection, 581
Telephone sickness, 467
Thaw case still, 327
This way to madness lies, 246
Toothsome morsel, 246
Transaction and confusion, 483
Treves, Sir F., and the public, 694
Two persons and one clerk, 109
Unconscientious objectors, 246
Undertaking, conscientious objection, 82
Union of hearts, 328
Union at Wimborne, 218
Vaccination bill, 495
Vaccination at home, 483
Value of a name, 467
Wimborne fight, 483
Zancigomania, 81

NOTES ON CURRENT TOPICS.

Abortion, crime of, 329
Alcohol, counter-manifesto, 498
Alcohol, use of, 384
Ambulance service, London, 32
Anæsthesia, fatal, 470
Anæsthetics, administration of, 697
Anæsthetics, deaths under, 276
Anatomical teaching, supply of bodies, 470
Anatomical material in Dublin, supply of, 443
Animals, experiments on, 610
Annual summary, Registrar-General's, 611
Another imposition, 301
Anti-suicide bureau, 56
Anti-vivisection and falsehood, 276
Anti-vivisectionist "expert," 696
Anti-vivisectionists in Ireland, 442
Army male nursing, co-operation suggested, 610
Belfast, health of, 220
Bergmann, Prof., death of, 357
Bone-setter's challenge, 31
Brentford hospital scandal, 442
British health resorts, development of, 329
British Medical Association and its charter, 498, 659
Burial law reform, 221
Bryce's, Mr., Irish university scheme, 168
Cancer and the lay press, 668
Cancer, another marvellous cure for, 194
Cancer, Royal Commission on, 696
Cancer serum, Dr. Doyen's, 32
Cancer and trypsin, 302
Carlyle and women, 221
Cerebro-spinal fever in Belfast, 169
Cerebro-spinal fever in United Kingdom, 219, 470
Cerebro-spinal fever, 249
Cerebro-spinal meningitis invasion, 193
Cerebro-spinal fever, a warning note, 219
Chest, military, 276
Chinese medical college, 277
Churches and disease, 113
Consumptives, marriage of, 331
Consumptives and St. Maws, 642
Coventry dispute, 386, 668
Crimean medical hero, 583
"Dairy World" and milk trade, 470
Dakhyl v. Labouchere, 302
Death certificates and coroners, 556
Death-rate, a record, 32
Diplomas for nurses, 441
Disease or vice, 113
Doctors limited, 329
Doctors' mistakes, 583
Domestic compensation and hospital patients, 497
Drainage by suction, 32
Drug trade, fraudulent, 385
Dublin, health of, 527, 555
Dugong oil as medicine, 697
Edalji Case, 83
Egypt, public health in, 411
Emergency beds at hospitals, 248
English royal colleges and diplomas for women, 220
Episcopal surgery, 275
Eugenics in practice, 359
Evans Brothers and Mr. Stead, 303
Fasting man in Fun City, 84
Federa universities, 412
Gambling and climate, 112
Gangrene carbolic acid, 690
Garden City, the first, 167
General Medical Council as a court, 610
Haffkine, Mr., and Indian Government, 302
Health of London and Dublin compared, 85
Hop-picker, hygiene of, 413
Hospital abuse, 31
Hospital abuse and lay press, 557
Hospital nurses and the Employers' Liability Act, 219
Hospital Saturday fund, 168
Indian Government and Mr. Haffkine, 641
Inebriate home, 498
Inebriety commission on, 469
Infantile mortality, 5, 668
Illegal practice in France, 220
Insanity growth of, 386
Institute curative, 141
Insurance companies and the hospitals, 112
Ireland, Royal university, prevention of disorder, 275
Irish Medical Association, Presidential address, 642
King Edward's hospital fund, proposed charter of, 57, 140, 641
King Edward's hospital fund bill, 497
Knee, housemaid's, 585
Lead poisoning by drinking water, 275
Lister, Lord, celebration, 358
Lister, Lord, and R.C.S. England, 410
Liverpool hospitals, centralisation of, 113
Liverpool school children, 55
Local government board in action, 112
London medical societies, the union of, 56
Lunacy law, new, in France, 193
Meat essence dangers, 4
Medical alliance meeting, 386
Medical charges, army, 4
Medical defence union, 525
Medical education, reform of, 412
Medical fees, no provision for payment of, 194
Medical and lawyer's law for, 583
Medical man or matron, 140
Medical manifesto 668
Medical men and a day of rest, 499
Medical men under new compensation Acts, 331
Medical protection Society, London and Counties, 471
Medical slander, 387
Medical society, United Service, 526
Midwives and Devonshire C.C., 303
Milk for children's hospitals, 527
Mosquito "torture trough" 248
Motor car taxation, 526
Muscles, fallacy of, 84
Night-calls in Vienna, 33
Nitrogen, from air, 113
Opsonic Index by immune serums, 642
Palate, identification by, 695
Paupers palatial, 525
Pasteur institute, embarrassment of the, 248
Phosphorus poisoning, 471
Physical training of recruits, 194
Physiology, teaching of, 696
Pleurisy, study of, 690
Plumbers, proposed registration of, 497
Pneumonia, opsonic treatment of, 412
Poison in a beer bottle, 358
Poison regulations, chemists' knowledge of,
Polyclinic, 359
Poor law school scandal, 249
Poor law reform, 194
Post-graduated work in Dublin, 584
Practice by companies, 499
Proprietary medicines in America, 471
Public health interest in the, 195
Public officers, personal freedom of, 169
Quack's agent, 643
Queen's nurses, 695
Railway carriages and dirt, 277
Railway carriages and disease, 85
Red Cross organisation, 584
Restaurants, inspection of, 168
Royal commission carelessness of, 357
Royal society of medicine, 220
Sanatorium, national association 556
Sanatorium treatment at moderate fees, 443
Scarlatina case, Ealing, 526
Science and English public, 610
Science, another martyr to, 277
Seasickness, approaching conquest of, 358
Seasickness and Christian science, 358
Servants, insurance of, 84
Servants' insurance and medical examination, 167
Small-pox, cost of, 556
Standard pharmacopœia, an international, 357
Starch in cream, 301
Sterilisation of certain degenerates, 584
Straw and strawberries, 696
Street noises and milkmen, 329
Suffragettes and hysteria, 330
Sweating, cost of, 411
Telegraph office, overcrowding, 5
Toothbrush in schools, 442
Trailing skirt, 248
Trypsin treatment of cancer, 56
Tuberculosis, a journal for, 4
Tuberculosis in London, 695
Tuberculosis, pulmonary, heredity in, 386
Unexpected danger, 442
Unfit, survival of, 4
Union hospital, Sheffield, 441
University schemes in Ireland, 194 643
Unqualified practitioner of medicine, 84
Vaccinated veal, 359
Viewing the body and Parliament, 219
Wakley, Mr., death of, 387
Women and public health, 330

OBITUARY.

Bain, Dr., 461
Balfour, Dr., 21
Barker, Dr., 319
Bates, Dr., 488
Bateman, Dr., 319
Bellow, Dr., 656
Bennett, Prof., 710
Bourne, Dr., 237
Brooks, Dr., 347
Browne, Dr., 602
Campbell, Dr., 404
Carter, Mr., 237
Cockey, Mr., 186
Davies, Dr., 404
Falconer, Dr., 101
Fardon, Dr., 48
Fayrer, Sir Joseph, 602
Forbes, Dr., 212
Foster, Sir Michael, 155
Girdlestone, Mr., 574
Gornall, Dr., 186
Groves, Dr., 602
Harrison, Dr., 430
Herbert, Hon. Dr., 294
Hicks, Dr., 656
Kingston, Sir W., 237
Huxley, Dr., 212
Innes-Kerr, Sir John, 374
Jalland, Dr., 544
Johnson, Dr., 48
Kendall, Mr., 21
King, Mr., 266
Lawson, Mr., 21
Little, Dr., J. 156
Little, Dr. R., 319
Lodge, Dr., 543
Lofthouse, Surgeon-General, 74
Luscombe, Dr., 543
MacCormack, Dr., 129
MacDonald, Dr., 48
MacDougall, Dr., 516
Macfayden, Dr., 293
Masters, Dr., 631
Maule, Dr., 656
Morley-Collison, Dr., 461
Myrtle Scott, Dr., 402
O'Hare, Dr., 544
Oldham, Mr., 129
O'Sullivan, Dr., 48
Parry, Dr., 430
Partridge, Mr., 156
Pearse, Dr., 293
Phillips, Dr., 403
Porler, Prof., 544
Prees, Mr., 156
Purchell, Dr., 430
Ransom, Dr., 461
Ross, Dr., 73
Sansom, Dr., 319
Seaman, Surgeon-Major, 237
Snedden, Dr., 430
Strange, Dr., 293
Toller, Mr., 101
Travers, Dr., 21
Wakley, Mr., 403
Walker, Dr., 266
Wedderburn, Dr., 574
Wright, Dr., 237

OPERATING THEATRES.

CHILDREN'S HOSPITAL, PADDINGTON GREEN—
  Hernia, umbilical, 395
  Liver, ruptured, operation for, 204
GREAT NORTHERN HOSPITAL—
  Abscess, tuberculous, 749
  Hernia, strangulated femoral, 13
  Sinus, lateral rupture of, 651
  Skull, fracture of, 677
  Tongue, epithelioma of, 451
KING'S COLLEGE HOSPITAL—
  Cerebral concussion, 677
  Ear, middle disease, 285
  Hæmatoma of thigh and leg, 422
  Laparotomy, exploratory, 369
MIDDLESEX HOSPITAL—
  Patella, fractured, 149
NORTH-WEST LONDON HOSPITAL—
  Abscess, mammary, 67
  Mouth, epithelioma of, 338
  Tendons, plastic elongation of, 536
ROYAL EAR HOSPITAL—
  Mastoiditis influenza, Schwartze operation, 178
  Mastoid, radical operation, 508
ROYAL FREE HOSPITAL—
  Cholecystostomy, 312
  Cyst-bronchial, case of, 228
  Hernia, congenital inguinal, 566
ROYAL SOUTHERN HOSPITAL, LIVERPOOL—
  Tongue, excision of half, 257
ST. PETER'S HOSPITAL—
  Uretero-Lithotomy, 94
ST. THOMAS'S HOSPITAL—
  Biliary passages and cholecystostomy, 121
  Brain, œdema of, 41
  Cyst, pancreatic, undue mobility, 595
  Hernia, irreducible, 257
  ,, umbilical, radical cure of, 595
  Occipital lobe, tuberculosis of, 705
  Testis, carcinoma of, 620
TOTTENHAM HOSPITAL—
  Mesentery, tuberculous glands in, 121

ORIGINAL PAPERS.

TITLES

Abdominal operations, conservative surgery in, 704
Adenoids and nasal obstruction 40
Anæsthetics, improved gag, 391
Anæsthesia, general, following acid intoxication, 198

Ataxia Friedreich's, 505
Bronchitis infection, relation to consumption, 117
Cæsarian section, 647
Catgut iodised, 620
Cerebral abscess, 39
Cerebro-spinal fever, 672
Cerebro-spinal meningitis, 474
Cerebro-spinal meningitis, meningococcal, 173
Chest, exploratory puncture of, 144
Children, rearing of, 364
Colitis, ulcerative appendicostomy, 502
Disease, Malignant non-operative treatment, 417
Dysmenorrhœa membranes, 227
Epithelioma, 504
Fractures, treatment of, massage and movement in, 673
Frauenkliniks, Heidelberg notes from, 9
Gastro-intestinal affections, "organic" treatment of, 8
Gonorrhœa, antistreptococcus serum, 9
Gout and common salt-containing waters, 592
Gout and ingestion of common salt-containing waters, 292
Gynæcology past and present, 225
Hæmo renal salt index, 93
Headaches, ocular, 530
Heart-beat, cause of, 674
Heat continual, new splint for, 565
Infant feeding, 173
Insanity, medico-legal definition, 564
Larnyx intubation of, 531
Life assurance, examinations for, 36
Meniere's disease and hypnotic suggestion, 336
Meningitis, cerebro-spinal, ear and eye in, 203
Meningitis cerebro-spinal, in Glasgow, 201
Opsonic index, immune serums, 648
Ovary, cancer of, 334
Ovariotomy, history of, 89
Pancreatitis, chronic, 392
Peritonitis, treatment of, 175
Pneumonia, lobar prognosis, treatment, 309
Poor law medical service in Ireland, 254
Pregnancy, albuminuria and eclampsia, 589
Prostate enlarged, some points in, 282
Pruritus (a), some aspects of, 60
Psychosis, traumatic operative treatment, 419
Psychorhythm and recurrent psychoses, 252, 282
Pubiotomy, 368
Rickets, 649
School children, medical inspection of, 64
Syphilis, two cases of, simulating typhoid fever, 307
Tetania, para-thyro-puriva, 91
Therapeutic notes, 280
Tuberculosis, 366
Tuberculosis dispensaries, 145
Tuberculosis and marine climates, 390, 446, 476
Typhoid fever, value of Widal reaction in diagnosis of, 702
Ulcer, duodenal, non-malignant, treatment of, 532
Ulcer gastric, treatment of, 420
Uretha examination by electric light, 590, 616
Uterine appendages, inflammatory diseases of, 560
Uteri prolapsus abdominal colpopexy, 449
Uterus, ventro-fixation of, 116
Vagina, primary carcinoma of, 335
Young practitioner, letter to, 65

AUTHORS.

Aarons, Dr. J., dysmenorrhœa, membranous, 227
Affleck, Dr. J., Pneumonia, lolar prognosis, treatment, 309
Aramy, Dr., Ulcer, gastric treatment of, 420
Arkle, Mr., School children, medical inspection of, 64
Armstrong, Dr., Chest, exploratory puncture of, 144
Barendt, Dr., Pruritus, some aspects of, 60
Beale, Mr., C[illegible] abscess, 39
Briggs, Mr., Uterus, ventro-fixation of, 116
Brookes, Mr. Philip, Headaches, ocular, 530
Campbell, Mr. R., Anæsthesia, general, following acid intoxication, 198
Cathcart, Mr., Fractures, treatment of, massage and movement in, 673
Carpenter, Dr., Children, rearing of, 364
Carson, Mr., Peritonitis, treatment of, 175
Carter, Dr. W., Therapeutic notes, 280.
Chalmers, Dr., Meningitis, cerebro-spinal, in Glasgow, 201
Clarke, Mr., Catgut, iodised, 620
Corner, Dr., Young practitioner, letter to, 65
Cousins, Mr. W., Anæsthetics, improved gag, 391
Croft, Dr. J., Pregnancy, albuminuria and eclampsia, 589
Dally Halls, Dr., Heat continual, new splint for, 565
Donelly, Dr., Poor law medical service in Ireland, 254
Elder, Dr., Meningitis, cerebro-spinal, 172
Erdheim, Dr., Tetania, para-thyropriva, 91
Ewart, Dr. W., Tuberculosis, and marine climates, 390, 476
Fullerton, Dr., Uretha, examination by electric light, 590, 616
Gibson, Dr., Heart-beat, cause of, 674
Gibson, Dr., Pubiotomy, 368
Giles, Dr., Uterine appendages, inflammatory diseases of, 560
Gunn, Dr., Prostate, enlarged, treatment of, 282
Hollander, Dr., Psychosis, traumatic operative treatment, 419
Hutchison, Dr., Infant feeding, 173
Hyslop, Dr., Psychorhythm and recurrent psychoses, part i., 252, 282
Jacobs, Prof., Uteri prolapsus, abdominal colpopexy, 449
Jesset, Mr., Ovariotomy, history of, 89
Jessett, Mr., Ovary, cancer of, 334
MacNaughton-Jones, Dr., Frauenkliniks, Heidelberg, notes from, 9
Ker-Buchanan, Dr., Larynx intubation, 531
Kitley, Mr., Abdominal operations, conservative surgery in, 704
Latham, A., Dr., Colites, ulcerative, 502
Lloyd, Mr. W., Adenoids and nasal obstruction, 40
MacNaughten-Jones, Dr., Vagina, primary carcinoma of, 335
McWeeney, Dr., Tuberculosis, 366
Palmer, Dr. F., Ataxia, Friedreich's, 505
Parkinson, Dr. P., Gonorrhœa, antistreptococcus serum, 9
Parry, Dr., Meniere's disease and hypnotic suggestion, 336
Paton, Mr., Opsonic index, immune serums, 648
Pearson, Dr., Cæsarian section, 647
Philip, Dr., Tuberculosis dispensaries, 145
Potts, Dr., Disease, malignant, non-operative treatment, 417
Power, Mr., Ulcer duodenal, 532
Rolleston, Dr., Syphilis, two cases simulating typhoid fever, 307
Sandwith, Dr., cerebro-spinal fever, 672
Sers, Dr., Insanity, medico-legal definition, 564
Shaw, Dr., Meningitis, cerebro-spinal, 203
Shoemaker, Prof., Epithelioma, 504
Smith Shingleton, Dr., Life assurance, examinations for, 36
Spanton, Mr., Gynæcology past and present, 225
Thomson, Dr., and McDonald, Mr., Cerebro-spinal meningitis, meningococcal, 173
Turner, Dr. D., Hæmo-renal, salt index, 93
Warrington, Dr., Cerebro-spinal meningitis, 474
Weill, Prof. Gastro - intestinal, affections, organic treatment of, 8
Wheeler, Mr., Pancreatitis, chronic, 392
White, Prof., Bronchitis, infective, relation to consumption, 114
Williams, Dr., Gout and ingestion of common salt-containing waters, 292
Wilson, Dr., Typhoid fever, value of Widal Re-action in diagnosis of, 702

OUT-PATIENTS' ROOM.

CHILDREN'S HOSPITAL, PADDINGTON GREEN—
Coxa vara, 594
Nævous of forearm, 93
ROYAL FREE HOSPITAL—
Charcot's joint, 41, 650
Cyst, dentigerous, 396
Tuberculous epididymitis, 563
ROYAL EAR HOSPITAL—
Labyrinth it is, syphilitic, 676
KING'S COLLEGE HOSPITAL—
Abscess, gluteal, 204
Sinuses due to foreign bodies, 148
METROPOLITAN HOSPITAL—
Emphysema and blood tissue, 394
Heart disease, rheumatic, 66

REVIEWS OF BOOKS, AND LITERARY NOTES.

Alcohol problem, 713
Anæsthetics, 633
Anæsthetics, Hewitt on, 487
Anatomy, clinical, 22
Anatomy, human, 268
Animals, experiments on, 239
Aorta, aneurism of, 158
Artificial feeding and food disorders, 48
Bacteriology, Moor and Hewlett's, applied, 21
Body, builders of, 687
Brunton, Sir Lauder, collected papers by, 376
Cancer, a human scourge, 657
Chest, examination of, 545
Children, diseases, recent works on, 632
Children's diseases, study of, 576
Chloroform problem, 349
Clinical society's transactions, 462
Clinics, international, 658
Digestive system, diseases of, 23
Disease, war with, 432
Dorland on words, 378
Ear, nose, and pharynx, diseases of, 158
Eye, refraction of, works on, 659
Eye, Swanzy on, 376
Feeding, artificial, 48
Fleming's practice of medicine, 602
Food and digestion, Dutch on, 321
Food preservatives, 159
Forchheimer on internal diseases, 545
Freyer on enlarged prostate, 320
Frog, the, 350
Gastric and intestinal diseases, chemical investigation of, 431
Gynæcology, Philips on, 378
Gynæcology, system of, 659
Hay fever, Lloyd on, 712
Health resort, an Egyptian, 378
Hebblethwaite's notes on general practice, 350
Histology, student's manual of, 658, 686
Human anatomy, 268, 687
Human body, development of, 576
Hygiene of mind, 267
Hypnotism, Ash on, 75
Hypnotism, 689
Index catalogue
Intestines and stomach, operations on, 687
Jurisprudence, medical, Brend on 321
Latin, medical, 715
Lungs, diseases of, Lindsay on, 74
Massage and electricity, 239
Medical diagnosis, Whiting's aids to, 104
Medicine, practical series, 376
Medicine, practical, Carter on, 158
Medicine, system of, 633
Medico-legal society, 545
Mineral waters and health resorts, 713
Minor maladies, Williams on, 104
Nervous diseases, Stewart on, 159
Nurses' vade mecum, 602
Organotherapy, rational, 21
Pharmacy, year book of, 350
Phthisis, pulmonary, 659
Physics, elements of, 715
Plague, oriental, 321
Portugal, Riviera of, 378
Rectum, surgery of, 633
Rontgen rays in medical work, 517
Sanitation, practical, 576
Skin diseases, menstrual function in, 545
St. Bartholomew's hospital reports, 632
Surgery by many authors, 686
Surgery, manual of, 321
Surgery, minor, Heath's, 159
Surgery, treatise on, 545
Syphilis and small-pox, 350
Syphilology, Marshall on, 431
Therapeutic principles, Sainsbury on, 377
Treves the other side of the lantern, 376
Tropical diseases, 22
Ulcer, duodenal, treatment, 270
Unfit, elimination of, 377
United States, Surgeon-General's library index catalogue, 576
Urethrotomy, Harrison on, 320
Variation, heredity, and evolution, 575
Water examination, Savage on, 239

TRANSACTIONS OF SOCIETIES.

BRITISH GYNÆCOLOGICAL SOCIETY—
Dysmenorrhœa, membranous, 230
Kidney, mobile, 341
Meeting held, 706
Pregnancy, extra-uterine, 452
Specimens, 340
Uterine appendages, inflammatory diseases of, 566
Uteri, prolapsus, radical cure of, 452
Vagina, carcinoma of, 341
Ovary, fibroma of, 231
BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY—
Gout and rheumatism, influence of climate, 207
Gout, treatment of, 44
Tuberculosis in marine climates treatment of, 457, 397
CENTRAL MIDWIVES' BOARD—
Meetings, 261, 342, 627
Poor law institution, 343, 457
CLINICAL SOCIETY OF LONDON—
Abscess, psoas bilateral, 339
Acromegaly, case of, 122
Ataxia, acute, 480
Bacillus, anti-colon serum, 424
Bladder, prostatic knife, 122
Bones, metatarsal multiple chondromata of, 123
Bronchi, foreign bodies in, 596
Encephalitis, 480
Fat, subcutaneous disappearance of, 339
Head, enlargement of, 122
Heart block, 596
Heart disease, congenital, 122
Hernia, inguino-scrotal, 480
Hernia, lateral ventral, 479
Hernia, umbilical, 480
Hypernephroma, 537
Hypertrophy, congenital, 338
Jejunum, carcinoma of, 123
Jejunum, resection of, 229
Joints, excision of, 229
Kidney, polycystic, removal of, 339
Lower jaw and clavicle, enlargement of, 339
Lung, abscess of, 68
Myxœdema, fata case of, 68
Osteo-arthropathy, hypertrophic pulmonary, 338
Osteogenesis imperfecta, 339
Paralysis, general, 179
Paralysis, post-operative, 339
Patella, habitual dislocation of, 480
Pirogoff's amputation, 480
Psoas and iliacus muscles, acute suppuration of, 424
Pyloric congenital stenosis, treatment of, 286
Pyloric stenosis in infants, 286
Pyonephrosis, removal of stone from uterus, 122
Pyrexia, prolonged cases of, 596
Rectum, idiopathic dilation of, 179

Sacral region, meningocele in, 229
Tarsus, fracture of, 122
Tetany, 68
Thyroid, swelling, 339
Tongue, operation on, 122
Tongue, tumour of, 481
Typhoid, complicated by pericarditis, 178
Typhoid, and Widal's reaction, 539
Ulcer, gastric, gastro-enterostomy for, 537
EDINBURGH MEDICO-CHIRURGICAL SOCIETY—
Bier's method cases treated, 95
Clinical meeting, Royal hospital for children, 596
Diphtheria, laryngeal, 538
Fractures, treatment of, massage and movement in, 680
Gas and ethyl-chloride, administration of, 679
Gout, diseases regarded as, 181
Infectious diseases, notification of, 95
Kidney, hæmo-renal salt index, 95
Meningitis, cerebro-spinal, 182
Pharynx-naso, infection carrier, 680
Pneumonia, lobar, 312
Stereognostic sense, loss of, 95
Systole, extra, differentiation of varieties, 537
Tuberculosis, diagnosis of, 313
GLASGOW EASTERN MEDICAL SOCIETY—
Eczema, treatment of, 96
HARVEIAN SOCIETY OF LONDON—
Colities, ulcerative, 510
Nervous disorders in childhood, 511
Psychorhythm and recurrent psychoses, 258
Ureter, fatal extravasation of urine, 258
LARYNGOLOGICAL SOCIETY OF LONDON—
Achondroplasia, 15
Aphemia, 455
Endo-laryngeal growth, 455
Epiglottis, ulceration of, 96
Keratosis, pharyngo (mycosis), 456
Larynx, cystic disease of, 98
Larynx, fibroma of, 96
Laryngitis, tertiary syphilitic, 96
Morgagm ventricle, prolapse of, 455
Nævus, case of, 15
Nasal accessory sinuses, 96
Œdema, chronic, 15
Pachy meningitis, syphilitic, 15
Palate, circumscribed tumour of, 96
Stridor, case of, 15
Tumour, cystic laryngeal, 15
LIVERPOOL MEDICAL INSTITUTION—
Albuminuria, nucleo, 597
Cataract, extraction, 288
Chest wall, diagnosis of, 511
Cholecystitis, suppurative, 424
Cysts, benign, 424
Dysostosis, cleido-cranial, 288
Empyema, three cases of, 511
Epilepsy, focal surgical treatment of, 182
Exophthalmos, pulsating, 260
Gums, hypertrophy of, 371
Hernia, inguinal, femoral, etiology of, 125
Humerus compound fracture, 511
Izal, intra-tracheal injections of, 597
Kidney, calculus of, 598
Leukæmia, lymphatic, 44
Liverpool, housing of the working classes, 260
Lung, syphilis of, 182
Malaria, 288
Media, otitus, suppurative, 511
Membrane, mucous, intestinal, 511
Meningitis, cerebro-spinal, notes on, 598
Muscle, pectoral, swelling of, 371
Nasal septum, resection of, 260
Neuroma, plexiform, 314
Ocular muscles, recurrent paralysis of, 288
Pathogenic infections and sera, 371
Pancreatitis, hæmorrhage, acute, 124
Ulcer, duodenal perforating, 43
Uterus, ventro-fixation of, 125
Refractometer, a new, 182
Sarcoma, renal, nephrectomy in children, 314
Temperature, normal, variations in, 314
Therapeutics, modern role of mercury in, 424
Typhoid fever and operations, 43
Warfare, surgery, 314
NORTH OF ENGLAND GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY—
Cæsarean section, 15
Cervix, cancer of, 15, 96
Clitoris, sacroma of, 483
Fibromatoma, 15
Kidney, hypernephroma of, 96
Mole, tubal, 597
Ovarian fibroma, operation for, 15
Polypus, fibroid, 96
Pregnancy, abdominal, 15
Pregnancy, albuminuria and eclampsia of, 597
Tumour, cystic, 483
Tumour, ovarian, 483
Urethra, carcinoma of, 597
Uterus, fibroid removed, 483
OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM—
Conjunctiva, streptococcic infection of, 149
Cysts of pars ciliaris retinæ, 314
Eyeball, tubercle filling the, 149
Eye, foreign body in, 205
Irritation, sympathetic, 314
Meeting held, 653, 680
Paralysis of vertical movements, 205
Polychoria, 205
Sinus cavernous, thrombosis of, 313
Stereoscopic vision, Mr. Brooksbank James, 150
Tubercle, filling eye-ball, 149
Tuberculosis in eye, 206
ROYAL ACADEMY OF MEDICINE IN IRELAND—
Addison's disease, 455
Air sinuses, anatomy of, 569
Appendages, contribution to technique of, 232
Bier's method in gynæcology, 481
Calculus, vesical, 43
Cerebellum, abscess of, 395
Cerebro-spinal meningitis, organisms from, 287
Chorea, maniacal, 340
Colic, pseudo renal, 455
Cyst, cerebellar, positive, 651
Cyst, ovarian, 43
Duodenalis, uncinaria, from West Indies, 123
Forceps, a vulsellum, 481
Head, dissected, 569
Heart, traumatic rupture of, 124
Hydrothorax, suffocative, 123
Knee-joint, tubercular, 396
Leukæmia, spleno-medullary, 651
Liver, cirrhosis of, and carcinoma, 287
Lung, lympho-sarcoma of, 652
Lymphatism, cerebro-spinal fever 455
Lymphatism, 287
Meningitis, cerebro-spinal, 396
Nerves, sacral, 570
Nervous disease, 652
Nervous symptoms, unusual, 455
Ossea, leontiasis, 150
Plane, long median, two subjects cut in, 206
Poor law, Viceregal commission on, 258
Prostate, enlarged, treatment of, 150
Pubiotomy, 370
Rotunda Hospital, 482, 678
Sarcoma of femur, 396
Sinusitis, frontal, 313
Spleen, movable, case of, 340
Syphilis and the state, 509
Tumour, fibroid, 43
Tumour, sacra-coccygeal teratoid, 396
Tuberculosis treated by tuberculin, 652
Tuberculosis, urinary, 286
Ulcer, gastric, 180
Urine, estimation of urea in, 206
Uteri cervix, lateral fixation of, 569
Uterine dilator, a new, 482
Ureters, double, 570
Uterine prolapse, 42
Uterus, cancer of cervix, 42
Uterus, and cancer in cervix, 370
Uterus, carcinoma, of body, 370
Villa, musculature of, 206
Wrist bones, 570
SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN—
Abscess, cerebral, 233
Achillis, tendo, contraction of, 708
Addison's disease, 482
Ataxy, cerebellar congenital, 124
Bones, multiple fractures of, 538
Buthalmus, case of, 233
Cordis morbus, 538
Cerebro-spinal meningitis, 708
Cretinism, case of, 233
Development, premature, 129
Dexiocardia and valvular disease, 538
Diabetes, insipidus, 124
Exostoses, multiple, 538
Fever, glandular, 482
Fœtus, syren, 482
Friedreich's disease, case of, 124
Gland, mesenteric, 124
Hæmorrhagic papulatum erythema, 482
Hernia, inguinal, 233
Infantilism, 233
Knee joint, 233
Lupus multiple, valgaris, 342
Lymphangeioma, case of, 233
Monoplegia, 538
Œdema, in an infant, 124
Paralysis, Erb's, of the left arm, 538
Penis, webbed, 124
Rheumatism, acute, in childhood, 707
Rheumatic children, protection of, 124
Rickets, 14
Spinal caries, 358
Stomach, dilatation of, 124
Testis, tuberculosis of, 342
Tumour, abdominal, 342
Tumour, central, 342
Tumour, cerebral, 233, 538
Von Recklinghausen's disease, 482
THERAPEUTICAL SOCIETY—
Arterial pressure, super-normal, 456
Gonorrhœa, serum treatment in, 15
Iris, neoplasm, 69
Pneumonia, treatment with opium, 398
Tuberculous diseases, anti-diphtheritic serum in, 16
ULSTER MEDICAL SOCIETY—
Acid intoxication, 69
Amaurosis, case of, 69
Conjunctivitis, purulent, 69
Dupuytren's contraction of hand, 69
Glioma, double, 69
Meningitis, cerebro-spinal, discussion on, 208
Meningitis, cerebro-spinal, and pregnancy, 398
Meningococcus, 489
Opsonic index, diagnostic value of, 483
Ovary, cystoma of, 483
Ptosis unilateral, case of, 69
Stenosis, aortic, 397
WEST LONDON MEDICO-CHIRURGICAL SOCIETY—
Breast, carcinoma of, 425
Epithelioma, 69
Foot, traumatic flat, 425
Hip, congenital dislocation, of 69
Nasal obstruction, 538
Neck, tumour of, 425
Nose, epithelioma of, 425
Nose, lupus of, 425
Paralysis, laryngeal, 425
Rashes, hæmorrhagic, 538
Sclerosis, disseminated, 425
X-ray work, some aspects of, 681

WEEKLY SUMMARY OF MEDICAL LITERATURE.

ENGLISH AND FOREIGN.

Abdomen, trauma of, 270
Acetone, ring test for, 25
Adams-Stokes disease, 135
Adnexæ, inflammatory diseases of, 635
Adrenalin injection, effects of 106
Anæmia, pernicious in blood, 322
Anti-typhoid inoculation in army, 577
Appendicitis, acute, when to operate in, 718
Appendicitis, streptococcic, 161
Aristochin, 135
Arterio-sclerosis, experimental, 105
Arthritis, rheumatoid, 661
Asthma, the blood in, 547
Asthma, treatment of, 242
Athletes, functional albuminuria 323
Atmospheric lessened mechanical, effects of, 351
Atresia, vaginæ in a married woman, 188
Aural discharges, chronic, 50
Bacillus tubercle, infection of man with, 242
Barberio's spermin, reaction 243
Benzidin test and minute hæmorrhage, 578
Bier's treatment by hyperæmia, 660
Blindness, word, congenital, 50
Blood of normal, young adults, 213
Blood vessels, 660
Bronchiectasis, treatment of, 24
Bronchiectasis, surgical aspects of, 271
Cæsarean section, prolapse of cord, 187
Cammidge's pancreatic reaction in urine, 213
Cancers, cutaneous, errors in treatment of, 161
Cancer, immunity toward, 546
Cancer, rarity in Central Africa, 105
Carbon monoxide poisoning, 214
Carcinoma in animals, 660
Carcinoma of breast, 490
Carcinoma cervicis uteri, types of, 213
Carcinoma, gastric, Salomon's test, 213
Cardiac anomaly, 547
Children, rheumatic, protection of, 577
Cholera, diagnosis of, 546
Chorea during pregnancy, 40
Chloride sodium, elimination of, 689
Choriodal hæmorrhage, 381
Chorio-epithelioma, malignum, classical case, 77
Chyle, human, 214
Colles fractures, new method of reducing, 718
Colon, rupture of, 490
Colostomy, practical points in, 160
Cornea cervical, 271
Corpora lutea, cysts of, 296
Cyst, chylous, of thoracic duct, 718
Death, apparent, sudden, heart massage in, 135
Diabetes, insipidus nature of, 464
Diabetes, arsenic in, 25
Diabetics and alcohol, 24
Diaphragm, rudimentary eventration of, 351
Diaphragmatic reflex, the, 463
Diet, effect of salt in, 691
Diseases, malignant, infectivity of, 105
Dropsy, chylous, 134
Dulness behind left clavicle, 351
Dysentery, chronic, surgical treatment, 271
Eclampsia, a contribution to the question of, 406
Eclampsia, forty cases of, 188
Ehrlich's diazo-reaction in phthisis, 106
Emphysema and heart disease, epigastric pain in, 135
Empyema, total resection of thorax for, 270
Enterostomy, gastro, combined with gastrostomy, 380
Enucleation, under local anæsthesia, 491
Epileptics, blood serum in, 134
Epilepsy, new researches, 351
Epilepsy, and poor food in nitrogen, 242
Episiotomy, 187
Facial spasm, injection of alcohol in, 160
Ferments for disinfection of intestines, 464
Fever undulant in South Africa, 106
Fistula, urinary, 718
Fractures, operative treatment of 717
Gangrene, carbolic acid, 690
Gastric ulceration, diagnosis of, 213
Gastroscopy, 491
Glaucoma, primary, 719
Goitre, exophthalmic, 381
Gonorrhœa, 690

Gonorrhœa, irrigation treatment, 577
Grafting, ovarian, 661
Hæmophilia, 25
Hæmorrhoids and carbolised glycerine, 604
Heart-block, 690
Heart in acute infections, 25
Heart, position of, in pericardial effusions, 106
Hernia, strangulated, 295, 297
Hodgkin's disease, pyrexia in, 381
Hydrophobia, case of, 719
Hyperæmia, passive treatment of disease by, 578
Hyperchlorhydria, treatment for, 25
Insanity, hysterical, 578
Intestine diverticula, internal, 323
Intestine, paralysis of, 634
Intestinal wall, pseudo-carcinomatous infiltration of, 635
Iris, cysticercus of, 719
Jaundice, 381
Jaundice, blood in, 351
Joints, diseases of, present views on, 49
Kidney, tuberculosis of, 322
Knee, excision of, fixation of, bones in, 270
Labour, scopolamine and morphia during, 76
Langerhan's islands, adenoma of, 660
Leiomyomata, multiple of skin, 243
Leucocytes, proteolytic ferment of, 106
Leukæmia, mast cells in, 25
Lime salts, effect of, in pancreatic digestion, 105
Liver, cirrhosis of pancreas in, 106
Liver, iron-content of, 689
Liver and pyloric obstruction, supplementary lobe of, 49
Lupus vulgaris, treatment of, 243
Lutein tissue, pathology of, 188
Lymphocytosis, experimental, 214
Massage air, 242
Measles, necrosis of maxillary bones after, 547
Membranes, retention of, 188
Memory, loss of, 352
Meningitis, cerebro-spinal, communicability of, 578
Meningitis, cerebro-spinal epidemic, 242
Meningococci, 322
Mesosigmoiditis and gynæcological affections, 634
Metritis, chronic, pathology of, 187
661
Morphinism, chronic treatment of, 577
Myomata, uterine, treatment of, 187
Myometrium, diffuse adenoma of, 635
Myopia, high extraction of, 381
Myxœdema, following bullet wound, 352
Narcolepsy, 25
Nephritis, treatment of, 242
Nephritis, salt-free diet in, 464
Nerve, median, primary nature of, 604
Neuralgia, trigeminal, radical cure of, 380
Neuritis, multiple, simulating muscular atrophy, 464
Neuritis, peripheral, 463
Neuritis, retro-bulbar, in influenza, 271
Neuronal as hypnotic, 463
Nitro-prusside reaction, a new, 322
Nuclein, role of, in the animal economy, 134
Nucleus functions of, 214
Omentum isolated for plastic operations, 50
Ophthalmia ante-partum, 160
Opsonics, recent contributions on, 546
Osteitis, tuberculous simulating sarcoma, 547
Ovaries, prolapsed, 76
Palate, cleft, 717
Pancreas, cirrhosis of, 134
Pancreas, the, and food, 352
Pancreas, subcutaneous injury to, 717
Pancreatitis, acute, 547, 689
Paralysis of abducent nerve, 243
Paralysis agitans, parathyroid glandules, 351
Paralysis agitans, pathology of, 243
Parathyroids, physiology of, 661
Paratyphoid fever, 214
Patella, congenital dislocation of, 161
Pericolic inflammation, 577
Perineum and intercutaneous stitch, 76
Peritoneal cavity, absorption from, 546
Phlebitis, post-operative treatment of, 634
Pleural effusion, paravertebral triangle of dulness in, 134
Pleurisy effusions, 589
Pneumonia lobar, 464
Pneumonia unresolved, X-rays in, 352
Poliomyelitis, anterior, acute epidemic of, 464
Polycythæmia, splenomegalic, 660
Pregnancy, extra-uterine, ruptured, 406
Pregnancy in patients with one kidney, 407
Pregnancy prolonged, induction of labour in, 634
Prolapsus ani, operation for, 50
Pubiotomy in private houses, 635
Pubiotomy, its relative indications, 76
Puerp. mor., disinfection of vagina, 295
Pus tubes in the male, 604
Pyelitis pregnancy, 295
Pyelonephritis, 50
Rectum, cancer of, 381
Renal hæmaturia, obscure, 463
Rheumatic fever, bacteriology of, 105
Rheumatoid arthritis, diseases hitherto grouped together, 134
Scabies and balsam of Peru, 134
Scarlatinal nephritis,prophylaxis of, 242
Scurvy, infantile, diagnosis of, 57
Serum, antitetanic, 490
Sinuses, abdominal, 295
Sleep, reflexes during, 352
Sleeping sickness, diagnosis of, 547
Spinal analgesia, report on, 380
Spinal cord and reflexes, 578
Spine, fracture dislocation of, 491
Spinal cord and sensory impressions in, 322
Sprains, treatment of, 49
Sterilisation, artificial, of women, experiments, 635
Stomach, acute dilation of, 604
Stomach, malignant disease, surgical treatment, 50
Sunstroke, treatment of, 24
Syphilis, congenital spirochæte in, 323
Tabes dorsalis, usual form of, 463
Talipes vagus and paralytic talipes, 160
Tendon suture, technique of, 490
Testes, tortion of, 718
Thoracentesis, accidents following, 24
Thymus, the, and reproductive organs, 351
Tonsil as a defence, 323
Trichina, spiralis, lesions due, 323
Trypsin in cancer, 463
Trunks, large venous, surgery of, 161
Tuberculosis, pulmonary, agglutination in, 106
Tuberculosis, toxins of tubercle, bacilli, 578
Twins, premature birth of, 407
Typhoid bacillus, 661
Typhoid, myositis in, 135
Typhoid, Phillippovich's phenomenon in, 135
Urachus, anomaly of intestinal obstruction due to, 718
Uric acid, diurnal variations, 214
Urinary analysis, operative cases, 270
Urinary sediment, a hitherto undescribed, 213
Urine, retention in the new-born, 604
Uteri cervix, forcible dilation of, 406
Uteri, gravid, and laparotomy, 406
Uterine segment, lower, 77
Utero, sacral, ligaments contraction and shortening, 76
Uterus, intra-peritoneal implantation of, into colon, 160
Uterus fibroids, degenerations of 105
Uterus, movements of, 105
Uterus, ovarian influence upon, 322
Uterus prolapse, vaginal hysterectomy for, 77
Uterus, villous tumour of, 407
Vagina, tumour of, 661
Vagitus uterinus, case of, 406
X-rays on chronic bronchial affections, 24
Xiphopagus, separation of, 409

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NOTES AND COMMENTS.

Anthrax Report.

THE first annual report of the Anthrax Investigation Board for Bradford has lately been issued. The Board, it may be remembered, consists of representatives of the employers and workpeople engaged in wool-combing, spinning, and manufacturing hair, wool, and alpaca, and, aided by Dr. Eurich as bacteriological expert, they have already arrived at some important conclusions as to infection of workers. During the first year of their existence seventeen cases of anthrax were reported to them, but four of these were doubtful. Out of the thirteen undoubted cases, seven—all persons over forty years of age—were fatal, and six—all persons under thirty-three—ended in recovery. Of the former, all the patients but one were affected by internal anthrax, while the latter all had the disease in external form. All the patients, except the abnormal one mentioned, contracted the disease during the preliminary operations of handling the materials, principally before they had been washed. The most dangerous materials were Persian wool, camel hair, and some kinds of mohair, but the exact varieties which are liable to cause infection has not yet been determined. The majority of the cases occurred among people working for "commission combers," members of the trade who deal with the lowest and least easily worked materials, and many more cases occurred on some "commission combers'" premises than on others'. The Board recommend that certain dangerous kinds of work shall be scheduled, and only combed under the supervision of a government inspector.

Midwives Beware.

THE ways of the book-canvasser are sometimes dark, not infrequently circuitous, and always insinuating, so that it behoves his hosts to scan both him and his goods carefully before "parting." When he has landed his victim with some book which is not wanted, he is exceedingly difficult to catch. An adventurer of this type lately beguiled the police force of a large town into buying an expensive series of books which turned out very differently from what was represented, and though he was vigorously assailed by the law, he escaped scathless. The police are doubtless bigger victims than the humble midwife, but an enterprising gentleman who was tried last week for unloading "The Family Physician" on the midwives of Lancashire on the pretence that it was necessary for them to use it, was found guilty by a jury. The price of this stupendous work was £1 17s. 6d., and it contained only ten pages on the duties of midwives and seven on the management of young children, so that the women who were stupid enough to be taken in by the prisoner did not get much for their money to help them in their work. That is to say, the midwives who are content to remain midwives and do not aim at becoming family physicians. But the latter type is not yet registered off the face of the earth.

Education Committees and Certificates.

THE same want of proper appreciation of the value of medical work is shown in nearly all districts by education committees. These bodies require very properly that a child who is absent from school shall furnish a medical certificate, or be treated as a truant. But in the case of the poor who are unable to pay for a certificate, the committees grant no facilities. It is expected that medical men out of their charity shall furnish what is really their stock-in-trade, namely their opinion, for nothing. On this point a firm stand should be taken. Magistrates who are confronted with a batch of summonses for absence from school cannot convict, if the parents plead the children's illness, and equally they cannot receive this pet excuse unconfirmed. Mr. Harold Wright, the stipendiary for the Potteries District, last month spoke very strongly on the subject, and finally instructed the attendance officer to bring the matter before the County Education Committee. Medical men will be only too glad to give their opinion—when it is adequately paid for.

Another Doctor's Dilemma.

CAN a medical man betray to himself a patient's confidence? This may sound like a conundrum, but it was a practical question which recently stood the test of an action in the Newcastle County Court. A medical practitioner had a chauffeur who was taken ill, and subsequently admitted to the infirmary under his care. On examination the man was found to be the subject of aortic disease, and therefore manifestly unfit to drive a motor-car. The doctor accordingly discharged him on his return from the infirmary, paying him a fortnight's wages. The chauffeur was dissatisfied, and sued him in the County Court, as it turned out unsuccessfully. The interesting medico-legal point is that the doctor, being at once medical attendant and employer, in the former capacity came into possession of confidential information which affected him in the latter. Naturally had he been two persons instead of one, he could not have communicated the facts to the other party, but being a single individual, and human enough not to wish to have his neck broken, he did not retain the chauffeur. Which certainly was the commonsense course, and curiously, therefore, the one endorsed by the Court.

A Happy New Year.

IT is without affectation that THE MEDICAL PRESS AND CIRCULAR can wish its readers a Happy New Year, for while the relationship between itself and many of its subscribers is of the kind that age cannot stale nor custom wither, each year brings it many new and welcome friends, who generously recognise the part it plays in the fields of medical science and medical politics. The change that has been taking place in development of medical knowledge during the last quarter of a century is no more striking than that which has attended the conditions of medical practice, and it is appreciated by all those who are in the position to form a judgment that the lot of the medical practitioner becomes harder every year. The reasons for this state of things are to be found partly in intrinsic and partly in extrinsic circumstances; but the fact which stands out prominently is that it is only by taking up the cudgels himself and entering actively into the contest that the medical man can hope to obtain adequate recognition for his services. The fight is a righteous one, and we believe that the real happiness of 1907 will be found more in the joy of combat than in the partaking of *otium cum* (or *sine*) *dignitate*.

Social Evolution.

IT is now nearly a century since the real struggle between class and class began to show itself in this country, the struggle whose earliest fruits were garnered in with the first Reform Bill, and from a simple conflict between the old territorial magnates and the proletariat, this struggle has gone gradually on till every class in the community has become involved. The great middle-classes which supplied the brains and the energy of the country could not stand aside long, and now almost every section of society, from the House of Lords to the Bricklayers' Union, is fighting to justify the existence of its members. Medical men, who are primarily engaged in the service of humanity and secondarily in the study of the phenomena of health and disease, stood aside from politics as long as they could, but the pressure of events and the gradual process of "squeeze" to which they are subjected has made them feel that there are limits to human endurance. For their own self-respect and the sake of those dependent on them, they know they must struggle against inadequate pay, unfair competition, and ruthless sweating.

Medical Men and Free Calls.

THE practitioners in poor districts, for example, are regarded as fair game for any unscrupulous "bilker" who likes to prey on their generosity, and the newspapers are mostly only too glad to aid any outcry against them. Last week a leading London daily reports with sensational headlines a message from its Birmingham correspondent to the effect that on Christmas morning a poor woman whose husband was taken ill, called on seven doctors, each of whom refused to attend without his fee. It is grossly unfair that such an unconfirmed story should be published in a way to excite prejudice against the profession of medicine. The *Daily News*, the paper in question, does not give a single copy of its issue away without getting its halfpenny, and if a newsvendor had persistently swindled it and its contemporaries, it would refuse to trust him, even if he were ill or starving. In the case under notice, we have no particulars as to the character of the individual, but medical men all know the patient that goes the round of the doctors in a town, and pays none of them. If this man were of that class, the practitioners in question were perfectly justified in referring his wife to the Poor-law medical officer, and, as a matter of fact, there was no difficulty about his treatment, as he was removed to the hospital. But there is a type of paper and a type of individual who find no weapon too much envenomed to use against a medical man.

The Devil and the Deep Sea.

IF there is not venom there is often the most crass stupidity in the way that public bodies treat medical practitioners, and of such a charming instance was given last month by the Llanfrechfa Urban District Council. It appears that Dr. A. W. Hoyles of that district was attending an obscure case of illness which eventually turned out to be one of typhoid. When the diagnosis was established to his satisfaction, he notified the case in due course, but the wiseacres of the Council took it upon themselves to write complaining that he had not notified it earlier. Dr. Hoyles replied, very appropriately, that any ignorant busybody could be wise after the event, and that he had notified the case at the earliest moment he could. On a previous occasion his assistant had notified an infectious case, and because the diagnosis was not confirmed bacteriologically, the Council refused to pay the fee. He felt himself between the devil and the deep sea. A clergyman on the Council is reported to have characterised the letter as "an insult," and he finally proposed and carried a motion that Dr. Hoyles was expected to carry out his duty. A more glaring case of barbarous want of logic it would be difficult to find. The Council acted absolutely illegally in refusing the fee to Dr. Hoyles' assistant, and now they complain when he tries to save their face in a similar case! The Council might well study their own duties under the Act a little more carefully.

LEADING ARTICLE.

THE ANNUS MEDICUS 1906.

THE year that has recently come to a close naturally suggests some sort of a retrospect from the point of view of our medical readers. The researches of modern scientific medicine are so widespread and the energy of investigators so unparalleled, that marked progress can be recorded from all parts of the line. Every now and then the medical world is spurred on to greater effort by the discovery of some fresh fact, such as that of the tubercle bacillus, or of some hitherto unknown force, such as that of the Röntgen rays. On rarer occasions comes the general law enunciated by a Harvey or a Lister. During the past year no very striking discovery has been made. At the same time, it is impossible to say what epoch-making observation may not have been recorded in the vast flood of medical literature that is daily put forth in all quarters of the civilised world. The demonstration of the curative influence of the Röntgen rays in various leuchæmic conditions, for instance, may one day prove the key to a therapeutic advance of first-rate importance. Heart surgery, again, has been the object of gratifying advances; so much so that the surgical treatment of diseased valves might conceivably be brought to some extent within the range of the surgeon's art. An interesting point in anæsthetics has been the increased attention devoted to spinal anæsthesia induced by the injection of stovaine and other drugs into the vertebral canal. Serious operations can in this way be performed painlessly, and there are obvious advantages in the avoidance of so-called "shock" and subsequent vomiting. At the moment it should be carefully noted that a certain percentage of deaths have occurred under this method even in the most experienced hands. Clearly, the last word in surgical anæsthesia has not yet come to us in the shape of spinal anæsthesia. It would be out of the question here to attempt anything like a comprehensive review of the scientific advances of the year 1906. Some of its most interesting work has been performed in the study of tropical diseases, a field that has furnished the inspiration, as in some instances it has unhappily proved the grave, of some of the best men in the profession. The past twelve months has added greatly to our knowledge of the pathology and treatment, chiefly preventive, of that scourge of the tropics known as sleeping sickness. Nothing of great importance has been achieved in the war against tuberculosis. A significant fact, however, is the onslaught that has been made in some quarters on the policy of building palaces for the reception of tubercular patients. The vast cost of such institutions limits to a disastrous extent the number of poor patients that can be taken in. It seems likely that in future the sanatorium building will be of a simple and inexpensive nature. So far as the highly ingenious "opsonic index" of Sir A. Wright is concerned in gauging the extent of the disease and the progress of the individual under medical treatment, the past year cannot be said to have placed his method on any securer footing as a practical aid to the physician. This negative fact is noteworthy in view of the costly, tedious, and highly technical nature of the method. The interest in the excessive child mortality that forms so serious a blot on modern public health administration has been sustained during the past year. The original experiment of the Mayor of Huddersfield, who effected a great saving of infant life by offering a premium upon the babies born during his year of office, provided they survived twelve months, has furnished an important object lesson as to the ease with which a vast deal of this lamentable waste of life can be prevented. This example has been already followed in various parts of the United Kingdom. A great deal of mortality amongst infants is directly due to the use of patent medicines, such as teething powders and soothing syrups. It is clearly within the power of Government by legislation immediately to strike out that particular part of the causation. In the case of babies, as of grown-up persons, the indiscriminate use of remedies, often potent and poisonous, undoubtedly leads to a vast amount of injury to health and loss of life. In spite of many years of remonstrance on the part of the medical profession, the game goes merrily on, and is even sanctioned by the Government in the shape of a paltry patent medicine stamp. The sale of worthless nostrums under the ægis of official sanction not only inflicts a terrible and incessant injury upon the King's subjects, but also trenches upon the field of legitimate medical practice. On these grounds, during the past year the MEDICAL PRESS AND CIRCULAR has conducted a vigorous campaign against the patent medicine trade and against the journals that insert their lying and fraudulent advertisements. We are glad to see that the Treasury has at length come to realise its responsibilities in the matter, and has secured the conviction of notorious electrical and other quacks in various parts of the Kingdom. Were the Treasury to accept the logical consequence and prosecute newspapers who publish the obviously lying advertisement whereby these vampires of society secure their victims, then the trade would receive its quietus within a short space of time. In other directions there are signs that medical men generally are waking up to the necessity of self-protection. They have brought pressure to bear upon the lay managers of medical charities, and a conference of delegates was held in London last December to consider the question of hospital abuse. The attempt to thrust a number of cut-and-dried resolutions down the throats of the conference was resented by the delegates, and the matter was left for a second annual meeting to consider. The incident shows that determined wire-pulling is still a danger ahead in medical politics. Among other things the meeting was asked to give its unqualified approval to the pay system in hospitals, and generally to disapprove of small and special hospitals. Sir Henry Burdett, who moved the resolution, is notoriously in favour of both those views. It is high time, however, that medical men learned to think and act for themselves, apart from professional philanthropists and presidents of medical corporations. The General Medical Council has not taken any very important action during 1906. The recent election of Direct Representatives resulted in the unseating of three old and tried members of the Council. We cannot do more than mention army medical reform, medical inspection of schools, and the inclusion of many industrial diseases within the Employers' Liability Act, each pregnant with possibilities so far as the profession is concerned. With respect to the changes in the form of the MEDICAL PRESS AND CIRCULAR, we have solid reason to know that they have secured the approval of a large and increasing circle of readers, especially with regard to the foreign clinical lectures, some of which have come from the most distinguished medical authorities in Europe.

CURRENT TOPICS.

A Journal for Tuberculosis.

It is with great pleasure that we welcome a new contemporary, the *British Journal of Tuberculosis*, the first number of which has just appeared. The growing interest which the subject of tuberculosis has aroused of late years among medical men and the public is a phenomenon pregnant with possibilities for the future, and vast increase in pathological and clinical knowledge concerning the disease has made the publication of a special journal devoted to its consideration not only a desideratum but an absolute necessity. Such a journal, however, needs careful editorial handling and strong medical support if it is to be what it should aim at being, a trustworthy source of scientific information on tuberculosis, and not a mere *rechauffé* of work given elsewhere. The *British Journal of Tuberculosis* is under the capable editorial control of Dr. T. N. Kelynack, and if he succeeds in keeping his other numbers up to the standard of the one that lies before us, a long and useful career is assured. Besides the usual editorial matter, this number contains two capital articles, "A Retrospect," by Professor Clifford Allbutt, written in his happiest strain, and "An Anticipation," by Dr. R. W. Phillip, of Edinburgh, whose motto is *L'Avénir est aux Audacieux.* These are succeeded by contributions by Sir Richard Douglas-Powell, Dr. Byrom Bramwell, and Sir John Moore, discussing the Care and Control of the Consumptive Poor in England, Scotland, and Ireland respectively. Four original papers on various questions connected with tuberculosis follow, the authors of which are Sir Lauder Brunton, Sir Hermann Weber, Sir Samuel Wilks, and Dr. Francis Hare. Needless to say, they are all worth study. Illustrated descriptions of three typical sanatoriums—the King Edward VII., the Brompton, and the East Anglian — are given, as well as some account of various health stations for the tuberculous. Finally, a long list of books on tuberculosis and cognate subjects is reviewed, and careful notices of special appliances and preparations for the consumptive are supplied. The journal is well got-up and beautifully printed on really good paper by the publishers, Messrs. Baillière, Tindall and Cox. As it is to appear quarterly, and the subscription is only five shillings, no doubt the *British Journal of Tuberculosis* will soon have a large *clientèle* of admirers and supporters.

Army Medical Changes.

There have been many grumblers of late as to the promotion, and passing over for promotion, of the more highly-placed officers of the Royal Army Medical Corps. This, perhaps, was only to be expected in a service that had been reconstituted under a new head, but we are not in a position to say how far such complaints are substantial or not. However, still further changes have now been introduced into the corps organisation, and we hope they will work to the satisfaction of all. In the first place, the Army Hospital and Sanitary Committee, whose existence was obviously superfluous, has been done away with, and its functions will now be assumed by the Advisory Board. This Board has been reorganised also, and will consist of the Director-General, as chairman, the Deputy-Director-General, a civilian sanitary expert, a civilian physician, a civilian surgeon, a civilian physiologist—a rather odd choice—a military expert in tropical diseases, a Royal Engineer, and the President of the Indian Medical Board. The Board, thus manned, will advise on all medical questions affecting the soldier, upon questions of hygiene, training, clothing, and so on, upon hospital organisation, upon matters affecting the examination and admission of candidates to the service, and upon the education of officers. The promotion of officers is to be recommended by the Director-General and the Surgeon-Generals serving at home to the Selection Board, and an Inspector-General of Hospitals and Sanitation is to be appointed on the staff of the Inspector-General of the Forces. The effect of these changes, if carried out in the spirit that has dictated them, will be widespread and profound, and at present we can only say that we welcome them heartily.

Meat Essence Dangers.

People who favour tinned meat essences for the sick will do well to read the report just presented to the Local Government Board by Dr. G. S. Buchanan and Dr. S. B. Schryver. Information was laid before the Board by certain British manufacturers of tinned meat essences that consignments of their goods which were being returned to this country after the South African War, were in an unsatisfactory state. Some thousands of tins were therefore seized at Southampton by the medical officer of health, and examined by Dr. Buchanan. The contents were found, in many instances, to have undergone certain changes, the chief of which were that the jelly had become fluid, and that this fluid was turbid and dirty yellow in colour. Analysis showed that these changes were due to the action of the meat essence on the metal of the receptacle, which resulted in a certain amount of the tin being dissolved and later precipitated, either as a double salt of a meat base or as a metallic salt of an organic acid. In one case the quantity of tin discovered was as high as 21.87 grains to the pound, though the average was only between one and a half and two grains per pound. It is said that the manufacturers, for commercial reasons, do not in the ordinary way issue more than small quantities of their essences at a time, and that the chance of a purchaser getting an old tin is practically *nil*, but at the same time it will be advisable to notice if the contents of such tins are ever fluid, and, if so, to discard them. Perhaps the manufacturers will see their way to providing glass or other innocuous receptacles in the future.

The Survival of the Unfit.

It is a curious reflection that our advancing civilisation tends to secure the survival of the unfit rather than of the fit. The utmost care, for instance, is expended over the nurture and the tending of degenerates and of cripples, while whole armies of able-bodied men, women, and children are permitted to pass their lives in a state of semi-starvation and squalor. Sooner or later it may come about that reasoning mankind will bring stern logic to bear upon the question, and will decide to protect the producer rather than the non-productive cumberer of the earth. For what rational being could seriously contend that as a sensible nation we are justified in starving the fit in order to keep alive individuals whose survival is of doubtful benefit either to themselves or to the community at large. At the same time we cannot endorse the extreme view adopted by Dr. Trotter, Medical Officer of Bedlington District Council, who has the courage to speak out his mind on the matter. "When one finds the Legislature," he recently remarked, "passing laws for the benefit and education of feeble-minded, defective children, one is inclined to wonder whether we are not a nation of fools, whether we should not benefit the nation more if we followed the custom of the ancient Spartans, and stamped such types out altogether."

Overcrowding in the Central Telegraph Office.

So much has been done in one generation to improve the conditions of labour, that one would hope that in Government employment, at least, work might be carried on under favourable circumstances. So far, however, from Government being a model employer, in certain departments of State service there is evidence of sweating and other grave abuses. A great evil was made public by question and answer in the House of Commons at the end of session. Sir John Bethell drew attention to the serious over-crowding in the telegraph school at the Central Telegraph Office, and the Postmaster-General was unable to deny the charge. It would appear, moreover, that several months ago the accommodation was reported insufficient by the medical officer, but that nevertheless no steps were, until quite recently, taken to acquire more space. It is intolerable that young men and women should be crowded together in a manner dangerous to health in a Government office, and the public has a right to insist that its employees should be fairly treated. Charges have more than once been made that phthisis is unduly incident on telegraph and post-office workers, and it is scarcely matter for wonder if such be the fact.

Infantile Mortality.

Following on the heels of the Huddersfield and other municipal experiments in baby-rearing comes the report of Mrs. Boileau on the results of her work in the capacity of visitor to the Wakefield Sanitary Aid Society. It is not surprising to find that lady echoing the words that we have over and over again uttered when discussing the prevalent excessive infantile mortality. She forcibly points out that the mortality is only a measure of the injury inflicted upon the survivors, and that for one baby that succumbs to any particular form of error there are three or four who struggle through more or less maimed for life, either as ricketty cripples, or with the beginnings of chronic lifelong disease implanted in them before they are out of their cradles. Mrs. Boileau confirms the fact that the greater part of the mortality is due to the sheer maternal ignorance. The only excuse conceivable for their error is that they have never had any opportunity before matrimony of acquiring any knowledge of the proper methods of rearing their offspring, and have had no means of gaining any information when motherhood has come upon them. Many babies are killed owing to the belief that breast milk does not in itself furnish enough nourishment. Improper foods of all kinds are commonly administered, and babies die from intestinal disturbance thus provoked—virtually poisoned. By mere diffusion of necessary information on the practical effect of baby-rearing a great reduction in the death rate has been brought about at Wakefield as at Huddersfield. These experiments suggest how vast a field for social reform lies open to private effort, and how many of the sores that afflict society of to-day, to cure which new legislation is constantly clamoured for, might be dealt with by similar means, the efficacy of which has been demonstrated in the two Yorkshire towns, which have set so good and practical an example.

PERSONAL.

H.M. the King has given £450 out of the State Apartments Fund of Windsor Castle to the building fund of the new King Edward VII. Hospital, opposite the Cavalry Barracks, Windsor.

Dr. Slater has been authorised by the Bradford Guardians to inspect the system for treating ringworm by Röntgen rays in operation at the London Hospital.

Sir John W. Byers was lately presented by his colleagues of the Royal Victoria Hospital, Belfast, with a silver rose-bowl, on the occasion of his receiving the honour of Knighthood.

Mr. and Mrs. Bischoffsheim have given the munificent donation of £40,000 to the Imperial Cancer Research Fund on the occasion of the celebration of their golden wedding. Stock for this amount has now been transferred to the trustees of the fund.

Professor Kuenen, of University College, Dundee, has been appointed to the newly-established Chair of Physical Chemistry in the University of Leyden. He is a graduate, a gold medallist, and Ph.D. of Leyden University, and worked with Professor Ramsay in University College, London.

On Friday last, Mr. O. H. Fowler, of Cirencester, who retired from active professional work at the close of the year, after over forty years' devoted labour, was presented with an illuminated address, bound in book form, with the signatures of about 350 contributors, together with a very handsome and massive silver-gilt double-handled cup, of rich workmanship, of the period of George II., the date being 1752. The ebony plinth bore the following inscription: "To Oliver Humphrey Fowler, M.R.C.S., on his retirement after forty years' practice at Cirencester, the gift of many friends, who will always gratefully remember his skill, judgment, unfailing kindness, and attention.

A CLINICAL LECTURE

ON

ARTERIAL PLETHORA AS AN EARLY SYMPTOM IN CERTAIN CASES OF CHRONIC BRIGHT'S DISEASE.

By JOSEPH O'CARROLL, M.D., F.R.C.P.,

Physician to the Richmond, Whitworth, and Hardwicke Hospitals.

GENTLEMEN,—I have constantly impressed upon you that in examining the pulse at the wrist you should take note of five things, namely, the rate, the rhythm, the size or fulness, the tension or pressure, and, lastly, the character of the arterial wall itself. The first you estimate by counting the number of beats in the minute; the second means that you look for evidence of irregularity either as to rate or volume or force in the pulse; and it sometimes takes a good deal of skill and concentration of attention to discover such irregularities, although the grosser forms are easily appreciated.

The size or fulness of the radial artery is usually taken as an index of the fulness of the peripheral arterial system as a whole; though experience, physiological and clinical, teaches us that special arterial areas may be dilated and over-full while the remainder of the system is normal or below normal in fulness. The cases I propose to show you to-day illustrate the necessity of attention to this factor in the pulse. They will be examples of the full pulse combined with high tension, a condition which contrasts strongly with the full pulse of low tension, usually met with in the early stage of the continued fevers as well as many other conditions.

Arterial tension has within the past quarter of a century assumed a position of continually increasing importance. Many instruments have been invented for its estimation; all, or almost all of them, measuring the tension in any given artery as the amount of pressure necessary to extinguish the pulse in it. In clinical work it is not always convenient to use mechanical devices for such a purpose. Their application takes a good deal of time, and the reliability of the result is by no means proportionate to the time and labour employed by the physician; for between the imperfection of the apparatus itself, the personal factor of the observer, and the frequent agitation of the patient under an unaccustomed manipulation, there is large room for error. I do not desire to under-value such instruments of precision; far from it. You have seen me use the Riva-Rocci manometer frequently; but you will have observed that I rarely attach importance to the first or even the second observation on a nervous patient. In any case, we cannot always have a blood-pressure instrument with us, but we can always have with us two or three well-trained fingers. And the well-trained finger is almost always capable of informing us whether a given radial artery is decidedly above or below the limits of normal tension. Applying the index and middle fingers of the right hand to the right radial artery of the patient, one slowly presses down the index till the middle finger ceases to preceive the pulse; the force which one is conscious of having to use for that purpose is the measure of the radial tension. Occasionally on account of a back flow through the *superficialis volæ*, or other communicating artery a pulse may be felt in the radial when the index has manifestly occluded it above. It may then be necessary to occlude the artery below with the ring finger. Then raising the index gradually till the pulse wave from above is again felt, and again pressing it down till the pulse barely disappears, one gets from the index as before an impression of the minimal pressure necessary to annihilate the pulse; and this may be taken as the arterial pressure in the patient's radial.

Finally, one gets an estimate of the condition of the arterial wall itself, whether it is thickened or hardened, by rolling the artery across the lower end of the radius under the fingers pressed tightly against that bone. This manœuvre is necessary because a thick artery or an atheromatous one may easily be mistaken for "a strong pulse," unless one realises that a good pulse by no means implies that the emptied artery itself should be perceptible at all. Unless in very thin persons, the actual tube of the radial artery should not be at all perceptible to the fingers. When it is perceptible, no matter how young the individual, the artery is either diseased or has undergone a senile degeneration. I say senile degeneration because the ordinary healthy, active man tends to get more and more perceptible arteries as he gets beyond fifty years of age. In the labouring classes the healthy individual may show hardening of the arteries long before that age; and premature hardening of the arteries may show itself also in persons who devote too much attention to athletics, especially those forms of physical exercise such as prolonged bicycle-riding which demand long continued muscular exertion. Long continued mental exertion may produce the same result, especially that nervous tension which one now and again sees in energetic and successful commercial men; or the long continued and anxious, though not often proportionally successful existence led by our own profession.

I have recapitulated these commonplaces this morning because I propose to show you two cases in which they are highly apposite. You will remark in both of them that the radial tension is above that which your experience has taught you to be normal. But you will also be struck with the very large volume of the arteries of these two cases. As it happens, both these men occupy a level in life distinctly higher than the labouring class, from which most of our hospital patients come.

Our first case, J. C. He is manager of an important wholesale and retail drug shop, where he superintends not merely the constant counter work, but a large amount of country business. This latter part of his work takes him away for about two days a week, which he spends rushing from town to town getting orders for his firm; always with the nervous tension begotten of the anxiety to do as much business as possible in each town, and at the same time not to miss the train for the next. He is 47 years of age, married, has healthy children. There is no reason to suspect syphilis, and it is denied; but, of course, one cannot positively exclude it. He takes alcohol, rarely, and in extremely moderate quantity indeed. His medical history, for much of which I can vouch personally, as I have attended him frequently before his admission to hospital, is as follows: About five years ago he began to suffer from fronto-occipital headaches. A year later he had an attack of bleeding from the nose which lasted on and off for four days. Two years ago I saw him first. He complained to me of dyspeptic symptoms, flatulence, and some tendency to constipation, of headache, and of this symptom more than any other, that any excitement, such as that due to business worries, makes him feel as if he should lose his mental control.

In appearance he was above the average height, spare, but not thin, had perhaps an excess of colour in his face, but looked on the whole a healthy enough man. The radial arteries, and, indeed, all the arteries within reach of investigation, seemed somewhat too perceptible when rolled under the fingers; but what was much more striking was their large size, in fact, their undue fulness. The tension was somewhat in excess, and the second sound at the base of the heart was accented. The cardiac area was not markedly enlarged, but the precordial movement was unduly evident. The urine was of specific gravity 1,018, and showed a faint trace of albumen, not enough to make ¼ per 1,000 in Esbach's tube; one or two doubtful casts were found.

Exactly a year later, not having seen him for some months, I found a systolic murmur at the base of the heart. The second sound was more decidedly accentuated, and it had taken on a ringing or metallic character. From that onwards he suffered more and more from paroxysms of cardiac excitement, with dyspnœa, forcible palpitations, and extreme and acute mental anxiety; and these paroxysms usually attacked him late at night, some hours after his work was finished, and about the usual hour for going to bed, or shortly after he had gone to bed. Four times I saw him in these attacks, and on three of these occasions I bled him from the arm to the amount of half a pint, producing almost immediate relief, and a quiet, restful night. About four months ago he first gave evidence of a diastolic basal murmur, and since then he has developed into a more or less commonplace case of aortic regurgitation, with concurrent chronic interstitial nephritis.

To-day you see nothing very remarkable about the case, but you will notice the unusually large throbbing arteries with the typical Corrigan's pulse; and I may inform you that since his admission a fortnight ago he has had two or three attacks of nocturnal dyspnœa. You will find all the evidence of cardiac hypertrophy; while the urine, with specific gravity varying between 1,016 and 1,012, shows about one part per thousand of albumen, and the daily output of urea is under 250 grains. One would now offer the diagnosis, and rightly, of chronic contracting kidney with aortic regurgitation. He is quick in intelligence, and in his general vital reactions; but there is no doubt that he is suffering from what I may call sub-uræmia; and the prognosis is very bad indeed.

The second case you have already seen once or twice, so I shall not go into the history at great length. He is a curate, aged 45, with a large family and small means, has led a temperate life so far as the world's luxuries go, but has come in for more than his share of its anxieties. He has had to do a great deal of work, for the most part conducting a service in one part of his parish in the morning and at a distant part in the evening. The *res angusta domi* has always weighted down his shoulders. Brought in to us a month ago, apparently in a sub-comatose apoplectic condition, it was difficult to make out any special paralysis. Both knee jerks were excessive, but Babinski's toe-extension sign was not well marked. The urine was found to contain about one per thousand of albumen. The arteries were excessively large, and throbbed with undue force; the precordial cardiac movement was excessive; the second sound was unduly loud, and I suspected at the time a faint whiff of a diastolic murmur. So urgent was the condition of the patient, and so markedly did the arterial plethora compel our attention, that at my first visit I bled him to the amount of twelve ounces, or more than one-third of a litre. There was no marked improvement, so I directed our assistant physician to bleed him again before nightfall. In the evening ten ounces of blood were removed. Next day a marked change was evident. Some consciousness had returned, he moved his limbs freely by way of making himself comfortable. Within a few days the attack had almost completely passed away. Now there is little to attract your attention except that, like the other case, he has very large, full arteries, no longer, however, of high tension; a distinct aortic regurgitant murmur, and about ¼ per thousand of albumen in the urine. He is no doubt a chronic nephritic case, and the prognosis is none too good. But he may be spared for a year or two if he can take things easily and is careful to keep down his arterial plethora as much as possible.

As I said to you earlier, I have chosen these cases to illustrate the chronic full pulse. You may fairly tell me that I am showing you two cases of chronic Bright's disease. That is true enough, but I may fairly rejoin that you are thereby merely affixing a generic label, while I prefer a more specific one. As a matter of fact, it has long been a matter of controversy as to whether chronic Bright's disease is primarily due to a vascular or a renal lesion. So far as these cases go, having in view the very early prominence of the arterial plethora, I think they suggest a vascular origin. As to the cause of the vascular mischief—the vascular hypertrophy, as it may be regarded—we can for the present hardly get further than suggesting some chronic toxic condition of the blood itself, due, no doubt, to a complex of causes, some of them external to the body and begotten of social habits and obligations, the others intrinsic and referable to faulty metabolism in the tissues, and more especially in the liver and gastro-intestinal tract. To just the same causes, no doubt, one would refer the degeneration in the kidneys where such degeneration seems to be the primary event. And these reflections bring us back to the fundamental fact that the kidneys may be regarded as a part of the circulatory system. Of the bulk of blood which leaves the left ventricle a part is delivered into the veins, a part into the lymphatics, and a part is filtered away by the kidneys. If any set of causes conspire to fill the arterial system to harmful excess, the brunt of such harm must be borne by either the heart or the arteries or the kidneys, and ultimately by all of them. Hence arise hypertrophy of the heart, hypertrophy of the arteries, and no doubt for a time if not hypertrophy at least hyperæmia, and ultimately cirrhosis of the kidneys. When one of these results anticipates the others it is probably due to some selective action of the toxins circulating in the blood, or, as I prefer to think, to some selective defence residing in the organism calculated to oppose as far as possible the circulatory toxins. In the first case I showed you there is very little doubt but that the arterial changes came first; they were gross and unmistakable for years before any cardiac or renal changes became prominent. The sequence of cardiac involvement has occurred almost under our eyes. The systolic basal murmur was at first the result not of aortic valve mischief, but of atheromatous changes in the aorta above the valves. These extended within the past few months downwards to the valves till they became calcareous or sclerosed, and ultimately unfit for that delicate apposition which prevents regurgitation from the aorta into the left ventricle. The renal mischief, decided as it is even at present, is not the most prominent or most urgent lesion; for although the excretion of urea is much below the normal, it is to be remembered that his diet has been reduced to as low nitrogenous limits as possible.

In the second case, although I am not as well acquainted with his medical history, I find circumstantial evidence in favour of the vascular origin of what is no doubt a terminal chronic Bright's disease.

I am not for an instant contending that this is the sequence of events in all cases of chronic Bright's disease; but rather for the view that the primary change is in one set of cases in the vascular system, in another group in the renal filter, and sometimes perhaps, though very rarely, in the heart. If we accept this view we shall not be committing ourselves to any too narrow conceptions; and we shall at least be interested in classifying our cases of chronic Bright into those with early marked thickening of medium-sized, or even small, arteries, and those which for a considerable period present arteries which are very large and full, which may for a long time have only intermittent high tension, and in which the parietal degeneration tends to be central, that is in the aorta, rather than peripheral, in the radial and other small arteries.

Granted this distinction, some indications for treatment arise from it. In the more common arterio-sclerotic form, without any great plethora, the treatment can be little more than dietetic, and perhaps in less measure medicinal. Under this latter head comes the use of purgatives and of the vasodilators, the nitrites especially. In the cases in which arterial plethora is characteristic dietetic measures are even more valuable than in the other form; brisk purgation is useful, but vasodilator drugs are practically valueless. In my first case they sometimes aggravated the paroxysmal distress; they never substantially relieved it. In these cases one may with safety aim at a reduction of the actual gross quantity of blood in circulation; and I am satisfied that no measure is so effective and so harmless as periodical venesection.

☛ Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Dr. Robt. Alex. Fleming, F.R.C.P., Lecturer on the Principles and Practice of Medicine in the Edinburgh Medical School, Assistant Physician to the Edinburgh Royal Infirmary, the subject being "Optic Neuritis and Its Relationship to Intercranial Tumours."*

CLINICAL LECTURES FOR 1907.

We have already been favoured by promises of Clinical Lectures from the following Hospital teachers and Post-Graduate Lecturers:—

Wm. Alexander, M.D., R.U.I., F.R.C.S., Lecturer on Clinical Medicine, University of Liverpool.
Sir C. Ball, F.R.C.S.I., Regius Professor of Surgery, Dublin University.
Sir James Barr, M.D., F.R.C.P., Lond., Physician, Royal Infirmary, Liverpool.
Arthur H. Benson, M.A., Dub., B.A., F.R.C.S.I., Surgeon, Royal Victoria Throat and Ear Hospital, Dublin.
John Bland-Sutton, F.R.C.S.,Eng.,Surgeon to the Middlesex Hospital and to the Chelsea Hospital for Women.
Sir John Byers, R.U.I., M.A., M.D., Professor of Midwifery and Diseases of Women and Children, Queen's College, Belfast.
Hy. A. Caley, M.D., Lond., F.R.C.P., Lond., Physician to and Lecturer on Materia Medica, St. Mary's Hospital and Dean of the Medical School.
Wm. Calwell, M.A., R.U.I., L.M., F.R.C.P.I., Consulting Physician Ulster Hospital for Women and Children, Belfast.
Albert Carless, M.B., Lond., F.R.C.S., Eng., Surgeon to King's College Hospital, Professor of Surgery in King's College.
Andrew Clark, D.Sc., Oxon., F.R.C.S., Eng., Surgeon to and Lecturer on Surgery at the Middlesex Hospital, Consulting Surgeon to the St.Marylebone Gen. Dispensary and the Eastbourne Convalescent Hospital
Wm. Carter, M.D., F.R.C.P., Lond., Professor of Materia Medica, University of Liverpool.
Thos. S. Clouston, Lecturer on Mental Diseases, University of Edinburgh, Physician Superintendent of the Royal Morningside Asylum.
Sir J. Halliday Croom, M.D., Ed., F.R.C.P., Cons. Gynæcologist, Royal Inf., Edinburgh; Professor of Midwifery, University of Edinburgh.
John M. Day, M.D., B.Ch., Medical Superintendant, Cork Street Fever Hospital, Dublin.
J. Debove, M.D., Doyen de l'Académie de Médecine, Paris, Physician to the Beaujour Hospital.
Patrick Dempsey, F.R.C.S.I., M.R.C.S., L.R.C.P., Lond., Visiting Surgeon for Diseases of Throat, Nose and Ear, Mater Miser. Hospital, Dublin.
Henry C. Drury, B.A., M.D., M.B., B.Ch., F.R.C.P.I., Physician to Sir P. Dun's Hospital, Dublin.
Jakob Erdheim, M.D., Professor of Clinical Medicine, University of Vienna.
Wm. Ewart, M.D., Cantab., F.R.C.P., Lond., Senior Physician to and Joint Lecturer on Medicine, St. George's Hospital.
A. Freeland Fergus, M.D., C.M., F.F.P.S., Glasg., Surgeon to the Glasgow Eye Hospital.
Robt. Alex. Fleming, M.D., F.R.C.P., Lecturer on the Principles and Practice of Medicine in the Edinburgh Medical School; Assistant Physician to the Royal Infirmary.
Geo. A. Gibson, LL.D., M.D., Ed., F.R.C.P., F.R.S.E., Examiner in the Universities of Oxford and Edinburgh, Physician to the Royal Infirmary, Edinburgh.
Michael J. Gibson, B.A., Dub., M.D., M.B., B.Ch., B.A.O., L.M., Coombe Hospital, Dublin.
Arthur E. Giles, B.Sc., Lond., M.D., F.R.C.S.E., Surgeon, Chelsea Hospital for Women, and the Tottenham Hospital.
John Glaister, M.D., F.F.P.G., Glasg., D.P.H., Camb., F.R.S., Ed. Regius Professor of Forensic Medicine and Public Health, University of Glasgow.
Thos. R. Glynn, M.D., F.R.C.P., Lond., Professor of the Principles and Practice of Medicine, University of Liverpool.
A. Pearce Gould, M.B., Lond., F.R.C.S., Surgeon, Middlesex Hospital.
J. Dundas Grant, M.D., Ed., F.R.C.S., Eng., Surgeon to the Central London Ear and Throat Hospital, and to the West-End Hospital for Nervous Diseases.
Peter Horrocks, M.D., F.R.C.P., Lond., Senior Obstetric Physician Guy's Hospital, Lecturer on Obstetrics and Diseases of Women, Guy's Hospital.
Jonathan Hutchinson, LL.D., M.D., Dub., F.R.C.S., Eng., Consulting Surgeon to the London Hospital, the Royal London Ophthalmic and Skin Hospitals.
Theo B. Hyslop., M.D., Ed., M.R.C.S., Resident Physician Superintendent of Bethlem Royal Hospital, Lecturer on Mental Diseases, St. Mary's Hospital.
H. Lewis Jones, M.D., Cantab., F.R.C.P., Lond., Phys. Electrical Department, St. Bartholomew's Hospital.
Robt. Jones., F.R.C.S., Surgeon to the Royal Liverpool Southern Hospital, the Liverpool County Hospital for Children, &c.
Charles R. B. Keetley, F.R.C.S., Eng., Senior Surgeon, West London Hospital.
Richard J. Kinkead, A.B., Dub., M.D., L.R.C.S.I., Professor of Obstetric Medicine and Lecturer on Medical Jurisprudence, Queen's College, Galway.
John S. McArdle, L.R.C.P.I. and L.M., F.R.C.S.I.,Dublin, Surgeon St. Vincents' Hospital, Dublin.
John Macintyre, M.B., C.M., F.R.M.S., Surgeon for Diseases of the Throat and Nose, Glasgow Royal Infirmary.
Edmond J. McWeeney, M.A., R.U.I., M.D., Examiner in Pathology, R.U.I., Pathologist Mater Miser. Hospital, Dublin.
Elie Metchnikoff, M.D., F.R.S., Professor at the Pasteur Institute, Paris.
Thos. K. Monro, M.D., M.Ch., F.F.P.S., Glas., Physician and Clinical Lecturer, Glasgow Royal Infirmary, Professor of Medicine in St. Mungo's College.
Alex. Morison, M.D., F.R.C.P., Lond., Physician, Gt. Northern Central Hospital.
Wm. Murrell, M.D., F.R.C.P., Lond., Physician to the Westminster Hospital.
Sir Thomas Myles, M.D., B.Ch.,Dub., F.R.C.S.I., Surgeon Richmond Hospital, Dublin.
Sir Lambert Ormsby, A.B., M.D., Dub., Surgeon, Meath Hospital.
H. Oliphant Nicholson, M.D., Aberd., F.R.C.P., Ed., Assistant Physician to the Edinburgh Maternity Hospital.
Frank Thos. Paul., F.R.C.S., Eng., Surgeon, Liverpool Royal Infirmary.
R. W. Philip, M.D., Ed., F.R.C.P., Examiner in Clinical Medicine Edinburgh University, Physician to the Royal Victoria Hospital for Consumption, &c., Senior Assistant Physician to the Edinburgh Royal Infirmary.
Fred. J. Poynton, M.D., F.R.C.P., Lond., Sub-Dean University College Hospital, Assistant Physician to University College Hospital and to the Hospital for Sick Children.
Seton S. Pringle, B.A., M.B., Dub., Surgeon Mercer's Hospital, Dublin.
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ORIGINAL PAPERS.

THE "ORGANIC" TREATMENT OF GASTRO-INTESTINAL AFFECTIONS.

By Prof. G. A. WEILL, M.D.,
Physician to the Paris Hospitals.

(*Specially reported for this journal.*)

Since the bacterial origin of so many diseases gained universal admission, one of the principal objects of medical research has been to combat the disease-producing organisms, introduced from without, which gain a footing in the body, and cause more or less serious functional disturbance. The surgeon takes every conceivable precaution to avoid pathogenic organisms when called upon to open possible doors of entry in our first line of defence, which is the skin, while the hygienist disinfects dwellings and recommends sterilisation of the food in order to ward off attacks *via* the lungs and stomach.

But apart from the bacteria from without, there are immense numbers of micro-organisms which make the human organism their *habitat* after the first few hours of life, and they live and multiply on what they find there. The most important of these organisms are certainly those which people the digestive tract. To begin with, the mouth is inhabited by a whole series, to describe which would require an article to itself. Even the stomach, in spite of the fact that it contains an acid distinctly unfavourable to their growth, has its distinctive flora. The small intestine is comparatively free from micro-organisms; but the larger intestine is the happy hunting-ground of a large number of micro-organisms belonging to the group of bacilli, as well as micrococci and spirillæ.

Notwithstanding an immense amount of research, we are not yet in a position to enumerate the varieties and distinctive features of the numerous micro-organisms that inhabit the digestive tube. They are said to be extremely prolific, the number of microbial units figuring in billions

It was some time before medical science took cognisance of this microbial population, but recent advances in bacteriology have brought them within the sphere of our attack. Physicians specially addicted to the study of disease in children were the first to investigate the microbial growths met with in the alimentary canal. The frequency of intestinal diseases in the young led them to seek for micro-organisms capable of explaining their causation. Although these researches cannot as yet be said to have yielded very tangible results, we are justified in arriving at the conclusion that intestinal microbes play an important part in our existence, and that it is incumbent upon us to take them into account.

It has been shown that, if not all, at any rate a certain proportion, of the micro-organisms inhabiting the large intestine are unquestionably pathogenic. Among them we find anærobic bacilli that set up butyric and putrefactive fermentation, with the formation of substances productive of mischief to the human organism. These researches, indeed, have given birth to the theory of auto-intoxication, due to the products of intestinal microbes, and medical science has been directed to the discovery of the means of destroying these intestinal microbes without harm to the host. But the problem presented too many difficulties ; indeed, it is well nigh insoluble, because microbes in general are much more resistant to antiseptics than are our own tissues.

Under these circumstances we have had to look elsewhere for the means of preventing the multiplication of this pathogenic flora. It has long been known that the fæces of young breast-fed infants are devoid of the usual fæcal odour, and these fæces contain but a very limited microbial flora. We know, on the other hand, that milk keeps good outside the organism much better than other albuminoid substances, such as blood, meat, eggs, &c., which become decomposed in a comparatively short space of time. Milk, instead of decomposing, curdles, although retaining an agreeable taste and smell—in fact, milk undergoes lactic acid fermentation, which protects it against the germs of putrefaction. On the strength of these observations, lactic acid has been introduced into therapeutics as a remedy for the intestinal disturbances of children and adults. The results of the treatment having proved eminently satisfactory ; attempts have been made to implant lactic germs upon the intestinal soil. These lactic germs, living among the other microbial inhabitants of the alimentary canal, secrete their characteristic products, lactic acid and others. These products hinder the development of the butyric and putrefactive germs, thus getting rid of a fertile source of disease.

Many diseases are associated with fœtid stools, due to the presence of putrefactive organisms, and we know, on the other hand, that fæcal stasis, consequent upon constipation, facilitates intestinal putrefaction, and permits the absorption of putrefactive toxins. Lactic fermentation, taking place in the very bosom of the organism, enables us to combat preventively all diseases of the intestines, vascular system, kidneys and skin due to this cause.

Pastoral peoples who breed cattle, and make extensive use of curdled milk (negroes of Central Africa, Arabs, &c.) usually enjoy excellent health and live to a ripe old age, and we are justified in attributing their longevity in part, at any rate, to the freedom from intestinal complaints associated with intestinal putrefaction.

Modern bacteriology has turned all these data to useful account, and has evolved a practical application therefrom. Instead of introducing the sour milk treatment, a method has been devised by Professor Metchnikoff for the preparation of curdled milk by the aid of specially-selected lactic ferments. Two species have been chosen in particular, one known as the Bulgarian bacillus and the other as the strepto-bacillus or paralactic bacillus.

In order to purify the intestinal canal of its ordinary microbial contents, it occurred to us to introduce pure cultures of these two micro-organisms in the form of a mixture now knownas lactobacilline. These cultures can be prepared either with milk that has been boiled, sterilised, or thoroughly pasteurised, or with infusions of malt. Dr. Teissier, of Paris, has obtained remarkable results in the treatment of intestinal diseases by the administration of pure cultures of the paralactic organism prepared in peptonised beef tea. This method of treatment has now been before the profession for several years, and has proved very efficacious in all affections dependent upon, or associated with, intestinal putrefaction and butyric fermentation.

FURTHER EXPERIENCES IN THE USE OF AN ANTISTREPTOCOCCUS SERUM IN GONORRHŒA AND OTHER INFECTIONS. (a)

By J. PORTER PARKINSON, M.D.LOND., M.R.C.P., F.R.C.S. ENG.
Physician to the North-East Hospital for Children.

THE author opened his paper by recapitulating the striking results obtained by Dr. Fenwick and himself in gonococcal septicæmia, pyæmia, and arthritis, which were published in a paper read before the Royal Medico-Chirurgical Society in April, 1906. He then alluded to the protean character of the gonorrhœal joint affections, of which Osler mentions seven varieties, and pointed out in which of these the serum was specially efficacious.

(a) Abstract of paper read at the December meeting of the Therapeutical Society.

In the *arthralgic* type there are wandering pains about the joints, with neither redness nor swelling, sometimes lasting for years, and in this the serum may produce an unexpected improvement. A gentleman, about 60, who as a young man had suffered from gonorrhœa, followed by "rheumatism," had never been quite free from pain in the knee-joints, and during the last ten years it had become so severe that he was unable to go upstairs except on his hands and knees. There was no enlargement of the joints or ends of the bones, Five or six months ago he was treated by three rectal injections of polyvalent antistreptococcus serum on alternate days, after which the pain and stiffness gradually improved, and for the last few months he has been free from pain for the first time for years, while the stiffness also gradually lessened, and has now disappeared.

He related also notes of another case of ten years duration of the same type in which the serum was equally successful. *Chronic hydrarthrosis* of gonorrhœal origin is frequently monarticular, involving a knee-joint, and often associated with a prolonged gleet or a urethral stricture. The effect of the serum is not so satisfactory in these cases.

The *bursal and synovial form*, which attacks chiefly the sheaths of the tendons, may be combined with the more serious type in which endo- and peri-carditis, pleurisy and evidence of a general infection occur. In these the effect of the serum is remarkable, as shown in the former paper. Where the disease is limited to the sheaths of the tendons and bursæ, a rapid disappearance of the pain is to be expected, though some swelling may remain for weeks.

In the *polyarthritic variety* the serum seems always to effect a rapid and permanent improvement. Further experience of the treatment in cases of acute urethral gonorrhœa have shown that it is not very efficacious, though as the former paper showed, the gonococcus is inhibited from growing in a culture to which this serum has been added, though it will flourish in a similar culture in which the antigonococcus serum is present.

The author remarked that he had recently tried the effect of the serum in cases of fibromyositis, such as lumbago and so-called muscular rheumatism, with a good proportion of cases in which the treatment was successful, some of which he related, where one injection of 20 c.c. was followed by complete cessation of the symptoms. He considered there was now little doubt of the connection of these symptoms with certain microbic diseases, of which gonorrhœa is one. These organisms or their products produce a local reaction in certain fibrous structures, with inflammatory proliferation of tissue, and hence the racking pains.

At present it is impossible to say which organism is the causal factor, and so a rational serum treatment cannot be employed, but trial has shown that a considerable proportion of these cases yield rapidly to the serum injection in the absence of any other medication.

The writer did not wish to claim for this treatment more than its due, but considered the results already obtained are sufficiently encouraging to suggest a more extended trial of the remedy.

He finally alluded to the results obtained by Dr. S. Fenwick and himself in cases of purpura hæmorrhagica, which have been previously published.

NOTES FROM THE FRAUENKLINIKS OF HEIDELBERG AND FREIBURG. (*a*)

By H. MACNAUGHTON-JONES, M.D.

(*Continued from our last issue.*)

PART II.

HEIDELBERG.

I AM greatly indebted to Professor von Rosthorn, Dr. Kermauner and Professor Schottlander, as well as to the assistants in the clinic, for the most interesting work I saw while at Heidelberg. Professor Schottländer especially I have to thank for the time given to me in the pathological laboratory, and for the specimens which, through his kindness, I am enabled to show to-night.(*b*)

Asepsis is here carried out with the same scrupulous care insisted on in all German clinics. The method is: thorough ablution with Schlinck's mercuric soap without brushes, then alcohol-mercuric sterilisation; gloves are used. Gut is the principal material employed, the skin being closed with Michel's clamps. Trendelenburg's position is adopted in nearly all gynæcological operations, notwithstanding the spinal anæsthesia, though not to an extreme degree.

Every operation I saw was performed under the influence of spinal anæsthesia. The lumbar area is prepared by thorough scrubbing, and then painted over with iodine. The puncture is made between the first and second lumbar vertebræ; the spinal fluid, when aspirated, is mixed with the novocain and re-injected. Two injections have been previously given of 0.0003 scopolamin and 0.007 (gramme) morphia. The dose of the novocain, 0.1 to 0.15 gramme. An anæsthetist always sits at the head of the patient to give chloroform if required to supplement the spinal anæsthesia. This was occasionally necessary in very long operations, the quantity given being always carefully ascertained. It is generally but a very small amount.

I saw anæsthesia maintained in this manner in two Freund's operations, in which careful search was made by Dr. Kermauner for any infected glands, in ventro-suspension, plastic operations on the vagina, and adnexal operations. The severest and longest operation was a Freund, in which a large solid carcinomatous ovarian tumour, fixed by adhesions, had to be removed from the right side of the pelvis before the uterus was taken, and finally a solid metastasis, which grew from the wall of the bladder and involved its opening, was ablated. (Vaginal iodoform gauze drainage was used in the pan-hysterectomies.)

I need not remind you of the splendid work which has emanated from the Heidelberg Klinik, and to which Dr. Karl Kehren, who is not now on the staff, has so largely contributed.

Amongst recent investigations at this clinic is that of Professor Rosthorn, *Tuberculosis in Pregnancy.* In this paper the whole bearing of pregnancy on pulmonary tuberculosis is dealt with. He shows the aggravation of tuberculosis by pregnancy, and the unfavourable influence of parturition—this whether at abortion or at full period. He deprecates induction of labour, the only time that it can do good being in the early period. Later on, expectant treatment is best. In quiescent, stationary, and well-localised cases pregnancy has not such pernicious consequences. The

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(*a*) Read at the British Gynæcological Society, on Dec. 13th, 1906.

(*b*) These included a unique complete section of a normal hypertrophied ovary; primary adeno-carcinoma of the ovary; lymph-endothelioma in a uterine polypus; carcinoma (primary) of the Fallopian tube; adeno-carcinoma of the uterus; &c. (Shown with the Epidiascope).

more serious the complication, the graver the effects of pregnancy. No set rule can be laid down for interference.

Another of Professor Rosthorn's later communications deals with his experiences in *Operating on Recurrent Uterine Cancer*. Seven operations were done by the abdominal method. The earliest case operated upon remained free from recurrence at the end of three years. Three cases are still living. One died, but this was inoperable, and only an exploratory incision was made. Owing to adhesions, difficulties of buried stitches, and deep pelvic hæmorrhage, &c., some of the operations took from two to three hours. When it was not possible to deal with the ureter it was simply ligatured, and in two cases when this was done no ill effect followed. The involved kidney atrophied.

Rosthorn's conclusions are :—(1) Even advanced cases of recurrent growth can be operated on by the abdominal route. (2) Scar recurrences preponderated over gland recurrence. (3) In scar recurrent cases the glands were found free. (4) Where the glands were involved the results were more disheartening from rapid recrudescence of the disease. (5) The important point as regards recurrences is the topographical relation of the growth and the involvement of other organs.

An interesting example of an unusual accident from a myoma is recorded by Professor Rosthorn, viz., death from intra-abdominal hæmorrhage brought about by tear of a large superficial vein. When the abdomen was opened, within twenty-four hours from the onset of the symptoms, it was found full of blood. The patient died forty hours after operation.

Rosthorn's *Operation for Cancer of the Cervix* is a very radical one. He removes the connective tissue and glands, clears the iliac vessels and the ureters, ties the uterine artery as far out as possible ; if the ureter cannot be implanted in the bladder it is tied, the peritoneal flaps are brought together, and the subperitoneal wound is packed with iodoform gauze, which is brought out into the vagina.

Last year Professor Rosthorn discussed the important question of the etiology and physical signs of *Adenomyoma of the Uterus*. He notices the connection between tuberculosis in children and delayed puberty, with amenorrhœa and sterility in after life, as associated with adenomyoma. There are attacks of pelvic peritonitis, and urinary affections are common ; short vaginal canal, anteflexion of the uterus (which may be infantile) and conical cervix ; at times there is a flattened protuberance on the posterior wall of the uterus, and a tendency of the growth to invade the cervix.

The most important of the recent researches of Dr. Kermauner is that on *The Anatomy of Tubal Pregnancy*. This is a careful investigation of the tubal changes, the presence of a pseudo-decidua reflexa, and the formation of hæmatocele. Five cases proved that fœtal elements can penetrate the maternal tissue, and these can be traced to the lumen of the maternal vessels. Only in six out of forty cases were decidual changes found in the tubal mucosa.

Pubiotomy.—Professor Rosthorn has had one death. It occurred from uncontrollable venous hæmorrhage. No artery was injured.

Freund's Operation.—Rosthorn considers that Freund's name should be the one associated with the radical operation for cancer. Freund first removed the glands, and was followed in the attack on the parametrium by Emil Ries and Rumpf.(*a*) He considers that the question of the future is that of the removal of the glands. He does not practise Schuchardt's operation. If the malignant disease be localised, then the old vaginal panhysterectomy is sufficient ; if the connective tissue be involved, then the abdominal route is best.

Puerperal Infection.—Professor Rosthorn believes in Trendelenburg's suggestion of attacking the thrombosed pelvic veins by ligature or extirpation. Death had followed in one case, but here there was pus in the pelvis.

FREIBURG.

I do not intend to delay to describe the details of the Freiburg Klinik. Enough for me if I arouse sufficient interest in your minds to induce you to visit it and see the installation for yourselves.

A prominent feature is the powerful electric light, which is so arranged at the end of the theatre opposite the window (the latter being constructed like a half horseshoe, running from the ground to half-way along the ceiling) that it can be directed on a mirror placed at such an angle as to reflect the light directly into the pelvis, thus avoiding the unpleasant heat which is experienced from the electric lamp reflector. I was struck also by the small nickel-covered openings through the tiled walls for the passage of any sterilisation appliances, or the sterilised saline solution direct from the steriliser. And yet, with all this apparent perfection, I learn from Professor Krönig that the State is about to build a new theatre, a short distance from the present one, and still more perfect. Truly, the State recognition of excellent work in Germany is an object-lesson to the world !

Anæsthesia.—All the cases I saw operated upon, either by Professor Krönig or Dr. Penkert, in the Frauenklinik were treated by medullary anæsthesia. These included abdominal, vaginal, and perineal operations. For example, there was a complete procidentia uteri, with prolapse of the bowel, and a laceration of the rectum, without exception the worst case of its kind I ever saw. Professor Krönig completed this operation without any sensitiveness on the part of the woman, in about half an hour. In this case the tissues were also subcutaneously injected with novocain. In no single instance did I see the least evidence of sensibility in such operations as hysterectomy, removal of the adnexa and appendix, and plastic operations on the tubes. The drugs used were scopolamin-morphine, and stovain " Billon."

Two hours before operation, the scopolamin 0.003 with morphine 0.01, in aqueous solution, is given, and the same dose is repeated one hour before operating. Immediately before operation, the stovain " Billon " is introduced into the spinal canal, taking about two minutes for the injection, which prevents quick distribution along the cord to the medulla. Rapid injection is injurious through the pressure it causes. After the introduction of the stovain, the patient sits up for two minutes. The process is the same as in making ordinary lumbar puncture, and the point usually selected is between the second and third lumbar vertebræ. Following the injection, and all through the operation, a strong light or any noise is avoided, and to accomplish this, Professor Krönig places large dark glasses over the patient's eyes, and large pads of gauze over the ears. Sharp or piercing noises are sure to disturb the patient.

This method of anæsthesia is used in all abdominal, vaginal, perineal and obstetrical work, but according to the nature of the operation different dosage is used. In vaginal, perineal and obstetrical work, including forceps, version, &c., the usual dose of scopolamin-morphine is given, but of stovain " Billon " only 0.06, while in abdominal work a larger dosage is practical, the stovain " Billon " being increased to 0.12. The only contra-indication observed by Professor Krönig is extreme old age, and even then this form of narcosis is not altogether contra-indicated, but smaller doses are used. This method Professor Krönig regards as satisfactory for gynæcological purposes.

Post-anæsthesia is unaccompanied by any disagreeable symptoms whatever—even headache is frequently absent. Several cases have been operated upon successfully with severe mitral and other valvular lesions.

Billon (Paris) uses smaller doses than Krönig, with immedate Trendelenburg posture, with the idea of spreading it. The period of complete anæsthesia under its influence is from one to one and a half or two hours ; following this period sensation begins to reappear.

Out of a series of 380 gynæcological, and 130

(*a*) Emil Ries first removed the pelvic glands in 1895.

obstetrical operations carried out to date at the klinik, Professor Krönig records but two deaths following this form of anæsthesia.

Case I.—Patient, æt. 64, with carcinoma of uterus. Died two hours after operation.

Case II.—Case of uterine myoma with aggravated mitral lesion. Had been previously refused for operation by other surgeons. Death occurred before the operation could take place.

In these cases the usual scopolamin-morphine dosage was given, followed by stovain 0.009, and Professor Krönig thinks that the dosage may have been too great for such cases. He now uses a smaller dosage, and has never seen either respiratory or cardiac disturbances or depression.

Altogether, he looks on this form of anæsthesia most favourably.

Professor Krönig has devised an apparatus which rolls on castors, and which contains in separate compartments chloroform, ether and oxygen. By moving an indicator the desired vapour is turned on to the mouthpiece, and the quantity is regulated. Two of these charged anæsthetisers are always at hand in the theatre.

Sterilisation of the Hands.—This is completed, after ten minutes' scrubbing, by washing for five minutes with sublamin, 1 in 1,000 (Scherin, Berlin). When the hands are dried, they are coated over with a covering of zylol paraffin, 5 per cent. Rubber gloves are not used in ordinary cases—only in carrying out spinal anæsthesia and where there are septic conditions, or when the rectum has to be explored.

Trendelenburg's Position.—I noticed that this was seldom resorted to, and, in consequence of the cardiac complications in some myomata, Professor Krönig considers it contra-indicated in operations in these tumours. Also, in spinal anæsthesia he believes it favours the too rapid distribution of the anæsthetic along the cord to the medulla. The objection is based on his experiments on dogs. Out of a series of eight dogs, in which the stovain was tried, out of the first four, on which immediate Trendelenburg position was tried, three died. In the case of the remaining four, in which the Trendelenburg position was not tried, nothing untoward happened.

Material for Sutures and Ligatures.—Catgut is almost entirely used save in enterostomy and appendisectomy, and as re-inforcing sutures (three in number) of the wound in Cæsarian section.

Professor Krönig nearly always adopts the *Pfannensteil Transverse Method* of opening the abdomen, believing that the closure of the wound after this method affords greater strength to the abdominal walls and support to the viscera. This incision is specially used in operations on myomata, and in morcellement, and always in Cæsarian section. He reserves the longitudinal incision for certain carcinomatous cases, but now uses it very rarely.

When the fascia is divided it is caught up above and below the incision, and is attached to the skin by a single suture, which saves the necessity for a retractor and keeps the wound well open. An assistant uses lateral retractors to draw apart the recti muscles and peritoneum. At Freiburg, as at Heidelberg, the second stands (on a small platform if the Trendelenburg position be chosen) between the thighs of the patient.

Cystoscopy.—The principal methods followed are Luy's and Nitze's, with a preference for the former; Kelly's seldom.

Skiography.—In skiographing the ureters and pelvis of kidney, the ducts and pelvis are filled with xeroform oil. This defines the urinary tract. I saw a most interesting series of skiographs illustrative of the various abnormal conditions of kidney and ureters, taken by Professor Krönig in this manner. A few notes on certain gynæcological and obstetrical questions may be of interest.

Removal of the Appendix.—This is practised as the rule in all abdominal operations, whether the appendix be normal or otherwise, unless the additional length of time involved be detrimental in a prolonged and exhaustive operation. Curiously enough, I saw at the klinik one case, operated upon by Professor Krönig, in which the appendix was absent.

Wertheim's and Schuchardt's Operations.—In general, Wertheim's method is followed, save in very obese women, when Schuchardt's is preferred. If abnormal, the glands are removed. The Wertheim method is carried out in 90 per cent. of the cases.

Suspension of the Uterus.—Save in cases where there are adhesions and adnexal complications (when ventro-suspension is practised) the Alexander-Adams operation is performed.

Lavage of the Abdomen.—This is rarely employed.

Pubiotomies.—Professor Krönig has performed thirty of these, without any maternal death; two children died. When the head is high, there is the danger of rupture of the bladder. This danger is minimised if the bladder be low. He does not consider pubiotomy in any sense superior to symphisiotomy.

Postpartum Management.—The patient, after normal labour, rises the day following delivery, and is taught deep-breathing exercises up to the sixth day, after which she pursues such gymnastic exercises as arching of the spine while lying on her back, and elevation of the lower limbs. Alternate douches of hot and cold water are given over the perineum, thighs, and abdomen, to stimulate muscle tone. Postpartum peritonitis is usually treated by multiple abdominal openings to allow of free drainage. Professor Krönig in some cases unites the cæcum to the abdominal wall until the symptoms subside, subsequently closing the fistula. He has not yet operated for septic thrombosis or cellulitis by the methods advocated by Trendelenburg—viz., removal of the thrombosed veins.

In *Antepartum Eclampsia* rapid removal of the child is the main indication. For this purpose the cervix is divided, and the delivery completed by Duhrsen's method.

Gentlemen, my excuse for detaining you at such length is that it must happen to all of us that we are occasionally tired of hearing our own voices; perchance —more rarely—that we are wearied of the perpetual chanting of our own deeds, and the doxologies which wind up the recitals of our victories—often not very glorious ones—over our common enemy, disease. Even our failures afford us a certain grim satisfaction, and it might be well for us if they taught ourselves and our hearers even more than our successes.

It is a break, then, in this monotonous rhythmic monthly recital of what the "I" is doing, to change to the possibly more instructive description of what "they" are doing. We get down from the giddy heights of our self-satisfying survey of our excellencies to the lower plain of the more humble if not humiliating realisation of what some masters in our art can teach us.

CLINICAL RECORDS.

A CASE OF ACUTE HÆMORRHAGIC PANCREATITIS.

(*Fatal termination within three-quarters of an hour from onset of symptoms.*)

Under the care of F. W. BAKER YOUNG, M.B., Ch.B. (Vict.),
Clinical Assistant, Hospital for Women, Liverpool.

PATIENT was a male, æt. 30, a fitter by trade. On December 28th, 1905, he was taken ill while at work. Remarking to the foreman that he was out of sorts, he walked home, and almost immediately expired. On my arrival the patient was dead. He was lying in bed on his back. His expression was tranquil, skin pale, pupils dilated.

The past history was as follows:—A native of Ireland, he had come over to England about five years ago, and, as far as known, he had never had a day's illness. He was in the habit of excessive beer-drinking, the bouts often lasting several days. This Christmas he had taken his share of beer, but was not thought to have been intoxicated. On the day of his death he resumed work for the first time after Christmas. He refused breakfast before starting at 9 a.m., and should have worked until 1 p.m.; but at 11.45 he told the foreman he was ill and would have to knock off, but made no further complaint. He went home, a distance of fifty yards, and some bovril was prepared; but after waiting for it he refused to touch it, and said he would go upstairs and lie down. Ten minutes later he was heard to be choking, and on his friends going up to him he was unable to speak, although he recognised them.

Autopsy (twenty-eight hours after death).—No marks of violence to be seen. Rigor mortis well established. Post-mortem stains present only over dependent parts. Surface quite cold. No discharge from external orifices. The body was particularly well nourished. On opening with usual incision, marked engorgement of the omental veins was observed. No fluid in pleuræ. No adhesions. Pericardium contained 1 oz. of pale, straw-coloured serum. Heart and lungs removed, floated *en masse*.

Examination of Heart.—Right side contained very dark fluid blood, but was not distended. Left side quite empty; valves and coronary vessels healthy. Septum ovale complete. Aorta healthy. Œsophagus healthy. Trachea of a reddish colour; contained a large quantity of frothy mucus. Larynx healthy; no obstruction.

Lungs.—Upper lobes normal, with exception of a spot one inch below apex on the anterior surface of right lung, where a healed phthisical lesion was found, containing a calcareous nodule the size of a Barcelona nut. The lower lobes in their entirety were engorged with dark fluid blood. On section, air, frothy mucus, and blood could be freely expressed. Portions floated in water.

Peritoneum.—Old firm adhesions found around appendix and cæcum. On introducing the hand into the lesser sac it came out stained with blood, and on opening the sac about two ounces of blood-stained fluid were found, and the position of the pancreas appeared to be occupied by a large blood-clot. The stomach was now ligatured and removed. Liver also removed, and on manipulating the intestines the pancreas was exposed in its whole length. It was now obvious that there had been a large hæmorrhage involving the body and tail of the organ, the head in comparison being free. The organ was dissected out, and was of a dark-red to violet colour, and on longitudinal section was found to be infiltrated with fluid blood. It weighed 6¼ ounces.

Stomach contained less than one ounce of bile-stained mucus. Post-mortem changes on posterior wall; otherwise healthy.

Liver.—Enlarged, somewhat fatty, engorged with venous blood. No gall-stones. Biliary ducts patent.

Spleen.—Normal in size, but on section darker than usual; rather friable and engorged with venous blood.

Kidneys slightly enlarged. In the left kidney there was an ecchymosis on its anterior surface, about 1½ inches in length and three-quarters of an inch broad, with its long axis parallel to the long axis of the kidney, and situated over the lower segment of the upper half or the organ. The capsule stripped with difficulty, but could not be removed from over the ecchymosis. On section through this portion the hæmorrhage did not appear to penetrate the kidney substance. *Right Kidney*.—Capsule stripped, but not so readily as usual. Other abdominal viscera normal.

Brain and Meninges.—The meningeal and cerebral veins and sinuses were engorged with dark fluid blood; brain and upper portion of the cord otherwise healthy.

Microscopic Section of Pancreas.—Dr. H. Clarke kindly cut sections of the organ for me, but, owing to the fact that I was unable to give him the specimen until forty-eight hours after death, it is impossible to give a certain opinion on the condition. The section showed necrotic areas, with a certain amount of hæmorrhage; but so much auto-digestion had occurred that it was impossible to state whether the necrotic patches were ante- or post-mortem.

The literature on the condition is not extensive. Von Ziemssen divides hæmorrhagic pancreatitis into three classes:—

1. Large hæmorrhagic masses due to pre-existing changes in vascular system. 2. Hæmorrhages into pre-existing retention cysts. 3. Cases in which the entire organ takes on a hæmorrhagic condition, death in these cases often occurring very suddenly. In these cases, besides the hæmorrhagic infiltration, fatty necrosis of the organ is found. Moynihan states that, in cases of hæmorrhagic pancreatitis, hæmorrhage may precede or follow the inflammatory stages. In those cases in which the hæmorrhage appears first, a fatal termination may take place before the inflammatory changes have had time to make their appearance.

The following points were of interest in my case:—

1. Age. The disease has generally occurred after the fortieth year.

2. Rapid onset and equally rapid fatal termination. Most authorities, including Allbutt, Osler, and Butler, give as the fatal period from two to four days, with occasionally the saving remark of "sometimes earlier."

3. Absence of vomiting may in this case be accounted for by the patient not having taken any food since the previous night, although he was noticed to be retching when he ceased work.

4. Absence of pain severe enough to make patient complain. He was only observed to hold his hand to the pit of his stomach.

5. Situation of hæmorrhage—the usual site being in the head and neck. Here the principal effusion occupied the body and tail, which point, perhaps, would account for the rapid termination, owing to the effect the lesion would have on the solar and semilunar ganglia.

6. The well-marked venous congestion and fluid state of the blood. These last two conditions I am unable to account for, and so far have been unable to trace any similar condition found in published cases.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

Operation for Strangulated Femoral Hernia.—**Mr. Arthur Edmunds** operated on a woman, æt. 50, who had presented herself at the out-patient department with a small lump over the saphenous opening. This lump had been present for two or three weeks, but had not given rise to any considerable discomfort; ultimately, however, she consulted her doctor, who sent her on to the hospital. The swelling was about the size of a small walnut, and situated below Poupart's ligament and internal to the vessels. Its nature was not very certain, but in view of its position, and of the fact that there seemed to be a pedicle passing from the deep surface of the tumour, the diagnosis of femoral hernia was made. There was, however, no impulse on coughing, and taxis, which was painless, had no effect on the swelling. Admission to the hospital was advised, but the case was not deemed urgent, there being no symptoms suggesting possible strangulation. While she was waiting for her name to be entered on the list of patients for admission, she vomited, and Mr. Edmunds decided to admit her for immediate operation. Accordingly, the patient was anæsthetised, and a curved incision with the concavity inwards was made round the swelling; the skin and fat were then raised in a flap, and the hernia exposed. This flap incision has the advantage, Mr. Edmunds said, that the resulting wound is situated further from the perinæum than that resulting from a straight incision, and further, the skin sutures are not directly above the deeper ones, so that any soiling of the wound subsequently to the operation is less likely to cause deep infection. The sac was now cleaned, and a quantity of retroperitoneal fat removed. The sac was found to be distended with fluid, and when this was let out a small knuckle of bowel was seen projecting through the femoral canal. The neck of the hernia was incised inwards in the usual way, and the bowel pulled out for examination. It was then seen that the whole of the circumference of the gut was not involved, the hernia being of the type known as Richter's hernia. There was no question about resection; the bowel would obviously recover, although considerably discoloured, and accordingly it was returned to the abdomen. The sac was transfixed, ligatured and cut away. The question now arose of the closure of the femoral canal. The radical cure of femoral hernia presented, Mr. Edmunds remarked, many difficulties which do not obtain with the inguinal variety. Operations designed for this purpose, he said, fell under three headings: (1) in the first an attempt is made to suture Poupart's ligament to the deep crural arch, and to the periosteum of the pubes. This would be quite a satisfactory operation were it not for the fact that these fibres are too feeble to hold the sutures satisfactorily. (2) In the second group of operations a flap of pectineus is turned up and drawn into the femoral canal by means of a mattress suture Unfortunately this proceeding deprives the reflected portion of the muscle of its innervation; as a result of this, the muscle atrophies and the operation fails. (3) The third type of operation was, he considered, the only one which could claim the title of a radical operation, and in this an attempt is made to fix Poupart's ligament definitely to the bone itself. Two methods are employed in Raux's operation. A staple, similar to that used to fix up electric bell wires, is passed through Poupart's ligament, and then hammered well home into the pubes. This, Mr. Edmunds thought, was a good operation, but the staple had a tendency to work loose, especially if it had not been hammered tightly home, and, in any case, the pressure of the staple will cause absorption of the bone around it, so that it cannot hold for any great length of time. The method adopted in the present case was that described by Nicoll ("Annals of Surgery," January, 1906). After the sac had been ligatured and pushed back into the opening, the anterior surface of the pectineus was exposed and an incision made along the middle third of its pelvic attachment exposing the pubes. A copper spatula was then introduced below Poupart's ligament behind the deep surface of the pubes, and two holes, about three-quarters of an inch apart, were drilled through the bone. A curved needle bearing a strong strand of silkworm gut was now passed deeply through Poupart's ligament, and the muscular structures attached to it. A piece of silver wire about a foot long was next taken and bent in half, so as to form a loop. This loop was passed through one of the drill holes and hooked up into the wound. One end of the silkworm gut suture was then put through the loop, and the loop withdrawn, carrying one end of the silkworm gut with it. The manœuvre was repeated with the other drill hole, so that the two ends of the silkworm gut suture which had been passed through Poupart's ligament and the abdominal muscles were drawn through the pubes from the deep to its superficial aspect. The suture was now tightened and tied, thus drawing down the structures which formed the anterior wall of the femoral canal to the postero-superior aspect of the pubes, and thus obliterating the canal. A few points of catgut suture were then inserted to attach the fascia over the pectineus to the external oblique. The wound was then closed. Mr. Edmunds said that at first sight this operation seemed complicated, but it was in reality very simple. The actual passage of the suture with the aid of the wire loop need not take more than from five to seven minutes, so that the operation is feasible even for cases of strangulated hernia. The result was extremely satisfactory, and the patient need wear no truss. He pointed out also that the operation he had just performed differed from the one described by Nicoll in one or two minor points, mainly in the employment of the wire loop in place of a probe and a loop of catgut.

TRANSACTIONS OF SOCIETIES.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Special meeting held on Friday, December, 14th, 1906.

Dr. E. Cautley in the Chair.

The subject for discussion was

Rickets,

which was taken under the following five headings.

The ætiological aspect was opened by Dr. **Dudgeon**, who discussed the climatology and the question of heredity.

The lactic acid theory of Heitzmann, and the lime theory of Voit were discussed and shown to be untenable. Mr. Bland Sutton's well-known experiments on the lions at the Zoo were detailed, and also the recent work of Dr. Chalmers Watson on rats, whose mothers had before pregnacy been fed on a meat diet and the young animals also fed on the same; changes were found in the bones resembling rickets, but the microscopical changes were different. He also mentioned that in all cases of status lymphaticus changes occurred in the bones resembling those of rickets. He considered that there was no evidence as yet in favour of a toxic theory.

The symptoms and diagnosis were discussed by Dr. **Poynton**, who remarked that rickets was a disease beginning insidiously during the first two years of life. Early warnings were anæmia, general flabbiness, and profuse sweating about the head. The osseous symptoms were often the first to attract attention, but much tenderness of the bones points to scurvy or osteogenesis imperfecta. Fractures are less common than usually supposed. Head-nodding is due to a local irritation from the teeth or ears. Craniotabes is much commoner in syphilitic rickets. Hirschgarser found rickets in 89 per cent. of cases of laryngismus stridulus and in 79 per cent. of tetany. A convulsion in a rickety child might be the beginning of epilepsy. He believed in the existence of fœtal rickets, but suggested a discussion as to the nature of late rickets. Was it a true rickets? and, if so, was it a relapse of early rickets or did it develop *de novo*? Under diagnosis he alluded to latent syphilitic rickets, achondroplasia and osteogenesis imperfecta, the latter disease being characterised by its congenital origin, the frequency of fractures, softness of bones, and by failure of anti-syphilitic and anti-rachitic remedies.

The discussion on pathology and morbid anatomy was opened by Dr. **Milligan**, who, after discussing the various experiments performed on animals with a view to ascertain what the essential pathology of rickets was, pointed out that no definite result had as yet been arrived at. The morbid anatomy was illustrated by many gross and microscopical specimens. The visceral changes in the liver, spleen and lymphatic glands were described, and it was commented on that it was curious that no changes had been found in the central nervous system considering the frequency of nervous symptoms.

The discussion on the surgical aspect was opened by Mr. **Betham Robinson**, who, in drawing attention to the common deformities, made a special reference to genu valgum, and considered it offered points for discussion. The use of skiagraphy had thrown much light on the pathological conditions present.

swallowing might also be an early symptom of struma. The disturbances of circulation and of the heart, such as arhythmia of the pulse and omissions, &c., were not the direct results of compression, but were to be explained by pressure on the laryngeal nerve. Disturbances of the local apparatus were extremely rare, so long as the struma was not malignant. The anatomical structure of the struma gave no key to the kind of trouble arising from the disease. Simple parenchymatous hyperplasia was more common in youth; the colloid or cystic degeneration follicle in later life. Vascularity varied enormously.

The external use of iodine the speaker considered of no value, but it had an undoubted influence sometimes when given internally, and particularly so in young people. The same might be said of thyroidine and similar preparations.

Injections also of iodine or iodoform were not always without effect, but the speaker had given them up on account of the danger attending them, and because, if operation had still to be performed, it was made much more difficult by the previous injection.

He therefore, when the patient was young, first of all gave iodine if the case was one of simple hyperplasia; if this did not succeed after trial, he proceeded to operation. In older patients he proposed operation at once.

The question was: Extirpation or enucleation? The latter only, however, came into question in encapsuled goitres. But even then enucleation was not advisable. Generally besides the encapsuled cysts there were others that were not visible at first, and which led to recurrences; moreover, the hæmorrhage might be very great in such enucleations. Taken as a whole, enucleation was only advisable in superficial easily accessible, isolated cysts, which could be recognised as such through the integument.

Otherwise, extirpation was advisable under all circumstances. This, thanks to Brons, Kocher and others, had developed into a typical operation that, rightly performed, entailed but little loss of blood. The vascular condition, it was true, was very variable, but if one proceeded systematically, and keeping the varieties in view, any free hæmorrhage, might be avoided.

For the skin, the speaker preferred the horizontal "cravat" incision, which for cosmetic reasons, should not be longer than circumstances required. It was important to take care of the laryngeal nerve that it was not included in the ligature of the inferior thyroid artery. If possible, a general anæsthetic should be avoided, and in place of it two or three injections of a 1 per cent. solution of cocaine might be given. Patients felt no actual pain during the operation, but only the disagreeables such as difficulty of breathing, which, however, ceased as soon as traction on the goïtre ceased. As compensation, they did not vomit after the operation.

After operation patients often had transient troubles both with breathing and swallowing; any bronchitis present often got worse or pneumonia developed. Post-operative temperature also varied very much, but suppuration never followed.

The mortality did not amount to more than 0.3 to 0.5 per cent. When death took place it was from pneumonia, secondary hæmorrhage, or cardiac failure in patients with already irregular hearts.

The prognosis was therefore good, and he advised operation whenever the goitre was the source of trouble.

It was very different, however, with malignant goitre. These were generally rapidly growing hard tumours, or an ordinary soft goitre become hard. They occurred in comparatively young people of thirty or but little over. They looked well, and yet these malignant goitres soon became inoperable, as tumour thrombi formed early in the vessels. Of twenty cases of malignant goitre that he had operated on only one remained free from recurrence for a year. All the others died either from the operation or from rapid recurrence. As benign goitres might undergo malignant degeneration, and as the prognosis in this class of cases was so extraordinarily bad, this was another cogent reason for early operation.

Hr. Levy-Dorn remarked on the absence of permanent results in cases treated by X-rays.

Hr. v. Hausemann spoke on discrimination in using thyroidin. In parenchymatous hyperplasia it was useless, but sometimes did good in colloid or cystic degeneration; the follicles might become smaller, but not fewer in number.

Hr. Mendel mentioned a case that showed caution should be exercised in using iodine in the treatment of goitre. The goitre disappeared, but Basedow's disease developed, which, however, improved under thyroidine.

Hr. Unger had never seen a cure from X-rays, although he had used it in about 30 cases.

AUSTRIA.

Vienna, Dec. 30th. 1906.

ATHEROMATOSIS OF AORTA AND SYPHILIS.

Ehrmann presented a patient to the members of the Gesellschaft suffering from an atheromatous condition of the aorta associated with a gyratory form of tubercula cutanea syphilitica. An interesting feature in this case was a white marble shadow of a tree on the skin over the pelvic region, which was also strewn with tubercles of a syphilitic nature. These neoplasms were distributed over the cutaneous surface of the trunk and limbs.

Ehrmann thought this phenomenon was very rare, or little understood, although four such cases had recently come under his own personal observation; all of them with the atheromatous aorta and enlarged vessels.

The microscopic examination informs us that a sclerosis of the arterioles exists and is probably the cause of the phenomenon. Owing to this sclerosis the wall of the vessel becomes rigid, so that cardiac systole of the left ventricle is lost after entering these inelastic tubes, which become mere sinuses for the reception of the blood, as they have no power to propel it through the capillaries. If the vessels lying in diastole be rubbed in the direction of the current the blood can be forced through the capillaries mechanically, but no contractions in the vessels will be produced, as the stiff arterioles will again resume their rigid state, becoming congested with the next systole.

With this form of arterio-sclerosis we have produced a cutis marmorata or an extensive maculose exanthema. In the early eruptive stage of syphilis we have an efflorescence appearing as a livid copper-coloured syphilide. If one of these efflorescent patches be excised, the spirochetæ pallidæ of Schaudin will be found in the walls of the vessels and neighbouring tissues. Now it is assumed that these microbes persist, as this often recurs, and thus increase the sclerosis in the vessels which would soon produce the cutis marmorata, as that seen in the case presented.

PITYRIASIS LICHENOIDES CHRONICA PRURIENS.

Ehrmann also showed a girl, æt. 13, with small glittering nodules resembling lichen ruber. The more advanced desquamated like psoriasis, a white covering leaving a dark orange-coloured surface. The treatment usually followed in psoriasis was adopted with very transitory results, owing, no doubt, to our ignorance of the etiology.

PERFORATION OF STOMACH HEALED.

Schnitzler exhibited two cases where he had performed laparotomy for perforation of the stomach, with excellent results.

One of the cases was specially interesting from the fact of its having been done twice for the same thing, which Schnitzler considers positive proof of the practicability of the operation. The origin of these ulcers was due to a preceding operation of gastro-enterostomy, which invariably produces ulcers in that organ after the healing, and function of the stomach has commenced. Both of these perforating ulcers commenced within a year after the gastro-enterostomy. He is of opinion that stenosis calls for early operation; but where there is no mechanical obstruction and the ulceration has proved deficient to all internal treatment, the surgeon should not hesitate to operate.

Eiselsberg said that he had long ago recognised the treatment of ulcers of the stomach by surgical means as the best and most effectual. He would go further and recommend jejunostomy where the patient was very weak and unable to absorb enough of nutrition to keep the body up.

"Huhnerpest."

Schiffmann showed a number of microscopic preparations taken from the blood of fowls suffering form the pest.

Paltauf said these demonstrations opened up a wider field for speculating on the convection of disease, as the product of cell degeneration seemed to be an active agent in disseminating disease. To this group he would assign Guarnieri's small bodies which we meet with in variola and vaccine. Two days after a fowl has been very ill with the pest no micro-organisms can be found in the blood, tissue, or organs of the animal, although the disease is intensely infectious at this stage of the illness. If the disease last for one or two weeks, *i.e.*, the animal survive one week, the virus will be found to localise itself in the brain, where relatively large cells will be found encysted or in a state of quiescence with all the properties of the virus. There are no micro-organisms to be found—nothing but these enveloped bodies which are evidently the product of cells, and contain all the virus of the disease in an invisible form of division.

Rontgen Rays and Metabolism.

Reuss gave a report of his experiments with the Röntgen rays on the healthy subject. The rays, when intense, do not greatly increase the elimination of the nitrogenous bodies, but this slight increase continues for a few days after the application, and again falls back to its normal condition. The elimination of P_2O_5 commences rapidly and ceases speedily after the rays are withdrawn, but the constituent P_2O_5 is slow in recovering and appears in very small quantities in the secretions for a long time after the exposure.

This is parallel with the changes observed in the blood where a sudden form of hyperleucocytosis appears from some explosive change in the lymphoid tissue continuing for twenty-four or thirty-six hours. During this anatomical change the cholin appears suddenly in the blood and as quickly disappears, after which the PO_5 gradually increases. All this tends to prove that lecithin and its allies are the substances principally attacked by the Röntgen rays.

Cholesterin and Gall Bladder.

The controversy of cholesterin being formed in the gall bladder or secreted from the blood is far from being settled. Aschoff affirms from his results that cholesterin is extracted or separated from the gall after it has been collected in the gall bladder, and not obtained from the epithelial lining of that viscus, as affirmed by other physiologists. The substance is first secreted as a cholesterin ester with a neutral fat in combination. In the bladder this mixture is split up, the cholesterin remaining in the bile, while the neutral fat passes off in the lymphatics.

HUNGARY.

Budapest, Dec. 30th, 1906.

Dr. Kohrman Muller, Commissioner of Health of Budapest, stated the sources of typhoid fever in about the order of their importance as follows:—(1) milk, (2) fish, (3) uncooked vegetables, (4) imported fruits, (5) secondary cases, (6) ice, (7) domestic water supplies, (8) public water supplies. (Dr. Müller does not agree with Leverle, of New York, who counts flies also to the sources of typhoid). With regard to the milk supply, Budapest is ahead of any other city in caring for this, and while there is no doubt that many cases occur from milk infection, the danger is ever growing less. The uncooked vegetables are lettuce, tomatoes, and the like, which can only be imperfectly cleaned before being put on the table. At times typhoid fever has been traced to the use of night-soil for the manuring of these. As for ice, it has been shown that the mere freezing of water did not kill the typhoid germs in it. As a result of this investigation, a number of other investigations have been made, and now it is known that though the bacilli are not killed by freezing, they gradually lose their vitality when kept in a frozen state for any considerable period.

Dr. Hultl Humer read a paper in the Medical Society with the title, "For how Long a Time should we enjoin Rest in Bed after Abdominal Section?" Therein he stated that he allowed his patients up just as soon after operation as they chose. This statement aroused a great discussion. Many surgeons thought that any endeavour to diverge from the habitual in operative treatment should be welcomed, yet the safety of the patient should be the first consideration. The following factors have to be considered:—Condition of patient, character of operation, length and locality of incision, method of suturing and suture materials. In conclusion, it was accepted that the tendency to shorten the period of rest in bed is advisable, except for suitable cases, and that any attempt to shorten this period to a few days was a hazardous experiment.

The annual report of the Statistical Bureau shows an alarming increase of insanity among the Slav inhabitants of Hungary. The figures show unmistakable evidence of increase in insanity and mental degeneracy in the Slav race. It would take too long a chapter to attempt to explain all the causes to which the increase of insanity in the Slav population may be due. The patients do not seem to owe their mental downfall to excessive brain work, but rather to physical conditions and degeneracy to which their lax, indolent, inhygienic methods of living naturally lead. Hereditary influences, too, are gradually asserting themselves as a not insignificant factor in producing additional physical and mental defects in the race. Poverty and painful struggling for life may also have a considerable rôle in provoking so many insanity cases. The number of patients accommodated in hospitals during this year was 117 more than the previous year, showing an increase of about 50 per cent.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

COMPULSORY NOTIFICATION OF CONSUMPTION IN EDINBURGH.

At a meeting of the Town Council, held on December 18th, a motion in favour of the compulsory notification of phthisis was carried by a large majority. The proposal was brought forward by Councillor Cullen, the convener of the Public Health Committee, whose statement on the subject we referred to a few weeks ago. Some of the objectors to the proposed inclusion of phthisis among the diseases scheduled under the Infectious Diseases Act took up the position that some of the clauses in that Act would bear hardly on consumptive patients, and urged that instead of proceeding as is proposed (namely, by approaching the Local Government Board for permission to schedule phthisis), the Council ought to obtain a provisional order enabling them to deal with the disease. Such objections have not been limited to the Council, but have been raised in letters to the *Scotsman*. Dr. Cullen, however, was able at the meeting of the Council to give such assurances in respect to the practical working of the Act as ought to relieve any anxiety which may exist that it will in any way operate harshly or oppressively on members of the community afflicted with consumption.

DR. MATTHEW HAY, ABERDEEN, ON THE MILK QUESTION.

A considerable part of the annual report on the health of Aberdeen is devoted to the important matter of a proper milk supply. Experience shows, he says, that with proper care and cleanliness in the production, transmission, and sale of milk, milk can be produced on a commercial basis, of such a quality that there is little need for sterilisation. One important step would be the replacement of registration of dairies by licensing which implies power on the part of the licensing authority to refuse, unless the required conditions are complied with. At present, every dairy, however unsuitable, can claim to be registered. Until Parliament grants such powers, Dr. Hay advises that the Town Council should institute a voluntary register of dairymen who agree to certain reasonable requirements, and would allow their farms to be inspected by veterinary inspectors. Such dairymen would have their names on a public list, and the consumer could be reasonably certain that he was getting wholesome, clean milk. Dr. Hay alludes to a recent English trial in which a dairyman was mulcted of several hundred pounds damages for allowing his milk to be infected with typhoid, and thinks that the trade ought to welcome any supervision which would reduce such serious financial risks. During the year the Public Health Committee conferred with the dairymen of the town as to the possibility of veterinary inspection of the dairies. The majority of the dairymen reserved their opinion, and were desirous of learning to what extent tubercle occurred in the milk supplies of the city. Dr. Hay accordingly made some investigations on 27 samples of commercial milk from various sources by inoculating guinea-pigs with 1 c.c. of centrifugalised milk. Two of the animals succumbed to tuberculosis; in one the disease was thought to be due to natural causes; in the other it was undoubtedly due to milk infection. There is thus no doubt that some of the Aberdeen milk is contaminated with tubercle, though the percentage is much less than in some of the English Midland towns. Since the conference took place certain of the leading dairymen have themselves arranged for veterinary inspection. What is required is that such inspection should be made general, and should be carried out by an official appointed by the Corporation as representing the consumers.

Epilepsy as a Defence in a Murder Trial.—A case of some medico-legal interest was tried before the Lord Justice Clerk in the High Court of Justiciary on December 17th. The prisoner was indicted for the murder of his wife by shooting her, and the line of defence was that he was of unsound mind. Dr. Clouston was the principal witness, his evidence being to the effect that the prisoner, having once been struck by lightning and subject to fits, would, if he took drink, be liable both to suicidal and homicidal impulses. In the intervals between the attacks he would be perfectly sane. There was no more dangerous class of men than those who were epileptic and sometimes alcoholic. In his charge to the jury the Judge laid considerable stress on the plea of mental unsoundness as entitling to an acquittal of the more serious crime of murder. He quoted the principles laid down by Lord Deas in a case very much on all fours with the present one. Lord Deas pointed out, first, the unpremeditated nature of the attack; second, the prisoner's habitual kindness to his wife, except when he was the worse for drink; third, there was only one blow or stab; fourth, the prisoner was of peculiar mental constitution, had had his mind weakened by successive attacks of disease, had probably had sunstroke followed by epileptic fits. "If weakness of mind could be an element in any case in the question between murder and culpable homicide, it seemed difficult to exclude that element here." Following on this charge, the jury returned a verdict of culpable homicide, and the Lord Justice Clerk, following the precedent laid down in the former case, sentenced the prisoner to ten years' penal servitude. To the medical mind this seems rather illogical. If the prisoner was insane on the occasion of the act (or acted under an insane impulse), surely a criminal lunatic asylum is his proper place. It seems a little unfair on both the public and the prisoner to send him to a jail for ten years, after which he will be released, presumably as dangerous to the community as heretofore.

Edinburgh Hospital for Women and Children.—The annual meeting of this institution, which is staffed entirely by medical women, was held last week. The in-patients for the year number 179, the out-patients 2,451. The arrangements of the hospital and dispensary have always included a substantial contribution by the patients towards the cost of their treatment. During the year nearly £300 has been received from this source. That the finances of the hospital are in a satisfactory state is shown by the fact that the institution has been able this year to pay off half of the bond for £1,000 remaining over the hospital. The revenue was £1,439, the expenditure £1,165. Mrs. Basil Orr, M.B., Ch.B., has been appointed anæsthetist and clinical pathologist to the hospital.

BELFAST

Death of Dr. A. S. Merrick.—On December 19th, at his residence in Belfast, Dr. Alexander Stewart Merrick passed away after a long illness. He was born in Cork sixty years ago, and educated in that city, passing through Queen's College with great distinction. After graduation he was appointed assistant medical superintendent of Cork Lunatic Asylum, and in three years was promoted to the office of medical superintendent of the Donegal Asylum at Letterkenny. In 1875 he was transferred to the charge of the Belfast and District Asylum, where he remained till he retired on pension in 1897 on account of failing health. He had been highly myopic for years, and latterly became nearly blind, as well as feeble in general health. He succumbed to cerebral hæmorrhage in the end.

Dr. Merrick was a most kindly and amiable man, a true Irishman of the best type, and was highly respected by all who came in contact with him. Many medical men trained in the Belfast school passed through his classes in Mental Diseases at the Belfast Asylum, and there are few who will not look back with pleasure to those warm afternoons in the summer session when the lectures were enlivened with a fund of native wit and of shrewd common-sense which were so characteristic of the man. Dr. Merrick leaves a widow, a daughter and three sons. The eldest son, Dr. Warren Merrick, has adopted his father's profession.

LETTERS TO THE EDITOR.

MEDICAL CLUBS.

To the Editor of the Medical Press and Circular.

Sir,—"A joint meeting of the Liverpool and Birkenhead Divisions" was recently held in the Liverpool Medical Institute to consider an amended report of the sub-committee appointed to "investigate the Liverpool Municipal Guild Medical Insurance Society," whatever that is! "All resident medical practitioners resident in the district are invited to be present," so ran the summons.

For the first time the resident practitioner is aware that the members of the B.M.A. are endeavouring to get up a club comprehensive enough to swamp the half of the profession! There is no limit to the "Guild"—its members may be legion, and the sub-committee propose to accept these members at :—

"Males—6s. per year for those not earning more than £120 a year.
,, 8s. 6d. per year for those earning between £120 and £150 per year.
Females—7s. per annum for those not earning more than £120 per annum."

"Proportionately higher terms shall be arranged for higher salaries," *e.g.*, the Lord Mayor would be on a higher scale!

The Guild considered these terms too high, to which the B.M.A. replied in a prolix letter that they are not in possession of all the facts!

At this point in the meeting someone asked the Chairman what *locus standi* he had, as he had been invited here to listen to negotiations he had no business with; could he vote and speak? "Yes," was the reply, which gave rise to some dissent. "It would be all right if recorded on the minutes!" was one interjection. "It was usual for this association to invite outsiders, as a sprat often caught a whale," was given in apology by another. The latter remark was considered too honest, and was ruled out of order.

A member then commenced on the philosophy of the situation, and related how he and other two of the members attended to a club at 1½d. per head, which he did not consider a profitable undertaking. From this it was inferred that the number of visits required by the Guild might bring the medical profession to the same level, if not a little lower. It was finally resolved to close this ordinary meeting of the Joint Divisions with a postliminium in order that a reconciliation or entente cordiale might be established. What are we to conclude from these proceedings?

I am, Sir, yours truly,
A Resident Medical Practitioner.

STAG-HUNTING AND VIVISECTION.

To the Editor of The Medical Press and Circular.

Sir,—More terror, pain, and lingering torment are inflicted upon helpless animals in a single day's battue than is caused in all the physiological laboratories in the kingdom in a whole year. Besides this form of sport there are the numerous varieties described by the Rev. J. Stratton in the Medical Press and Circular of this date. Among the noble promoters of these sports are to be found some of the most influential and wealthy of the patrons of anti-vivisection, such as Lord Llangattock, the Duke of Portland, and Colonel Lockwood. In my letter which appears beside the Rev. J. Stratton's, I have spoken of the harm to the suffering poor to which the fanatical abuse of the profession by anti-vivisectionists is giving rise. Can this Christian minister not take the trouble to ascertain at first hand the facts about experiments upon animals, and in the meantime direct his further energies to the gross and unjustifiable forms of wholesale cruelty he rightly denounces. Physiologists and pathologists throughout the world are agreed that the progress of science depends upon experimentation upon animals; and they affirm that the amount of pain they inflict is literally infinitesimal compared with that occasioned by the use of lower animals in the service, and the feeding of mankind. In these latter directions the greater part of the suffering could be done away with without in the least detracting from the advantages to mankind. There is surely room here for the energies of all the anti-vivisectionist societies. Why they do not recognise this fact seems inexplicable.

I am, Sir, your truly,
S.

Reigate, Surrey, December 26th, 1906.

THE CANCER PROBLEM.

To the Editor of the Medical Press and Circular.

Sir,—Mr. Edmund Owen, in his Bradshaw Lecture on "The Modern Treatment of Cancer," observes, "In the world of therapeutics there are still dark tracts and continents which can be discovered only by men of imagination and energy; and possibly the Columbus or the Raleigh is to-day with us, who later on will bring back the glad tidings that he has found out the nature of cancer and can tell us of its cure."

Now doubtless that possible Columbus or Raleigh would individually be the happiest, and would be acclaimed as the greatest of men, but would he do a real service to humanity in general? I make bold to doubt it.

What is a cure? It may be defined as some agent which when introduced into, or made to react on the body, neutralises at the least or destroys at the most the products of a morbid process, the cause still persisting. In other words, the results of insufficient knowledge or wilful negligence of the laws of nature, can be nullified by some stronger power. A cure therefore would enable mankind to persist in the courses which lead to disaster, but indemnify themselves against it. Is such a consummation possible, or to be desired? Obviously the better course is to acquire the knowledge and avoid the negligence. A formidable bar to progress in that direction is the present-day assumption that cancer differs in kind and not merely in degree from other diseases. This probably is due to the quicker and greater formation of new tissue in the cancerous process. But is there any diseased process in which new tissue is not formed? Will anyone assert that the nasal or gastric mucous membrane is in the same position structurally after an attack of catarrh as before? No, beyond doubt there is no such thing as functional disease.

If there is no cure, in the sense above indicated, for such mild maladies as nasal and gastric catarrh, how then should we expect one for cancer? But is prevention not nearer at hand, and easier?

Let us turn to the Bradshaw Lecture for guidance in this direction. Dr. Dawbarn's "Method of Local Starvation" surely conveys a hint. If, as he asserts, —as others have before him—that cutting off the local nutriment leads to atrophy of the product of the cancerous process when actually present, or "to control of malignancy" when it has been removed, surely a general diminution of nutriment to the organism as a whole would tend towards its prevention.

In other words, if the supply of nutriment to the body were sufficient for its normal growth alone, there would be no possibility of abnormal growth occurring, and no need for it. Sir William Banks held that cancer was a disease of "repletion." The inference is obvious. Let mankind endeavour to find out that kind of nutriment, and that amount of it, necessary to normal growth, and there will be no necessity to discover a "cure" for abnormal.

Finsbury, Dec. 28th, 1906. I am, Sir, yours truly,
Hope Grant, F.R.C.S., Eng.

SLEEPING SICKNESS.

To the Editor of The Medical Press and Circular.

Sir,—Many statements have lately appeared in the press to the effect that Dr. Koch has at length discovered, in the compound of arsenic known as Atoxyl, a cure for sleeping sickness. I should like to say that this drug was first suggested and experimented with for the disease by Dr. Wolferstan Thomas, of this school, two years ago; that ever since then we have continued our study of it; that its complete efficacy has not yet been proved; and that premature announcements on the point are to be deprecated.

I am, Sir, yours truly,
Ronald Ross,
Professor of Tropical Medicine, University and School of Tropical Medicine, Liverpool.

SAUCEPAN AND APPENDIX.

To the Editor of the Medical Press and Circular.

Sir,—Referring to the annotation in the last number of your journal, I may mention that only a few days ago an intelligent cook showed me how the enamel scales off in a badly enamelled cheap saucepan. It seemed to me no difficult matter to understand how the use of such a faulty cooking vessel might spread sharp gritty particles broadcast in the food, and so create a degree of intestinal irritation likely to cause appendicitis. More evidence is, of course, needed to establish the connection so clearly put before the Medical Society of Birmingham by Sir James Sawyer.

I am, Sir, yours truly,
John C. Thorowgood, M.D., F.R.C.P., Lond.
Bognor, Dec. 28th, 1906.

OBITUARY.

MR. R. P. LAWSON, L.R.C.P.LOND., M.R.C.S.

BY the death of Mr. Lawson, of Higher Openshaw, a well-known Manchester citizen has passed away. He had an extensive practice in the district, and was a warm supporter of all charitable movements. Deceased was a comparatively young man, having obtained his diploma in 1893.

WILLIAM TRAVERS, M.D., F.R.C.S.

We regret to record the death of Dr. William Travers at Kensington, where he had practised for 40 years. He was one of the senior Fellows of the College of Surgeons, and took his M.D. of Durham University in 1879. He was the first resident medical officer appointed to Charing Cross Hospital, when he took office there in 1860. In 1866 he moved to Kensington, where he practised until his death. He was physician to the Chelsea Hospital for Women from 1883 to 1894. Dr. Travers was well known to the various societies connected with his profession.

MR. HERBERT W. KENDALL, F.R.C.S.

We regret to announce the death of this gentleman, who died at his residence, Burlington Road, Bristol, on December 22nd. A few days previously he had undergone an operation for appendicitis, and things appeared favourable until an attack of pleurisy supervened. The immediate cause of death, however, was from a blood clot. Mr. Kendall was a native of Gloucestershire, having been born at Bourton-on-the-Water, near Cheltenham. As a student at the Middlesex Hospital he earned a high reputation, having filled the offices of House Surgeon and Obstetrical Assistant with much credit. Only lately he had taken a new residence at Bristol, and his premature death just as he was acquiring an excellent practice is a matter of deep regret. A widow and three children are left to lament his loss.

DR. ANDREW BALFOUR, J.P.

DR. BALFOUR died suddenly on December 26th from heart failure. In him the community among whom he laboured has lost one of its most useful members. He was born in Hong Kong in 1852, and settled in Portobello as an assistant to his father in 1873. Since his father's death twenty years ago he has been in partnership with his brother, Dr. John Balfour. Dr. Balfour has taken a prominent share in the public life of the community. He was medical officer of health for Portobello until it was merged into the Edinburgh city area, and was also medical officer under the Duddingstone, and subsequently under the Edinburgh Parish Council. In 1877 he founded the Portobello Working Men's Institute, and took an active interest in the reading and recreation rooms at the adjacent village of Niddrie. He was a keen politician, and held high offices in the local Conservative Association and Union Club. How many-sided his interests were may be gathered from the fact that at the time of his death he held about 30 appointments, which, with the exception of his professional ones, were of an honorary nature. He leaves a widow, three sons, and a daughter to mourn him. He will for many a day be missed from and remembered in the borough of Portobello.

OUTBREAK OF ANTHRAX IN SOMERSETSHIRE.—A serious outbreak of anthrax has occurred at Chew Stoke. The disease broke out on a farm where the carcase of a cow, which had died in an adjoining district, had been boiled up for feeding purposes. Three people who have handled the carcase are ill, and stringent measures have been taken to prevent the spread of infection, and to stamp out the disease.

REVIEWS OF BOOKS.

MOOR AND HEWLETT'S APPLIED BACTERIOLOGY (*a*).

IN bringing out this new edition of his book, "Applied Bacteriology," Mr. Moor has been fortunate in securing the assistance of Professor Hewlett, and we may say at once that the work is a great advance on what it was in its first and second editions. It is obvious that no one not thoroughly *au fait* with bacteriology in all its practical developments in relation to disease can write a satisfactory book on the subject, but now that he has enlisted Professor Hewlett's help Mr. Moor has turned out a serviceable manual. The difficulty in preparing a work of this kind is the terrible one of deciding what out of a mass of material, formed, unformed, and in process of formation, should be included and what left out. Bacteriology is an almost impossible subject to deal with sufficiently in its present stage of development, so multifarious, contradictory, and confusing are the various observations on the subject. It is, then, hard to blame the authors for not treating some important questions at greater length, and for not giving a more complete criticism of results arrived at, for we know that to have done so would have meant curtailing the rest of the descriptions. But it is somewhat open to question whether the plan of the work is not too large for a handbook. The two chapters that follow the introduction are devoted to bacteriological apparatus and methods of bacteriological study, and they are of the practical character one expects from laboratory teachers. Then the general questions of the methods of spread of diseases, immunity, bacterial products and serum-therapy are discussed clearly and comprehensively, and thence the reader is carried on to the consideration of the specific bacteria of the various diseases. The protozoa and parasitic fungi are next described, and then follow some sections on certain diseases of animals and plants and certain diseases of man not dealt with previously. Afterwards we pass to what we consider the most satisfying part of the work, namely the chapters on fermentation, disinfection, and the bacteriology of water. Indeed, the chapter on disinfection and disinfectants is particularly good, and we could only wish that its teaching would penetrate into the bosoms of those who buy and those who sell disinfectants. For the student reading for the D.P.H. this book should be even more valuable than it has been in the past, and its previous success testifies to the estimation in which it has been held. Among the features that deserve the highest commendation are the coloured bacteriological plates. These are of great beauty and accuracy, and represent the cultural characteristics of the various organisms with astonishing fidelity.

RATIONAL ORGANOTHERAPY. (*b*)

THE volume on "Rational Organotherapy," which lies before us is described as the first, but we do not quite understand if it is the first of a series on organic remedies, or if it is to be followed by a second on the same subject. For it is almost exclusively occupied by the consideration of spermin and its effects on metabolism and tissue-resistance, as studied by Professor von Poehl. The book is none the less interesting for being the work of an enthusiast, and that Professor von Poehl certainly is. Indeed, he has been the chief worker at the subject for some fifteen years, and his belief in his theory and its success in practice

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(*a*) "Applied Bacteriology: An Elementary Handbook for the Use of Students of Hygiene, Medical Officers of Health, and Analysts." Revised and edited by Cresacre G. Moor M.A.Cantab., F.I.C., formerly Public Analyst for Exeter, and Senior Demonstrator in Public Health, King's College, London, with the co-operation of Richard Tanner Hewlett, M.D., F.R.C.P., D.P.H., Professor of Bacteriology, King's College, London. Third Edition. University Series. London: Bailliere, Tindall and Cox. 1906. 12s. 6d. net.

(*b*) "Rational Organotherapy with Reference to Urosemiology." By Prof. Dr. A. von Poehl, Prof. Prince T. von Tarchanoff, Dr. Alf. von Poehl, and Dr. P. Wachs. Translated from the Russian text. Vol. I. London: J. and A. Churchill.

seems to grow stronger with time. It is certainly well worth a medical man's while to make himself acquainted with the scope and range of spermin as here described, for not only does its employment rest on a scientifically conceived theory, but the therapeutic results obtained clinically also seem well established in fact. Spermin is an organic body which has been found by von Poehl in all the tissues, and he believes it to be a product of the decomposition of nuclein. Now the invasion of a part by bacteria is followed in normally active tissues by leucocytosis, and if the blood is of due alkaline reaction, the destruction of the leucocytes is accompanied by the release of soluble, active spermin. Spermin is said to have the power of greatly increasing tissue exchange with oxygen (textural respiration), and consequently the vital activity of the part is much enhanced. Spermin, moreover, by promoting this internal respiration, is also useful in auto-intoxication, for it helps rapidly to transform leucomaines that are clogging the tissues into soluble bodies that can be removed by the blood-stream. Spermin, in fact, is a ferment of the class "katalysator," that is, one able in infinitesimal quantities to promote or retard a reaction, without itself suffering any loss of weight. Von Poehl's studies have taken a wide range, and he has diligently pursued his object, the elucidation of the action of spermin in every direction, and we are sure that his book, for its variety and interest, will well repay anyone who reads it, quite apart from the importance of the subject itself. It is somewhat odd that a book which is not only well but even idiomatically translated, should contain words such as "octaëders," "baryt," "clysma," and many similar ones which jar ungracefully on the British medical ear.

TROPICAL DISEASES. (a)

"Lectures on Tropical Diseases" by Sir Patrick Manson need no other commendation to the English-speaking world than their title. They recommend themselves. For not only is Sir Patrick the very Hippocrates of tropical medicine, but he writes with tha vivacity and speaks with that fluency which carries the student along *nolens volens*. The facts that stand out in all his writings are that he is in deadly earnest, and that his past researches and victories are as nothing to what remains to be done, and what he means to do. So these Lane Lectures delivered at San Francisco last year may truthfully be said not only to mark the soundest views on the latest questions of tropical pathology, but also to leave the reader wondering how it is possible for a man of the lecturer's engagements to keep himself so thoroughly posted in the last details of research. In view of the catastrophe that wrecked San Francisco since the lectures were delivered, it is not a little curious to read the prophecies made at their inauguration "It takes little prescience to foretell that ere many years have passed, thousands will annually leave your shores for tropic (*sic*) countries, and thousands will return to them from tropic exile. San Francisco will become a yet greater commericial centre, and will stand in this respect to the west of the American continent very much in the same relationship as London used to stand to the west of Europe. The San Francisco of to-day is but a village as compared to the vast metropolis of the Pacific which it is her destiny to become." So, indeed, may it yet be!

But the real interest of these lectures lies in their clear, definite, and—if the word has not grown opprobrious—dogmatic teaching, and in the happy illustrations, culled from Sir Patrick Manson's rich experience, which emphasise his points. "Personally, I have never seen a malarial fever which has altogether resisted the proper use of quinine, provided the case has not already passed into a hopeless condition." "Any fever which persists unmodified after forty-eight hours' dosing with quinine, is not a malarial fever." "In this way, the filaria passes from man to man, and in this way (*i.e.*, by mosquito-transference) the elephantoid diseases are acquired and communicated. The knowledge is a sure and certain guide to efficient prophylaxis." These quotations are typical examples of the firm rocks which peep out among the shifting sands of theory and conflicting views, and which will make this book of real value to the enquirer. His interest, too, will be kept agog all the time by the clinical cases quoted, and he will respect Sir Patrick Manson all the more because he does not mind "giving himself away," and, when he can do so anonymously and without malice, his friends. His story (page 172) on the value of serum-diagnosis in Malta Fever, for instance, is as amusing as it is "teaching." We cannot say more for the volume as a whole than it is so interesting that we forget we are not reading a novel.

CLINICAL ANATOMY. (a)

The authors of "Clinical Applied Anatomy," Dr. Box and Mr. Eccles, have themselves set the standard by which they wish to be judged, for they open their preface by saying: "In 1862, there appeared a work which is now classical, 'Rest and Pain,' by John Hilton. In the preparation of the present volume we have endeavoured to follow, in some degree, the lines suggested by that author." Now "Rest and Pain" was one of the early attempts, like Sir Charles Bell's "Hand," to clothe with life the dry bones of anatomy, and Hilton succeeded as no one before or after him has succeeded in raising anatomy from the region of drudgery and mnemonics into the realms of poetry. But then Hilton brought to his task not the unimaginative mind of the formal anatomist, not the confined outlook of the student's mentor, but a degree of sweetness and light pecular to his artistic and spiritual nature. To follow Hilton, then, demands a particular type of temperament in which philosophy blends with utility, and utilitarianism finds no place, and such a disposition would be an ill equipment for a modern hospital physician or surgeon who has to nurse his students through exams to get a reputation as a "teacher." We may say at once that the present volume is as different from Hilton as the second and third parts of "Henry VI." are from the rest of Shakespeare; but that is not to deny that the work has an important function. It is curiously unequal; some parts, such as the section on the nervous system, on the malformations of the heart, and on hernia, being excellent, whilst others are of a distinctly lower order of merit. On the whole, we should describe the book most accurately by saying that it seeks to show the mechanism of disease, that is to say, it endeavours to explain why certain symptoms are produced in certain disorders, and how such symptoms are ultimately dependent on the anatomical conformation of the parts. The idea is good, especially in combining surgical and medical anatomy together, and no doubt the book will be largely read among students. They perhaps may not notice a good deal of the loose writing which frets the reviewer's eye. We might at any rate be spared such idiomatic expressions as "the right Poupart" (page 377), or such inelegancies as "almost always a much milder and usually uncomplicated disease" (page 50), and "pulmonic" (page 10). It is a pity that so useful a book and one which we take it is destined to be largely in request at two great hospitals was not a little more carefully edited. But there is much to praise in it, and its aim and somewhat original bent are highly to be commended.

(a) "Lectures on Tropical Diseases, being the Lane Lectures for 1905, delivered at San Francisco, U.S.A.' By Sir Patrick Manson, K.C.M.G., M.D., LL.D., F.R.S., F.R.C.P., D.Sc., Medical Adviser to the Colonial Office, &c. London: Archibald Constable and Co., Ltd. 1905. 7s. 6d. net.

(a) "Clinical Applied Anatomy, or the Anatomy of Medicine and Surgery." By Charles R. Box, M.D., B.Sc., M.R.C.P., F.R.C.S., Physician to Out-Patients and Lecturer in Applied Anatomy, St. Thomas's Hospital, and W. McAdam Eccles, M.S., F.R.C.S., Assistant Surgeon Joint Lecturer on Anatomy, and Demonstrator of Operative Surgery, St. Bartholomew's Hospital. 45 plates, 12 coloured; 6 figures in text. London: J. and A. Churchill, 7, Great Marlborough Street, 1906. 12s. 6d. net.

TRANSACTIONS OF THE ROYAL ACADEMY OF MEDICINE. (a)

THIS volume contains the papers read before the various sections of the Society during the year, as well as abstracts of the discussions on these papers.

We notice that an innovation was made last session, in that two evenings were devoted to general discussions on "The Diagnosis, Treatment, and Pathology of Empyema," and "Abdominal Tuberculosis." At these meetings papers were read by surgeons, physicians, and pathologists, treating the subjects from their different aspects; judging by these papers and the discussions which followed them, these two meetings must have had a considerable interest for all branches of the medical profession, and the idea of bringing together surgeons and physicians for the consideration of subjects more or less within the province of both cannot fail to be of advantage in these days, when such a tendency exists for the sharp demarcation between the two main divisions of the profession.

In the Section of Medicine is a paper of special interest on "Myelogenous Leukæmia and its Treatment." A very full clinical account of a case is given, accompanied by illustrations, charts, and tables. The main interest of the case lies in the fact that after remaining in hospital for over six months, and undergoing X-ray treatment, the patient left the hospital apparently cured. The leucocyte count, which on admission was 260,000, had fallen to normal, and the spleen had decreased more than 3 ins. in size. Among the papers read before the Surgical Section are two on "Sterilisation of the Hands"; both of these are founded on extensive bacteriological experiments. The results are surprisingly different. One observer found infection with both pathogenic and non-pathogenic organisms in nearly 40 per cent of the tubes inoculated; the other found a little over 3 per cent. of infection, and only with non-pathogenic microbes. Though the method of sterilisation varied in the two cases, this seems scarcely sufficient to explain the enormous difference in results.

A successful case of partial gastrectomy for supposed malignant ulcer is recorded; but on microscopical examination this was found to be a case of indurated inflammatory thickening around an old-standing ulcer. This case emphasises the great difficulty of making a differential diagnosis in these cases, even when the parts are exposed to view at operation, though some operators who have had considerable experience profess to be always able to recognise which condition is present.

In a paper on the treatment of Acute Peritonitis, the author very rightly advises against the use of morphia, unless a definite diagnosis has been made or a decision arrived at that operative treatment is or is not necessary. As regards the vexed question of the best method of removing foreign matter and exudation from the peritoneal cavity, the author's advice appears to be to rely on sponging only in cases of localised collections, but that in cases of generalised peritonitis free flushing with saline solution should be employed. The author also points out the fallacy of attempting general drainage of the peritoneal cavity owing to the rapidity with which adhesions form. Local drainage in the case of localised peritonitis is, of course, essential, and here the formation of adhesions is one of the objects most desired, in order to shut off the rest of the cavity from infection. But in the case of general peritonitis adhesions form around the drain, no matter what material is used, within the first twelve hours, so that the drain becomes purely local. The only exception to this is probably in the case of the pelvis, where there is a definite cavity in which fluids tend to accumulate, especially if the half-sitting-up posture is adopted. The advantages of copious saline injections are also touched upon.

Another paper of interest is one on "A Further Series of Enucleations of the Prostate." This series consists of eighteen cases with five deaths.

In the Obstetrical Section, will be found a paper on "Two Years' (Major) Operative Gynæcology in the Rotunda Hospital," also the Clinical Report of this hospital for the year.

In the Section of Pathology are numerous papers of great interest, some of which are illustrated. Among these we may mention the following:—"An Unusual Tumour of the Kidney," "A Case of Melanuria," and "Urticaria Pigmentosa."

(a) *Transactions of the Royal Academy of Medicine in Ireland.* Vol. XXIV. John Falconer, 53, Upper Sackville Street, Dublin. 1906.

DISEASES OF THE DIGESTIVE SYSTEM. (a)

THIS is no hackneyed treatise on the disorders of digestion, for the author asserts his individuality by attacking many things held in almost sacred esteem by practitioners: such beliefs for instance as that tea rapidly infused contains just as much tannin as tea left standing. He asserts that boiled milk is more digestible than plain milk, and that whiskey is obnoxious as a table beverage, and he throws cold water, metaphorically speaking, on the peptonisation of milk; he even goes the length of denying that its digestibility is thereby in any measure facilitated, though he would hardly deny that under no circumstances can peptonised milk be made to coagulate into the large hard curds formed in untreated cows' milk. On the other hand, we are told that "the use of liqueurs is justified after meals by their acting as stimulants to the muscular wall of the stomach"—a pronouncement for which many sinners will be very grateful.

Even more startling is the author's indictment of medication, having in view intestinal antisepsis, and he gravely declares that there "never was any ground in the antiseptic system of surgery" for such an attempt. Well, nobody ever suggested that there was, and the filiation of ideas would take us to Pasteur, the putative father of the germ theory of disease, rather than to Lister. But the fact that we cannot kill *all* the germs is hardly an argument against the use of intestinal antiseptics, for we may render the *milieu* more or less unsuitable short of killing anything; moreover, the excellent results that follow this medication can with difficulty be explained as merely coincidental.

The phraseology is occasionally a trifle obscure, as, for instance, when we are told in reference to the treatment of gastritis that "unfortunately the usual practice is to treat the gastritis more or less successfully . . ."; or when we are advised to dilute our wine with "mineral water"—any mineral water, apparently, chalybeate, alkaline, laxative, or what not.

We are quite touched to see our old physiology friend, Alexis St. Martin, referred to so often; we had thought he was dead and buried; indeed, this and the reiteration of explanations of ordinary terms, "atony, want of tone," and the like, suggest that the author was anxious to be understanded of the people as well as of the profession. Very much on a par with this is the solemn pronouncement that "the radical treatment of cancer of the stomach is undoubtedly surgical," and the statement in respect of secondary gastric dilatation that "surgery" is "ready and able" to effect a cure.

But these, after all, are minor if irritating blemishes, for the work as a whole is a sound practical guide to the dietetic and medicinal treatment of diseases of the digestive organs, winding up, as it does, with a list of well-known formulæ from the hospital pharmacopœia. As these diseases and disorders constitute a very large part of the general practitioner's work, the author, with his wealth of experience, is sure of an appreciative audience.

(a) "The Treatment of Diseases of the Digestive System." By Robert Saundby, M.D., F.R.C.P., &c., Professor of Medicine in the University of Birmingham, &c. London: Charles Griffin and Co. Ltd. 1906. Price 3s. net.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

The Treatment of Bronchiectasis.—Chaplin (*The Practitioner*, December, 1906) discusses the various forms of treatment which have from time to time been advocated for this complaint. He is of opinion that the onset of fœtid expectoration is in almost every case the starting-point of the course downward, and the aim of the physician must be to adopt methods of treatment to ward off this onset. For this purpose he has for some years past adopted the inhalation of creosote vapour with very considerable success. For the purpose of this treatment a small room about seven feet square is used, to which only a limited amount of fresh air is allowed access. In the centre of the room a fairly deep enamel dish, with five or six ounces of creosote, is placed, and under this is placed a lighted spirit lamp. The creosote vapour is driven off from the dish, and when the room is fairly thick with the fumes the patient enters, and remains in it for from twenty minutes to an hour. The patient's eyes are to be protected with watch-glasses, and the nostrils stopped with cotton-wool. The treatment is continued daily for about three months, and after that bi-weekly sittings are given. Chaplin states that he "has never met with a case unable to take the treatment, out of an experience of over a hundred cases treated." As regards results, only three of his cases have failed to be improved, while in the vast majority the improvement was most marked, the fœtor ceasing in almost every case, and in many not returning after long periods of time. K.

Treatment of Sunstroke.—Captain Foulds (*Journ. R.A.M.C.*, December, 1906) advocates the use of iced water enemata for this condition. Foulds points out that the treatment usually recommended of ice-packs is very difficult to carry out in India owing to the difficulty of getting large quantities of ice, and the statistics in that country show a very high mortality from sunstroke. Thus, in 1903, 307 cases were admitted to hospital, of which 54 died, besides which there were 15 deaths recorded out of hospital. During that year Captain Foulds had nine cases of sunstroke admitted to hospital, all of which were treated with repeated enemata of ice water and all recovered. Foulds recommends that an enema of about two pints should be given and repeated every ten minutes till the axillary temperature falls to 102 degrees F. K.

Accidents Following Thoracentesis.—Sears (*Amer. Jour. Med. Science*, December, 1906) reports four cases in which pneumothorax resulted from this operation, and suggests that the complication is more frequent than is generally believed. He also reports a case of sudden death following the introduction of a needle into the chest for the purpose of aspiration. The patient was a man, æt. 49 years, who had an effusion in the left side of the chest reaching to the third rib. On the day after admission to hospital, sixty-four ounces of bloody fluid were removed by aspiration, but the fluid re-accumulated, and three weeks later a second attempt at aspiration was made. The operation produced no mental perturbation, but when the needle was introduced he almost immediately collapsed, became cyanotic, and almost pulseless. All efforts at stimulation failed; he became unconscious, and died fifteen hours later. Only a partial post-mortem examination was allowed, and the brain was not examined. The left pleural cavity was found to contain a considerable quantity of blood-stained fluid, and the left lung was much compressed. Numerous tubercles were found scattered over both parietal and visceral pleura, both of which were considerably thickened. The heart was normal, but the kidneys showed acute glomerular nephritis. Sears does not offer any explanation of the death of this patient, though from the condition of the lung and its position, he is unable to accept the explanation which Russel has given of similar cases. From a careful study of three cases reported by him, and also from experiments on animals, Russel has concluded that the sudden syncope is due to afferent impulses conveyed to the medulla along the vagus nerve, whose terminal fibres, rendered unduly sensitive by compression or inflammation, are irritated by the needle. Sears points out that in his case it is hardly possible that the exploring needle could have reached the pulmonary branches of the vagus, since the two surfaces of the pleura were separated by a considerable layer of fluid. K.

Favourable Influence of X-rays on Chronic Bronchial Affections.—Schilling (*Mün. Med. Woch.*, 1906) had occasion to examine a patient with severe bronchial asthma, and used the X-rays to determine the exact status of the air passages. The patient found that his asthma was favourably influenced by the fluoroscopy, and Schilling thereafter applied the X-rays systematically in a large number of cases of chronic bronchitis and bronchial asthma. He tabulates the results as determined by the amount of sputum. In one case it dropped from 150 c.c. to 80 c.c. in three days after the X-ray exposure. Another patient, a man of 62, had been coughing and expectorating for months. The day before the X-ray exposure the amount of sputum was 170 c.c., the day following 140, then 110, 50, and decreased to 40 c.c. by the sixteenth day, and expectoration had entirely ceased by the end of the fifth week. In every instance the amount of sputum dropped nearly one-half the day after the exposure, and progressively declined thereafter. Every patient was favourably influenced, and the improvement or the complete cessation of the expectoration and asthma persisted for months. He suggests as explanation of the unmistakable and prompt benefit derived that possibly the proliferating cells of the microscopic glands in the bronchi react to the rays, similarly to the effect observed in X-ray treatment of hypertrophied prostate, lymphoma, goitre, etc. The extreme permeability of the lungs for the X-rays aids in the process. He used a 30 c.m. inductor, the patients were seated, and the exposure was made from two, four, or more directions, at the points where the rattling was most pronounced, avoiding those where the muscles were especially thick. The unexposed parts were protected against the rays, and the exposure lasted from 10 to 15 or 20 minutes, the distance from the tube being about 15 c.m. The total of the exposures was kept within the range of the maximal dose, and only a single sitting was given. Notwithstanding the unmistakable relief from excessive bronchial secretion and from the tormenting asthma, Schilling reserves his opinion in regard to the actual therapeutic value of X-ray treatment of bronchial affections until he can speak from a larger experience. D.

Alcohol in the Nutriment of Diabetics.—Benedict and Sörök (*Zeit. f. Klin. Med.*, 1906) attempt to show by substituting alcohol for a part of the food fat whether the acetone in these cases is derived from the fat. They find in diabetics that the acetone excretion is reduced by this alcohol substitution, but in non-diabetics there is little effect. In some cases there is also a decreased glucose and nitrogen excretion. In the metabolism of healthy individuals alcohol can replace proteids, but less effectively than is done by carbohydrates and fats. On the other hand, in diabetics alcohol seems more effective in replacing the proteids in metabolism than is the case with the fats and carbohydrates. These observations justify the use of alcohol in the diabetic dietary. Contra-indications for its use are albuminuria, neuritis, arterio-sclerosis. It should not be used in diabetes occurring in childhood. D.

Ring Test for Acetone.—Lange (*Mün. Med. Woch.*, 1906) has modified the Legal test and rendered it simpler and more reliable by substituting ammonia for the sodium hydrate. This avoids the disturbing creatin reaction. The urine (15 c.c.) is treated with glacial acetic acid (.5—1 c.c.), and then with a few drops of a freshly prepared solution of sodium nitroprusside; a few c.c. of ammonia are then cautiously poured on top of the mixture. In case of the presence of acetone, a bright violet ring appears at the point of contact. The violet ring grows brighter and brighter without spreading wider, irrespective of the quantities used in the test tube. Acetone .025 per cent. is readily detected by this test. Alcohol and aldehyde do not give the reaction. D.

Treatment of Hyperchlorhydria.—Rebizzi (*Gaz. deg. Ospedali Milan*, 1906) describes his experiences with eight patients with hyperchlorhydria, taking a test meal nearly every day with examination of the stomach contents. They were treated with glucose, atropine, or a mixture of equal parts of tinct. stramonium, belladonna and hyoscyamus, the dose of the latter being 20 drops morning and night. The effect of the last two was most excellent in the cases of primary hyperchlorhydria associated with gastric ulcer, and dubious in hyperchlorhydria associated with neurasthenia. The glucose did not seem to produce much effect. D.

The Heart in Acute Infections.—Ortner (*Zeitschrift für Heilkunde*, Bd. xxvi., H2.) has studied the circulatory system in a large number of typhoid patients, and finds in most of them accentuation of the aortic sound, dicrotism, irregularity, well-filled arteries, and a pulse of good amplitude. In some cases also he noticed a dicrotic capillary pulse in the finger-nails. He regards these phenomena as due to increased effort on the part of the heart, secondary to a toxic relaxation of the peripheral vessels. As Weisel's investigations have shown, there occurs in the peripheral arteries not only a toxic loss of tone, but also severe anatomical changes in the elastic tissues of the vessel wall. Similar changes may be found in other infective diseases, such as influenza and pyæmia. As long as the heart responds in the proper way to these peripheral changes, by augmenting the force of its beat, the prognosis is good, and this can be determined clinically by observing that the aortic second sound is louder than the pulmonary. When the pulmonary is the louder of the two, the prognosis is less favourable. M.

Narcolepsy. — Blodgett describes an interesting example of this condition (*Amer. Journ. Med. Sci.*, August, 1906). The condition consists of a sudden and irresistible inclination to sleep, coming upon an individual outside the hours usually passed in slumber, and appearing with a more or less regular periodicity. It is generally found in persons suffering from the arthritic diathesis, or during the course of the different auto-intoxications. The cause at work in the present case is supposed to be a syphilitic infection transmitted to the third generation, the evidence in favour of this being that all the members of the second generation presented well-defined symptoms of hereditary taint, and that many members of the third present similar stigmata. The patient is a woman, æt. 65, who first noticed at the age of 22 that she was subject to periodic and frequently returning attacks of somnolence. The attacks come on at all times of the day, and on awaking the patient is usually unaware that she has been asleep. Her sleep at night is good, and her general health excellent. Latterly it has been thought that her mental powers show some sign of deterioration. Occasionally a whole day is passed in rapidly following sleeping periods. The patient can always be easily aroused, and never presents any signs of mental confusion. M.

Hæmophilia.—Muir places on record a family in which bleeders have been known to exist during the last eight generations (*South African Med. Rec.*, Oct. 25th, 1906). The earliest case occurred in a male who was born in 1783. This individual died from epistaxis. He had five healthy sons, and four daughters. Of the daughters, two had healthy children, and two had hæmophiliac sons. One of these sons had six healthy male children, and two daughters, both of whom transmitted the condition to their male children. The writer refers also to numerous collateral branches of this family in which instances of bleeders were known. He also calls attention to the fact that the disease seems to have been twice handed on by the male line—namely, from the first to the second generation, and from the fourth to the fifth. In the present generation, the eighth, at least seven cases have already come under the writer's notice. M.

Arsenic in Diabetes.—Monsieur Verdalle writes on this subject (*Archiv. Gen. de Méd.*, March, 1906), and comes to several important conclusions with reference to the use of arsenical waters. These may be summarised as follows:—(1) Arsenical hydrotherapy is useful in all forms of diabetes, but especially in that form which is ascribed to hyper-activity of the liver. (2) Albuminuria is no contra-indication to the use of arsenic. (3) The result of a course of treatment is that in most cases the glycosuria completely disappears, and the excessive nitrogenous excretion also diminishes *pari passu*. (4) The general health is also enormously improved, and in no case have any signs of poisoning by the arsenic shown themselves. (5) The existence of anæmia, skin complications, and pulmonary trouble is an additional factor in rendering the use of arsenic of the greatest importance, if any improvement is to be gained; but the less complicated the case and the earlier it is got under treatment the better the result. M.

Mast Cells in Leukæmia.—Joachim reports the post-mortem findings in two cases of leukæmia, in the blood of which during life there was an enormous preponderance of mast cells up to 56 per cent. The one case was treated by arsenic, and the other by X-rays, but in neither did any improvement take place. The autopsy showed changes in the red marrow, great enlargement of liver and spleen, and also swelling of the inguinal, mesenteric, and mediastinal glands. In all of these there were found very large numbers of mast cells, while the liver and spleen showed throughout myeloid transformation. Very numerous Charcot-Leyden crystals were found both in the leucocytes of the fresh blood and also in the pathologically altered viscera. Under the X-rays the mast cells showed less relative diminution in numbers than the other white cells; thus, though they fell absolutely from 133,000 per c.m. to 79,000 per c.m., their percentage number at the same time rose from 56 per cent. to 80 per cent. M.

A Hard Case.

Lately, Mr. W. Adamson, president of the Royal Southern Hospital, Liverpool, speaking from long experience of the work carried on at that institution, mentioned that many strange facts came to his knowledge. One that specially attracted his attention was the fate of a patient from whom there were taken in five different operations 228 plum stones, 28 cherry stones, 90 grape seeds, and 12 extras, comprising stones, nutshells, and bits of stone. A further miscellaneous assortment of odds and ends would, no doubt, have been excavated had not the patient died.

MEDICAL NEWS IN BRIEF.

Case of Anthrax.

An inquest was held at Liverpool, on December 24, on the body of a widow thirty-four years of age. The woman's son said his mother, a healthy woman, got her living by making bags for a firm of sack merchants in Liverpool. When she returned home from her work on December 17, her neck was swollen. She attended the North Dispensary, and in the evening was sent to the David Lewis Northern Hospital. The manager at the sack and bag warehouse said that, in addition to making new bags and sacks, his firm repaired bags which had held sugar and various kinds of grain, but no animal matter. The bags were all more or less of a dusty nature. The woman sewed the bags, which were classified. Those which she attended to during the week before last, belonged for the most part to a firm of millers, whilst there were also a few sugar bags, which had come from grocers' and confectioners' shops. He had never heard of a case of anthrax arising through work such as the woman had been engaged in.

Mr. Evans (Inspector of Factories) said there were special regulations dealing with anthrax, but they did not apply to sack and bag warehouses. That was the first case of the kind that he had heard of.

Dr. Byrne, of the David Lewis Northern Hospital, described the measures taken. She was admitted on the Wednesday night. A typical malignant pustule or sore was found on the neck, accompanied by a good deal of swelling. About an hour later she was operated on. She seemed fairly well all that night and during the following day. About twelve o'clock at night, however, her pulse began to weaken, and gradually failed, in spite of everything. The case was undoubtedly one of anthrax. They took a slide of the affected part prior to the operation. They examined it microscopically, and found the anthrax bacilli there in enormous numbers. This was a case of external anthrax. The woman probably had a scratch or small boil, and thus got the infection. The period of incubation was two or three days, so that she might have got the germ before the pimple appeared.

Mr. Glover, solicitor, said he had been requested by Mr. Connolly to say how sorry he was that such an accident should have happened, and that so far as the woman's son was concerned, he would do all he could to find him employment and to look after him.

The Deputy Coroner, addressing the jury, said that unfortunately there had been a good many cases of anthrax in Liverpool lately. This, however, was the first case where the disease had appeared in anybody working at a bag warehouse. It was possible that the woman had got the infection from the bags, but it was equally possible that she had got it elsewhere.

The jury returned a verdict to the effect that death was due to anthrax, adding that as to how set up, there was not sufficient evidence to show.

Outbreak of Diphtheria.

A serious outbreak of diphtheria is reported from Totley and adjacent hamlets in Derbyshire, and it is estimated that there are upwards of a hundred cases. Recently a young man named Arthur Fell, who was affected with fatal results, was buried in the dead of night, in order to avoid a congregation of people, or anything in the nature of a demonstration. When nearly everybody in the village was asleep, the carriage wended its way up to the house in which the young man had lived, and his body was brought down to a burial ground at Dore. With as little ceremony as possible it was interred there. A few days before the young man's brother died from an infectious disease, and was buried in the ordinary way by daylight, although the relatives and friends took the precaution of limiting the number of mourners. Among them was the brother Arthur, and he was stricken with illness almost as soon as he got home. It is feared that a contributory cause to the disease spreading to such an alarming extent was the disinclination of a few parishioners to take the necessary precautions when the outbreak was in its early stages.

Wholesale Lead Poisoning.

Another lead poisoning scare has occurred at Saddleworth, said to be due to the drinking of the water supplied by the Ashton Joint Waterworks Committee. The water is acid from the decomposing peat, and so dissolves the lead service pipes. At a meeting of the Saddleworth District Council, Dr. Ramsden, the medical officer of health, said hardly a day passed without his having reports as to lead poisoning. Lead poisoning was wholesale, and he would have to write to the Local Government Board if things went on this way. The consequences on the future generation would be more than he could describe. It was also stated that people were giving up the Corporation supply and going back to the springs, so great is the alarm. As regards general health, Dr. Ramsden said he had never known a time when there was such an epidemic of all kinds of diseases.

Industrial Diseases.

As a result of the labours of the Departmental Committee which has for some months past been sitting at the Home Office, under the chairmanship of Mr. Herbert Samuel, M.P., about thirty so-called industrial diseases will be added shortly to the schedule of the Workmen's Compensation Act, to which the Royal assent has just been given. Among these scheduled diseases have been already included lead poisoning; “phossy jaw, which afflicts certain people engaged in manufacture which necessitates the use of phosphorus; anthrax, to which wool workers are more or less exposed; and ankylostomiasis. Among those who have been assisting the Parliamentary Under-Secretary with expert advice are Prof. Clifford Allbutt, F.R.S., and Mr. H. H. Cunynghame, the Assistant Under-Secretary at the Home Office.

Commission on the Feeble-Minded.

At a sitting of the Royal Commission on the Care and Control of the Feeble-Minded on December 13th, Dr. E. W. White, professor of psychological medicine at King's College, said he was of opinion that the Lunacy Commission was totally inadequate for the proper discharge of its duties. The paid Commissioners on the central board should be increased by three medical members. The amalgamation of the office of Lord Chancellor's Visitor with the Commissioners would certainly be a step in the interest of economy. He was strongly in favour of local Commissioners. Dr. J. Smith Whitaker, medical secretary to the British Medical Association, said the association recommended a board of Commissioners should have the central supervision of every variety of unsoundness of mind. The placing of persons suffering from habitual inebriety and drug habits should not be made dependent upon any previous criminal procedure, but the whole procedure should be made analogous to that of the Lunacy Acts. He also recommended the removal of the disqualification on certain medical practitioners in regard to the post of Commissioner in Lunacy. Dr. A. C. Buist, chairman of the lunacy (special) committee and of the medico-political committee of the British Medical Association, expressed his agreement with this statement. He would like to see in the House of Commons a Minister who would look after the health of the nation. On December 14 Dr. J. B. Spence, medical superintendent of the Staffordshire County Asylum, stated that he favoured the amalgamation of the offices of Commissioner and Lord

Chancellor's Visitor. He would like to see all legally recognised insane and imbecile institutions of the country placed under the control of the Commissioners in Lunacy. On no account should any power at present exercised by the various county councils be relegated to the new board. Mr. P. P. Pennant, chairman of the Visiting Committee of the North Wales Counties Lunatic Asylum, said his committee felt that the usefulness of the Lunacy Commission would be extended by the addition of a number of members selected from the visiting commitee of, say, groups of counties. Mr. William Hodgson, chairman of the County Asylum, Chester, criticised the Commissioners with regard to their attitude towards local authorities in the matter of the erection of buildings.

Midwife Blamed.

An inquest was held at Rhymney on December 20th, when the circumstances attending the death of Miss Edith Frances Lloyd, of Rhymney, resulted in Mrs. Thomas, a midwife, being severely censured.

The evidence was that the deceased was a single woman, and that she gave birth to a still-born child on the 8th ult. The mother said she did not send for a midwife until an hour and a half before the child was born. A doctor was sent for in the evening, for witness did not think the child would be born till January.

The Coroner: You are a bigger fool than you look. The Coroner also questioned the deceased's sister on the same points.

Dr. D. Ll. Thomas said that when he saw the patient she was barely conscious. The *post-mortem* revealed that the bladder was injured. The immediate cause of death was blood-poisoning by urine. The injury to the bladder was, in his opinion, caused by pressure on the bladder during confinement. A midwife who knew her ordinary duty would be expected to know of such a state of things and how to deal with it.

Mrs. Margaret Thomas said she had been a midwife for thirty years. The reason she was not registered was because she had been to the "States," and on coming back was not aware that she need be registered. She took charge of the case about seven o'clock in the morning, and left about half-past ten a.m., and the condition of the young woman then was very good. Deceased had been sick, but she did not take any notice of that because a good many people were sick and got over it.

The Coroner said the evidence of the midwife showed that she was an ignorant woman. She had confined hundreds of women, and brought their children into the world by luck, and not by skill. There was a moral blame attached to the mother and sister, but with regard to the midwife they had to consider whether she was not culpable.

A verdict of "Death by Misadventure" was returned. The Coroner said the jury had also added a rider, severely censuring Mrs. Thomas, the midwife, for her ignorance, and they had seriously considered whether they would not bring the case before another tribunal, as this ignorance of her duties directly led to the young woman's death. In doing this, however, they had not lost sight of the fact that she was called in late. The jury also considered that the mother and sister of the deceased had been guilty of a grave error of judgment in not sending for the midwife and doctor sooner.

Tuberculosis in Stirlingshire.

At a recent meeting of the Western District Committee of Stirling County Council yesterday, a subcommittee reported upon a scheme proposed by Dr. M'Vail, involving voluntary notification, the equipment of a laboratory, and the appointment of an assistant to the doctor to deal with tuberculosis. In the event of Dumbartonshire combining in working out the scheme, it could be carried out at an annual expenditure of £242, plus £100 for equipping a laboratory. This on a net valuation of £860,000 could be done at a rate of ½d. per £1, half on owner and half on occupant. The question of imported cases of tuberculosis was raised—cases of town consumptives going out into the country and taking lodgings. Several members thought the county should not be at any expense in their case. Ultimately it was agreed to adopt Dr. M'Vail's scheme, provided the other districts did likewise.

National Maternity Hospital, Dublin.

Last week the new wing attached to the National Maternity Hospital, Holles Street, Dublin, was opened by Archbishop Walsh. The ceremony attracted a large company. Archbishop Walsh, patron of the institution, presided. Dr. P. J. Barry, on behalf of the governors, mentioned that the outlay connected with the erection and equipment of the new wing would exceed £4,000, and the expenditure of so large a sum completely exhausted the resources of the institution. The governors felt it their duty to carry out these improvements, trusting to the generosity of the public to recognise the merits and claims of the hospital. It was further mentioned, as an additional proof of its merits, that 10,000 visits are annually paid by the nurses of the hospital to poor women at their own homes.

Archbishop Walsh then declared the new wing opened, and after some further speeches the meeting terminated.

PASS LIST.

London School of Tropical Medicine.

The following candidates have passed the examination held at the end of the twenty-second session of the School, December, 1906:—

Major S. A. Harriss, I.M.S., M.B., C.M. (Edin.), M.R.C.S., L.R.C.P., D.P.H. (Camb.), F. M. Suckling, M.B., Ch.M. (Sydney), P. H. Pereira, M.B. (Madras), M.R.C.S., L.R.C.P. (Colonial Service), W. B. Orme, M.R.C.S., L.R.C.P. (Colonial Service), and Major J. B. Smith, I.M.S., M.B., B.A., M.Ch. (R.U.I.), with distinction. O. Blumhe, M.D. (Havana), W. Cammack, M.D. (N.W. University, Chicago), Mrs. W. Cammack, M.A., M.D. (State Univ., Iowa), E. P. Caropoulos, M.D. (Athens), C. F. Fothergill, M.R.C.S., L.R.C.P., M.B., B.C. (Camb.), B.A., D. Giordano, M.D. (Rome), H. W. Gush, M.B., Ch.B. (Edin.) (Colonial Service), F. I. M. Jupe, L.S.A., M.A. (Cantab), (Colonial Service), E. J. Maxwell, B.A., M.B. B.C. (Camb.), M.R.C.S., L.R.C.P., H. B. G. Newham, M.R.C.S., L.R.C.P., D.P.H. (Camb.), H. McG. Newport, M.R.C.S., L.R.C.P. (Colonial Service), Capt. J. M. Phalen (U.S. Army), Ph.G. (N.W. Univ., Chicago), M.D. (Univ. of Illinois), Miguel Paz, M.D. (Guatemala), A. B. S. Powell, L.R.C.P. and S. (Edin.), (Colonial Service), C. C. Robinson. M.B. (Lond.), M.R.C.S., L.R.C.P. (Colonial Service), F. O. Stoehr, M.B. (Oxon), K. R. Tampi, B.A. (Madras), M.B., Ch.B. (Edin.), W. A. Trumper, M.R.C.S., L.R.C.P., A. W. Wilson, M.D., B.C. (Camb.) (Colonial Service), and W. W. Woolliscroft, M.R.C.S., L.R.C.P.

Society of Apothecaries of London.

The following candidates passed in surgery:—R. L. H. Davy, G. B. Messenger, F. B. O'Dowd, W. F. Skinner, and S. H. Watton.

Medicine:—A. E. Blythman, R. L. H. Davy, Q. S. Keat, D. E. C. Pottinger, and W. F. Skinner.

Forensic Medicine:—R. L. H. Davy, D. E. C. Pottinger, W. F. Skinner, and W. W. Stacey.

Midwifery:—R. L. H. Davy and D. E. C. Pottinger.

The diploma of the society was granted to the following candidates, entitling them to practise medicine, surgery, and midwifery:—R. L. H. Davy and Q. S. Keat.

The Gresham Lectureship.—The appointment from the City of London held by the late Dr. Symes Thompson will be filled in February next. The necessary qualifications of applicants for the Gresham Lectureship on Physics have been altered to the following:—Candidates must have taken the degree of M.D. in some university of Great Britain or Ireland, or must be Fellows of the Royal College of Surgeons. The age limit has been withdrawn.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

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CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

DR. F. N.—Yes, the term "metallic ferment" is used. It signifies the metallic brines prepared after the method of Bredig by the action of an electric arc upon metallic salt solutions These brines have catalytic effects, and are sensitive to chemical and physical agents as ferments a e. They have been used for the treatment of disease by subcutaneous injection.

N. S.—Too much discretion cannot be exercised in dealing with patients of the unfortunate class. It is better not to make any effort oneself beyond writing to a good home and trying to enlist their interest. Several admirable institutions exist for the purpose, and we should advise you to write direct to the secretary of one of them.

LOCUM.—You may of course approach members of committee before a vacancy is actually declared, but it must rest with your judgment as to whether it is advisable to do so. If canvassing is not permitted . it is not unlikely that members may object to being button-holed at any stage in the proceedings, and you may do more harm than good. If the body is anything like a fair one, it will not allow solicitations of any kind, and we should, in a general way, advise you to act exactly as those candidates who have not your information.

F. J. K.—Surely the mere male is not competent to give advice on such a subject. As a matter of good taste we should certainly say "No," but people do not seem to regard the doings of the Suffragettes with any particular degree of aversion. Such a procession as you describe might break the flinty hearts of the President and Fellows, but we "hae our doots." We do not know any police-station in the immediate vicinity.

LESTER.—The Nobel Prize in Medicine for this year was divided between Professor Camillo Golgi, of Italy, and Professor Santiago Ramon y Cajal, of Madrid. The amounts received by each were over £3,500. The announcement appeared in the usual journals.

AN IMPOSTOR

A CORRESPONDENT asks us to warn our readers against a German, speaking excellent English, who seems to be making a point of calling on medical men for pecuniary assistance under the pretence that his wife's maiden name is the same as that of the individual called upon, to whom he says she is remotely related.

MR. E. J. R. OLIVER'S letter is unavoidably held over for want of space.

THE MOST POPULOUS CITIES OF THE WORLD.

THE official returns of the great cities from which the Registrar General receives statistics, excluding of course such as the Chinese, whence no enumeration comes to hand, are as follows:—London (not including suburbs), 4,684,794; New York, 3,948,191; Paris, 2,660,559; Berlin, 2,035.815; Chicago, 1,932.315; Vienna, 1,897,630; Philadelphia, 1,438,318; St. Petersburg, 1,248,122; Moscow, 1,092,360; Rio de Janeiro, 850,000; Calcutta 847,796; Buda-Pesth, 836,267; Glasgow, 809,986; Bombay, 776,006; Hamburg, 772.852; Liverpool, 730,143; Manchester, 631,185; Boston, 617,950; Birmingham, 542,958; Amsterdam, 554,240; Madras, 509,346; Brussels, 586,936; Rome, 514,930; Munich, 528,000; Copenhagen, 426,000.

MR. A. DINGWALL K. is thanked for his appreciative letter.

DR. ERNEST J.—Your communication is marked for early insertion.

M. O. H.—The question of "return" cases of scarlet fever and other infectious diseases has been fully dealt with in a series of original papers published in THE MEDICAL PRESS AND CIRCULAR in 1904. Whatever the general tendency of notification and isolation may be in the long run with regard to the two maladies mentioned, it certainly has not so far reduced the incidence of the disease. Mortality, however, has fallen considerably in both instances.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 2nd.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: A Specimen will be shown by Dr. A. Routh. Papers:—Dr. A. Donald: Chronic Septic Infection of the Uterus and its Appendages. Dr. W. F. Shaw: The Pathology of Chronic Metritis.

THURSDAY, JANUARY 3rd.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m.: Clinical Cases.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Bullous and Vesicular Eruptions: V., Herpes; VI., Zoster; VII., Dermatitis Herpetiformis.

FRIDAY, JANUARY 4th.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.—Clinical Meeting.

Vacancies.

Edinburgh School Board.—Medical Officer. Salary £400 per annum Applications to G. W. Alexander, Clerk, School Board Offices Edinburgh.

King Edward VII. Sanatorium, Midhurst, Sussex.—Pathologist. Salary £250 per annum, with board, lodging, and attendance. Applications to the Hon. Secretary, 19 Devonshire Street, Portland Place, W.

South Devon and East Cornwall Hospital, Plymouth.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to P. J. Langdon, Secretary.

Down District Asylum, Downpatrick. — Junior Assistant Medical Officer. Salary £130 per annum, with board, residence, and laundry. Applications to M. J. Nolan, Resident Medical Superintendent. (See advt.)

Newport Borough Asylum, Caerleon, Mon.—Assistant Medical Officer. Salary £150 per annum, with board, apartments, and attendance. Applications to the Medical Superintendent.

Carmarthen, Cardigan, and Pembroke Joint Counties Lunatic Asylum, Carmarthen —Junior Assistant Medical Officer. Salary £150 per annum, with furnished rooms, board, washing, and attendance. Applications to W. Morgan Griffiths, Clerk to the Asylum Visitors, Carmarthen.

Royal South Hants and Southampton Hospital.—House Physician. Salary £100 per annum, with rooms, board, and washing. Applications to T. A. Fisher Hall, Secretary.

Royal National Hospital for Consumption, Ventnor.—Senior Resident Medical Officer. Salary £200 per annum, with board and lodging. Applications to the Secretary, 34 Craven Street, Charing Cross, London.

Appointments.

DUNLOP, J. B., M.B., B.C.Cantab., Assistant Physician to the Bradford Royal Infirmary.

FORTY, A. ALAN, L.D.S.Eng., Honorary Assistant Dental Surgeon to the Leeds Public Dispensary.

JOHNSON, G. JAMESON, M.B.R.U.I., F.R.C.S.Irel., University Examiner in Clinical Surgery, Dublin University.

LITHGOW, J. D., M.B., C.M.Edin., F.R.C.S.Edin., Assistant Surgeon to the Ear and Throat Department of the Royal Infirmary, Edinburgh.

MILES, G. L. N., L.R.C.P. and S.Irel., Certifying Surgeon under the Factory and Workshop Act for the Farnham District of the county of Surrey.

PURVES, W., M.B., B.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Milnthorpe District of the county of Westmorland.

ST. JOHN, W. ST. A., M.R.C.S., L.R.C.P.Lond., Honorary Anæsthetist to the Derbyshire Royal Infirmary.

THOMPSON, THEODORE, M.D.Cantab., M.R.C.P., F.R.C.S., Physician to the Poplar Hospital for Accidents.

TURNBULL, Miss J. H., M.D., B.S.Lond., Surgical Registrar to the Royal Free Hospital.

TURNER, Major R. G., I.M.S., Clinical Assistant to the Chelsea Hospital for Women.

Births.

BALLANCE.—On Dec. 27th, at 4 Royal Terrace, Weston-super-Mare, the wife of H. Stanley Ballance, M.D., B.S., of a son.

FERNANDES.—On Dec. 24th, at Smallburgh Place, near Norwich, the wife of Ramsden W. L. Fernandes, M.B., C.M., of a daughter.

GREENWOOD.—On Dec. 24th, at Sowood House, Ossett, Yorks, the wife of William Greenwood, M.R.C.S., L.R.C.P., of a daughter.

SMARTT. On Dec. 27th, at Bowmere Cottage, Tarporley, Cheshire, the wife of Walter Smartt, F.R.C.S.I., of a son.

Marriage.

CARTER—SAVERY.—On Dec. 22nd, at All Saints' Church, Ealing, Charles, younger son of the late William Carter, of Coventry, to Ruth Key, youngest daughter of the late John Charles Savery, M.R.C.S., L.S.A., of Hastings.

Deaths.

FOWLER.—On Dec. 19th, at Overstone, Northants, the widow of William Fowler, M.D., of Altofts, Yorks, and second daughter of the late Thomas William Elford Morant, aged 79.

GIBBS.—On Dec. 27th, at 5 Riggindale Road, Streatham, Surgeon-Major John G. Gibbs, aged 80.

HART-SMITH.—On Dec. 28th, at 21 Adelaide Road, Brockley, S.E., John Morshead, son of Dr. Humphry Morshead and Julia Hart-Smith, aged two months.

MORISON.—On Dec. 25th, at Springfield, West Hartlepool, Lizzie, second daughter of the late Captain Morison, Broadhempston, Devon, and beloved wife of Fred H. Morison, M.D.

NETHERCLIFT.—On Dec. 28th, at Thornhurst, Bournemouth, William Henry Netherclift, F.R.C.S., J.P., of Canterbury.

NORTON.—On Dec. 26th, at 6 Salford Road, Fanny Sophia, widow of the late Robert Norton, M.D., of Bayswater, aged 84.

SCUDAMORE.—On Dec. 26th, Annie Bell Scudamore, wife of the Rev. J. C. Scudamore, Rector of Ditchingham, and daughter of C. F. George, M.R.C.S., of Kirton-in-Lindsey.

TOLLER.—On Dec. 20th, at The Zephyrs, Scarborough, Ebenezer Toller, M.R.C.S., formerly Medical Superintendent of St. Luke's Hospital, London, and late Medical Superintendent of the Gloucester County Asylum, in his 77th year.

WADE.—On Dec. 26th, in London, Surgeon-General F. W. Wade, in his 78th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, JANUARY 9, 1907. No. 2

NOTES AND COMMENTS.

Unpaid Bills.

IN illustration of what we said last week about the virtuous indignation of newspapers against medical men who are put upon or actually cheated by careless or unscrupulous people, we may mention a striking instance which has come to notice. An inquest was held at Liverpool at the end of last month on a woman who died in a confinement. It appears that she was attended by an unregistered midwife, and that when things were found to be going wrong, the latter sent for an unregistered practitioner to help her. This person recognised that still further help was necessary, and sent for a local medical man, who replied that he could not meet him in consultation, but that he would attend if the unregistered practitioner retired. This having been accomplished, Dr. Billiard, the medical practitioner, went to the house, although he had an unpaid account against the patient, and finding the woman seriously ill he called in a colleague. Together they decided that the case was one for hospital treatment, and Dr. Billiard himself promptly went to the hospital and ordered them to send the ambulance at once. Through some misunderstanding this was not done, and eventually another practitioner, to whom money was also owing, was called in. By this time the child was partly born, and when it was delivered it was found to be dead. The mother, too, died shortly afterwards from rupture of the uterus.

And Gratitude.

Now what inferences do these facts obviously suggest? In the first place, surely, that people who run up accounts with medical practitioners and do not pay them should consider themselves fortunate indeed that in emergency these practitioners will still come to their aid; and in the second that the practice of unregistered persons, be they medical men or midwives, constitutes a grave abuse, and that people who employ them must take the consequences of their actions. And, thirdly, on reading the reports, we cannot fail to be struck with the care exercised by Dr. Billiard in the conduct of the case and his energy in going himself to secure the ambulance. No satisfactory reason seems to be forthcoming as to why it was not sent, and this appears to be not the least unfortunate part of the case. What actually happened, however, was that Dr. Billiard was severely censured by the coroner's jury for leaving the woman, and a prominent local paper published a leader dealing with the subject and expressing a hope that "this experience of the doctor will be wholesome in its effect"! If this is the way that medical men are to be treated by the public, it will be necessary seriously to revise the attitude of the profession to the community.

A Kindly Act.

IT is a comfort to turn from a case of such ingratitude to one in which a medical man was specially commended by a jury for his kindness. On Christmas Day, Dr. Conrad Basan was called to see the child of a street hawker in the East End of London and discovered that it was already dead. The mother said that she had been feeding it with a patent food and that it had been "wasting away." When she woke in the morning she found it dead. Dr. Basan saw that the parents were in a state of dire poverty—they had no food, no fire, and very little bedding—so he gave them five shillings and some fare appropriate to the season. At the *post-mortem*, the child's body was seen to be much emaciated, and Dr. Basan gave it as his opinion that it had died from exhaustion from want of proper and sufficient food. The jury, having found that the child died from "natural causes"—(Are starvation and improper feeding considered "natural" in East London?)—expressed a strong opinion on the doctor's kindness of heart. It is pleasant to have such testimonies to counterbalance the others.

Wrexham Guardians and Superfluous Luxuries.

THE Wrexham Guardians have covered themselves with glory. It seems that they recently built an operating theatre in connection with the workhouse infirmary, and when its erection was complete the Buildings Committee found the lighting had been so badly planned that it was necessary to build a special window at a cost of £30 before the theatre could be used. One would have thought that having thus been convicted of their own short-sightedness, the Guardians would have been only too eager to remedy any other defects that had been overlooked, but such was not the case. Their medical officer pointed out last month that no water-supply was laid on to the theatre, and that such a supply was not only essential for surgical reasons, but would cost only about £7 10s. Such a luxury, however, the Committee could not allow, and when their report came before the full Board the chairman said if they went on in this way they would never know where to stop. A medical member of the Board pointed out that it was practically useless to build a theatre without a water-supply, but his advice was contemptuously rejected by the "intellectuals," who decided to leave the theatre waterless. We should suggest that a matter of this kind involving the most vital question in connection with the efficacy of surgical treatment might with propriety be brought to the notice of the Local Government Board, which, fortunately, have mandatory powers in questions of public health. Recalling a *quondam* crusade of Mr. Stead's, we cannot help wondering what would happen if "Lister came to Wrexham."

Majolica Painting and Lead Poisoning. MEDICAL men have an important duty to perform in the education of people on questions of public health, and there are few departments in which it can be exercised more beneficently than in teaching the effects of dangerous trades. Many of these trades are created and kept alive by a demand for luxuries and ornaments, and if the demand ceased the trade would follow suit. For instance, if leadless glaze for pottery-ware were demanded by people, and lead glazes refused, plumbism among potters would be largely reduced. At Hanley recently an inquest was held on the body of a woman, aged 38, who died of chronic lead poisoning which she appears to have contracted in her occupation as a paintress of majolica ware. Now the world would be no little less happy if it were without majolica ware, and it seems likely that some miserable deaths might be prevented. The conclusion is obvious. It is hardly possible to believe that people who cry out loudly against wearing birds' feathers in ladies' hats, would not recognise the infinitely greater inhumanity of adorning their mantel-shelves with an absolutely unnecessary class of ornament manufactured at a cost to human life.

Medical Journalism and the Lay Press. AN important letter appears in the last issue of one of our weekly contemporaries from the pen of Dr. J. Hopkins Walters, of Reading, in which the writer refers to a matter of considerable importance to the profession from the point of view of medical ethics. It appears from his letter that a well-known monthly medical journal is in the habit of sending to the lay press advance sheets of its forthcoming numbers, and this Dr. Walters contends is a direct invitation to the lay press to publish extracts from them. The result of this practice was very apparent in the case of the last number of the journal in question, large extracts from which with sensational headings and the names of the authors attached, appeared in the daily press. Dr. Walters has addressed a letter to the editor of the medical journal in question, in the course of which he writes:—"Since it is very properly considered unprofessional for a medical man to publish communications in other than professional journals, I cannot understand why the editors of professional papers should consider themselves free from the same obligation." The letter is a timely one, and we trust that it will have the desired effect. If it does not, it will become necessary for would-be writers for the journal in question to consider whether by their contributions they are not involuntarily infringing a very direct precept of medical ethics. Sensationalism in medical journalism is as unsuitable as it is in the case of our venerable contemporary, the *Times*, and is certain in the end to meet with the censure of the medical profession.

LEADING ARTICLE.

A ROYAL COMMISSION ON QUACKERY.

The present Government, under the leadership of Sir Henry Campbell-Bannerman, appears to be directing its main energies towards social reform. That being the case, we venture to draw the attention of the Cabinet to a canker that is eating deep into the vitals of the nation, namely, that of quack medicines and quackery. The British legislature, on the one hand, has ensured that legitimate medical practitioners shall be well educated and duly qualified for the practice of their profession. On the other hand, they have made no provision for the exclusion either of professionally ignorant and untrained charlatans of all kinds. More than that, by the action of the patent medicine stamp, Government raises a paltry revenue and thereby sanctions the sale of remedies that are in many cases shameless and wicked frauds. There is no need here to enter into the story of the harm that is done. The tale is hackneyed enough. Every medical man knows of lives that have been cast away by the use of nostrums, of infants that have been killed by "soothing syrups" and "teething powders," of limbs distorted by bonesetters, of sufferers from malignant disease fleeced, deluded, and condemned to die in untold agony by "cancer curers." Every day of the week every general newspaper records instances of lives thrown away through one or other of these nefarious agencies. Yet, as we have often pointed out, the very newspapers that contain these damning reports publish the advertisements by means of which rogues and charlatans are enabled to secure their victims. As if our own insular roguery were not enough, the country is being constantly flooded with American frauds of a similar nature. Elsewhere we publish the report of an inquest held by the City of London Coroner upon a labourer who had spent three guineas upon an inhaler from Ohio, U.S.A. The poor man died of consumption, and was induced to pay five shillings an ounce for fluid to be used in the appliance. Probably the total value of inhaler and fluid would be a few pence, and their value in phthisis absolutely *nil*, yet the Government sanctions this traffic with an official stamp. The whole trade in nostrums and illegitimate medical practice is monstrous. In Bond Street, London, an unqualified woman has recently had the impudence to put a large brass plate on each side of a doorway with the words "skin specialist" after her name. Every large town in the United Kingdom, however, can produce its particular crop of parasites of society in the shape of cancer curers, bonesetters, rupture healers, electrical quacks, and so on. This is an Augean stable that should forthwith be cleansed by the State. The evil has been too long with us. It is wrapped up in various vested interests, among which various wealthy patent medicine companies and powerful journals many be mentioned. In Parliament itself, as a rule, there are members interested as shareholders in and directors of patent medicine companies whose claims are an outrage upon educated common-sense and reason. Not long ago we inspected the list of shareholders of a notorious "cure" for kidney diseases—its claims so outrageously false as to touch the fringe of fraudulency—and there we were surprised and pained to find the names of various prominent members of the House of Commons. What is wanted is the education of the moral and intellectual sense of the nation as to the harm that is being wrought on all hands by quacks and quackery. The best means of arriving at the facts of the case, in our opinion, is by the institution of a Royal Commission. The terms of reference might be made to include the extent of irregular medical practice, the harm done thereby, and the profits obtained therefrom, with evidence of inquests, prosecutions, and so on. The claims of patent medicine vendors might be similarly investigated by the Commissioners. The extent and nature of the trade and its relation to the public, the medical profession, and the newspaper and advertising agents would demand careful investigation. In this way the road would be paved to the ultimate removal of a traffic that is degrading to our boasted civilisation and to the latter-day sense of responsibility to our fellow citizens that marks modern altruistic government. To such a Commission as we have suggested the editor of The Medical Press and Circular would engage to bring a mass of evidence that would thrill the heart and conscience of the nation. We respectfully urge upon the Premier of this great nation that in defence of the bodily welfare of His Majesty's subjects he should take steps to protect them from the harmful practices of quacks and patent medicine vendors. As a first practical step in that direction we ask Sir Henry Campbell-Bannerman to institute an enquiry by Royal Commission into the existence and extent of this deplorable traffic.

CURRENT TOPICS.

A Bonesetter's Challenge.

In our issue for January 2nd, we criticised the methods of Mr. Barker, a bonesetter who recently issued a challenge to the President of the Royal College of Surgeons of England to a sort of public duel. We insisted upon the impossibility of a meeting on any common ground of a qualified medical man and an irregular and, from our point of view, technically untrained and ignorant person. A surgeon acts on principles and rules that are open to his fellows, and for that matter to the whole world. Mr. Barker, on the other hand, claims to achieve results unobtainable by the medical profession with all its accumulated wealth of knowledge and experience and its whole-hearted search after truth. Mr. Barker publishes long-winded statements of the wonders he can perform, and refers therein vaguely to some mysterious personal skill or knowledge, but he furnishes no details, and apparently trusts to his own native intuition for diagnosis, pathology and results. This sort of haphazard observation may be good enough for bonesetting, but is hardly likely to be countenanced by the exact science of surgery. As might have been anticipated, in answer to our strictures Mr. Barker has issued a challenge to the Medical Press and Circular It is impossible to avoid admiring his persistence, for by this time he must know that as the cartel cannot be accepted, to issue a fresh one is mere swashbuckler bravado. However, it is only fair that he should have his answer recorded. He wishes to pit his skill against that of qualified surgery in the treatment of six selected cases of talipes valgus, not congenital, and six of dislocated semilunar cartilage of the knee. As to the former condition, it is well within the command of any skilled surgeon, in fact, some cases can be completely cured by intelligent nursery manipulation. As to the latter, any one with a competent knowledge of surgery can restore a semilunar cartilage by manipulation. The difficulty is to keep it in position. As a rule, the dislocation recurs again and again, and in obstinate cases the only effectual remedy is to "moor" the cartilage, or else remove it altogether. It is seldom that the single replacement of a cartilage that has frequently slipped will be followed by an immediate and permanent cure. Mr. Barker sends us a letter from a well-known football player, asserting that he was cured of an obstinate knee by a single manipulation and that he has sent lots of his athletic friends with similar results. The letter, we find, was written two months after the "one and only" treatment, a period that renders the case worthless as evidence. The matter ends here, as it began, with Mr. Barker's *ipse dixit*. So far as we are concerned, he is welcome to any advertisement that may be gathered from his numerous challenges.

Hospital Abuse and the Profession in London.

Two significant meetings have been held during the past few weeks dealing with the subject of hospital abuse—the meeting of the Hospital Officers' Association on December 21st, and that of the Westminster Division of the British Medical Association on December 17th. The instructive element at the first-named meeting was the speech of Mr. Sydney Holland, denying *in toto* that any hospital abuse exists. This may be taken as the typical attitude adopted nowadays by the members of the governing boards of the great hospitals. The members of the medical staffs are in a slightly different case. Unable to deny the existence of the evil, they avoid the question altogether, or treat it as one of small importance. The tone of the Westminster meeting, however, and that of other meetings of practitioners recently held, show that this Gallio-like attitude will not be much longer tolerated The patience of the general practitioner is nearly exhausted. He is robbed in the house of his friends. And not only he, but the benevolent public, is being defrauded through the *laissez-faire* carelessness of hospital authorities. If certain of the threats made in speech and print by general practitioners recently be carried into effect, and hospital finances suffer, it is the hospital authorities, and they alone, who will be to blame.

Drainage by Suction.

Drainage by water has been so universally adopted throughout the kingdom that we are inclined to forget several of the disadvantages to which it is subject. A rich water supply, and a sufficient fall of ground are the first necessities. The system is, moreover, wasteful, and not unlikely to cause contamination of drinking water by percolation through imperfect pipes. It is of importance to remember, therefore, that there are alternatives, and the trial given to one of these at Stansted, Essex, is instructive. For the past four years, the system known as the "Liernur method" has been at work as an experiment at Stansted, and the local authority is so satisfied with the result that it has now obtained permission from the Local Government Board to purchase the works outright. The principle of the system is simply suction, all sewage material being drawn to a common storage tank. It may, in fact, be regarded as a gigantic "vacuum cleaner." It is claimed for the Liernur system that it is inexpensive and efficient, and it is obvious that it has applicabilities in places where there are objections to the water system Thus, Trouville has been for many years drained in this way. There, as in other seaside places, the discharge of sewage into the sea is distinctly unpleasant, in suggestion if not in fact, and it is likely that in such situations the Liernur system will before long be widely adopted.

London Ambulance Service.

IT is nothing short of a disgrace that a city of the immense size and importance of London should be without any organised method of dealing with street accidents, or means for transportation of the sick poor, and the fact that after years of agitation no definite plan of action has been devised speaks badly for the practical genius which is supposed to characterise the English. Since the matter has been mooted and brought before various responsible authorities, steps and countersteps have been taken, and now, after the County Council have been wrestling with the subject for more than a year, owing to political difficulties it has been necessary to place the matter in the hands of the Home Secretary. Mr. Gladstone has now appointed a Departmental Committee to enquire into what are somewhat facetiously called the "existing facilities" for dealing with street accidents and cases of sudden illness in the Metropolis, and these gentlemen may be urged to make all due speed in a matter that has waited far too long. The London County Council scheme for which they recently sought Parliamentary powers was modest enough. Its capital outlay was only £13,000, and £9,600 a year was all that was needed for maintenance. Considering that of street accidents alone there are some twelve thousand a year, these figures cannot be considered excessive. The City Corporation, which is in the happy position of being able to do much more what it likes with its money than the County Council, have already one motor-waggon at work and will soon have others. As the question for London has now been referred to the Home Office, probably the ambulance service will be associated with the police force, and one would suppose that little enough ingenuity would be needed to place the service on permanently satisfactory footing. But the delay that has taken place is a scandal which only a long-suffering and law-abiding people would have put up with.

Dr. Doyen's Cancer Serum.

One-half the mischief done by the advocates of this, that, or the other so-called "cure" for cancer is their pernicious habit of premature publication. It is clear that any surgeon who claimed success for his cases within a year or two of operation would become the laughing-stock of the scientific world. Why should the physician who uses a serum or other drug treatment be entitled to reject the wholesome restraint adopted by the surgeon by noising abroad his tentative theories and crude experiments? Perhaps the greatest offender in Europe is Dr. Doyen, of Paris, who persists in claiming success for his cancer serum, in spite of the fact that it has been fully investigated and discredited by Metchnikoff and others, appointed by the French Academy of Medicine. At one time it was generally believed that the late Countess of Clancarty had been cured by him. As a matter of fact, we believe that in the year 1904 the lady in question underwent the operation of hysterectomy for malignant mischief and placed herself later under Doyen's cancer serum treatment. Recently the disease returned, and a second operation was performed, but without success. Under similar circumstances any reputable and responsible surgeon would not have claimed the case as a success, but, as already pointed out, certain physicians appear to override tradition and etiquette when dealing with this terrible malady. No better illustration of the fallacy of their faith could be imagined than the death of the above-mentioned unfortunate patient.

A Record Death Rate.

The fourteenth annual report of Sir Shirley Murphy, medical officer of the Administrative

County of London, for the year 1905, shows a saving of 19,584 lives compared with the decennium 1891-1900. The death rate for 1905 was 15.1 per 1,000 living. These figures are the lowest yet recorded in the steady fall that has taken place since deaths were first systematically recorded. In the decennium 1841-50 the rate was 24.8. The record figure of 15.1 compares favourably with that of Paris 17.4, Berlin 17.2, Vienna 19.3, New York 18.3, Rome 20.6, and St. Petersburg 25.0 for the same period. In London itself there were the usual striking contrasts in the returns from different districts. Hampstead maintained its reputation as the healthiest suburb by the exceedingly good rate of 10.5, while Lewisham comes second with 12.2. Shoreditch, on the other hand, has the unenviable distinction of finishing the list with a death rate of 20.7. In many unhealthy slum sub-districts the rate has naturally been much higher. The birth rate, which has shown a further diminution, stands at 27.1 for the year 1905. On the whole the report is a most highly satisfactory and encouraging document. The fair ideal would be to bring the whole figure for London to the 10.5 now attained by Hampstead, although the latter is doubtless capable of improvement, chiefly, perhaps, by the restriction of infectious diseases.

Night Calls in Vienna.

The city of Vienna is taking practically in hand the question of calling medical men up at night. In Continental towns the conditions of life are considerably different from what they are in this country, for a medical man going out at night has to pay fees to the porter of the building in which he lives, both on going out and on returning, besides also frequently paying the corresponding functionary in the patient's building. As the practitioner has often and often found himself unpaid by the patient, he is rather chary about leaving his bed and incurring expense without knowing something of the people who send for him. An Ambulance Society have therefore taken the matter up, and they propose to keep at police-stations a list of medical men who are willing to respond to casual calls at night, whilst the society are demanding that the municipality shall guarantee the fees ot all practitioners called up through this agency. This step is a really practical one, and meets the arguments on both sides. Need we say that we wish our colleagues every success in their battle against ingratitude and imposture ?

PERSONAL.

Sir Alfred Jones, Chairman of the Liverpool School of Tropical Medicine, has sent the following telegram to the Emperor of Germany:—"As President of the Liverpool School of Tropical Medicine, I desire to congratulate your Majesty on recent valuable work done by Professor Koch in confirmation of the discovery made by the Liverpool School of Tropical Medicine of a possible remedy for sleeping sickness."

A complimentary dinner was given to Dr. Norman Walker last week in Edinburgh to celebrate his election as Direct Representative for Scotland on the General Medical Council.

Dr. Jas. Burnet, senior clinical tutor in the medical wards of the Edinburgh Royal Infirmary, has been officially recognised as a Lecturer on Materia Medica and Pharmacy.

Dr. R. R. MacNicol, of Taynuilt, and Dr. Lachlan Grant, of Ballachulish, have been placed on the Commission of Peace for the County of Argyll.

On December 29th, in the Drill Hall, East Linton, a public presentation was made to Dr. James Gordon, on his retirement after close upon forty years' professional practice in the county.

Mr. Andrew Carnegie has offered to place a fund sufficient to produce £500 a year at the disposal of Paris University for a Natural Philosophy Scholarship in honour of the Curies.

Mr. W. Bryce Orme, M.R.C.S.Eng., has received the Royal Licence to wear the insignia of the Fourth Class of the Imperial Ottoman Order of the Medjedieh, recently conferred upon him by the Khedive of Egypt.

The annual meeting of the Incorporated Society of Medical Officers of Health will be held on January 11th at Bristol, when Dr. D. S. Davies will deliver the presidential address.

Sir Rubert Boyce has sailed from Liverpool on a voyage to the Canary Islands.

We understand that Professor Rose, of King's College, has recovered from his recent illness, and will shortly resume his professional duties.

Mr. W. H. Brown, who has been honorary surgeon to the Leeds General Infirmary for sixteen years, has had to resign that position owing to ill-health.

Lieutenant T. J. Wright, R.A.M.C., has been appointed a specialist for the prevention of diseases in India.

Dr. D. S. Davies, Medical Officer of Health for Bristol, will give the Presidential Address to the Incorporated Society of Medical Officers of Health on January 11th.

Dr. J. H. Croudace has been appointed a Justice of the Peace for the Borough of Stafford.

Dr. T. W. Conway has been appointed as assistant to the master at the Coombe Hospital, Dublin, in succession to Dr. M. J. Gibson, whose term of appointment has expired.

Dr. H. M. Thompson was made the recipient of a handsome travelling and dressing-bag on leaving Mexborough to take up work at Grimsthorpe.

Dr. R. B. Sellers, on resigning his post as Senior Surgeon to the Rochdale Infirmary, has been elected Consulting Surgeon. A complimentary resolution was passed by the Board on the occasion of the election.

Surgeon-Captains A. B. Lyon, T. P. S. Ward, and R. T. Ferguson have been appointed Surgeon-Majors, and Surgeon-Lieutenant H. Stallard, Surgeon-Captain, in the Army Reserve of Officers.

The will of the late Dr. David Jones, aged 72, of Hampstead, has been proved at £16,008.

Dr. Robert Lancelot Sparrow, of Oldham, has been enrolled as a magistrate for the County Palatine of Lancashire.

A CLINICAL LECTURE

ON

CASEOUS PNEUMONIA.

By PROF. DEBOVE, M.D.,

Doyen of the Faculty of Medicine of Paris, Physician to the Beaujon Hospital.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

THE patient whose case I propose to discuss to-day is suffering, as you are aware, from caseous pneumonia. His history is of interest in that it raises several clinical and theoretical problems, some of which are *à l'ordre du jour*.

He is æt. 30, and is by profession a bookkeeper. He dates back his illness to three months ago, *i.e.*, to the early part of January. At that date he caught a slight cold, which did not oblige him to cease work, but on January 28th he suddenly got worse, the cough became more troublesome, and he was seized with a violent shiver and pain in the right side without any expectoration. He tried to go on with his work, and only took to his bed three days before his admission to hospital, namely, January 26th. When first seen the constitutional symptoms—prostration and fever—attracted most attention, and the house physician who examined him diagnosed typhoid fever and prescribed cold baths.

This was certainly an error of diagnosis—a very excusable error, and one which I should certainly have committed had I made the examination at that date, for the high temperature, with its morning remissions, the general condition, the absence of any localisation, and the existence of a fairly long period of invasion preceding the onset of serious symptoms, seemed to suggest this diagnosis.

On February 28th, the pain in the side became very severe, and attention was again directed to the right side of the chest. Dulness was found over the right base with blowing expiration and egophony. The cough was dry, harassing and without expectoration. On the supposition that he was suffering from pleurisy, two exploratory punctures were made without result, and from that moment the diagnosis of tuberculous pneumonia was established.

You will have noticed that I throw the blame of the errors of diagnosis on my house physician, who looked upon the case as an ordinary one, and only drew my attention to it when doubts arose in his mind. Had I observed the patient from the beginning, it is highly probable that, misled by the onset of the fever and by the general condition, I should have diagnosed typhoid fever, and that later, in presence of the local signs in the chest, I should have diagnosed pleurisy, arriving at the diagnosis of caseous pneumonia as a last resort.

I recall these details just to show you that the consultant who is called in at a late stage of the disease, at a time when it is fully developed, ought to be lenient towards errors of diagnosis on the part of a colleague. As a matter of fact, I was not called upon to correct any mistake, for the diagnosis had been made when my attention was called to the patient. This was the state in which I found him :—

Pale, much emaciated, he was so weak as to be unable to sit up without assistance, and he spoke in a low jerky voice. His temperature averaged 100.5° in the morning and 103° F. at night. He had profuse night sweats. Dyspnœa was very marked and was increased by the slightest movement. The expectoration was mucous, and bacteriological examination, several times repeated, failed to show any tubercle bacilli.

The dyspnœa, the expectoration, the pain in the side, and the history of the previous symptoms naturally directed my attention to the chest, and this is what I found : The right side of the chest was slightly retracted, or, at any rate, was less developed than the left side. It may occur to you that this retraction might be due to a former pleurisy, which has undergone absorption, but if so the absorption must have been very complete, for no trace of it remains now.

The dulness is well-marked over the lower half of the right lung, and is absolute in the axillary line ; percussion under the clavicle on the right side gives exaggerated resonance. I may tell you in advance that this is probably due to the pushing up of the healthy part of the lung by the caseous mass that occupies its lower half. On auscultation we find that the vesicular murmur has disappeared over the greater part of the lung ; it can be heard only at the apex, and there very imperfectly, because it is masked by the blowing sound which is audible all over the right side but most marked in the regions where the dulness is most pronounced. This murmur originally presented the character of the pleuritic rub, then gradually became tubular; at the present time it may fairly be described as cavernous. Now that we are in possession of these stethoscopic data we are in a position to diagnose the local lesion.

It is not pleurisy, though the pain in the side, the dulness, the skodaic resonance, and the pseudo-cavernous signs might lead one to suppose so. The futile exploratory punctures show that clearly enough, but there is one sign in particular to which I desire to call your attention—a very important sign in this instance—namely, the persistance of vocal resonance, which, in certain parts, is, indeed, exaggerated. It appears that this was not the case at the beginning, thus complicating the diagnosis. What, then, can the lesion be ? It certainly cannot be a lobar pneumonia ; its duration alone proves that. Cancer of the lung might, it is true, give the same local signs, but the general symptoms and the course of the disease at once negative this diagnosis. We arrive, then, by exclusion, at the only alternative, namely, that it is a case of caseous tuberculous pneumonia.

I presume you are familiar with the anatomical lesions that characterise this form of tuberculosis. One or several lobes of the lung are converted into a solid cheese-like mass. The presence of this compact mass explains the dulness, the persistence of vocal fremitus, and the audibility of the breath sounds in the larger bronchi with the production of pseudo-cavernous signs. The tuberculous infection explains the fever, the sweats and the bad general condition.

We do not, however, get the characteristic expectoration of tuberculosis, but clinical experience teaches us that these caseous masses may remain solid for long periods of time, and it is only when the mass begins to break down that we get sputum of the usual kind containing bacilli.

The symptoms in general justify the conclusion that there is tuberculosis, for although we are not able to demonstrate its existence in the lung we have succeeded, with the assistance of our pathologist, in discovering bacilli in the patient's blood and urine.

We owe the ability to discover these bacilli in the blood to M. Jousset's inoscope. The clot is dissolved in a fluoropeptic fluid, the formula of which is known to you. This sets free the bacilli imprisoned in the fibrin, and their presence is readily demonstrable after centrifugalisation by the usual methods of staining. This procedure has been criticised on the ground that the tubercle bacilli may be confounded with acid-resisting saprophytes which present the same reactions to stains as the tubercle bacillus, but these pseudo-tubercle bacilli multiply rapidly in ordinary culture media. Now the bacilli isolated by M. Jousset's procedure did not multiply, and inoculation of guinea-pigs gave positive results.

The urine, scanty and of a dark colour, is intermittently albuminous. This albuminuria, which has never been very pronounced, disappears on some days only to reappear later. The maximum quantity has been 35 centigrammes to the litre. There is evidently a cyclical nephritis, for on each occasion granular casts have been seen. The most interesting feature, however, was the presence of tubercle bacilli, the bacillary crises coinciding with the albuminuric crises, a coincidence to which M. Jousset has directed attention in his monograph on "The Kidney and the Tubercle Bacillus." (a) These data are not based only on microscopical examination, which is often fallacious in urinary researches, but on the results of inoculation of guinea-pigs with centrifugalised urine.

Our patient, therefore, is both bacilluric and bacillæmic, and the blood and the urine have furnished us with information which we were unable to obtain from the expectoration.

You may ask whether bacilluria necessarily implies tuberculous nephritis. By no means! It is met with in tuberculous patients exempt from nephritis, or in whom at any rate the nephritis is so slight that no clinical evidence of its existence is obtainable.

Let us now enquire into the genesis of the pulmonary symptoms presented by our patient, and seek to ascertain their origin. It may be taken for granted that every tuberculous subject contracted his malady from some other subject similarly affected. There is no such thing as spontaneous generation in respect of tuberculosis. When and where, then, did he contract the disease? He tells us that he lost a sister from galloping consumption some ten years ago. Could he, at that date, have contracted the germs of the disease which has remained latent for that space of time? This is theoretically possible, but it is highly probable that his infection is much more recent. He is employed by a large insurance company, working with fourteen other employés in an office of comparatively small dimensions. Several of his colleagues, he says, coughed and expectorated on the floor, and one of them recently died of phthisis. It is therefore probable, though hardly demonstrable, that he caught the disease at his office.

But if the mode of infection is difficult to establish, it is even more difficult to explain why the disease has assumed this peculiar anatomical form—that of caseous pneumonia. With regard to the various forms which pulmonary tuberculosis may take, it is customary to assume that the choice is determined by the individual receptivity of the subject or the special virulence of the bacillus, and by skilfully juggling with these two factors we can easily satisfy those whose critical spirit is not too highly developed.

But when we are called upon to explain why the disease assumes a particular anatomical form, we are at a loss what to say. What explanation can be offered of this invasion of an entire lobe of the lung by lesions comparable with those of pneumococcal pneumonia? How can we admit this methodical, massive invasion of the pulmonary alveolæ throughout an area of the pulmonary apparatus which is both extensive and yet strictly limited. That is a mystery upon which I am unable to throw any light, and it is at least as difficult to explain as that of lobar pneumonia proper. It is not the same germ, it is true, but in each case we do not know either why the disease sets in suddenly or why it remains strictly circumscribed.

The task is in no wise facilitated if we assume that infection is propagated, not by the air passages but *via* the blood. Let me remind you that our patient's blood contains bacilli. Now for some time past the trend of opinion is in favour of alimentary infection obtaining admission by the intestine and being propagated by the blood.

Bacilli that pass in with the food enter the chyliferous ducts, for which no solution of continuity on the part of the intestinal mucosa is required, and are retained (in the child and young animal) in the mesenteric glands. Thence they migrate to the thoracic duct, and ultimately pass into the blood.

If this be the case, the occurrence of pulmonary tuberculosis is not so much due to bacilli mixed with inspired dust as to the special anatomical situation of the lung in the circulatory system and also to the minuteness of its capillaries which arrest the bacilli all the more readily. The microbes are evidently more easily absorbed by the chyle ducts than by the veins, for tuberculosis of the liver is extremely rare compared to its occurrence in the lungs.

All these problems are still under investigation, and have not yet been solved. However this may be, whether the bacillus arrives in the lung by the respiratory tract or by the veins, no explanation is afforded of the reason why one whole lobe of the lung is invaded independently of the rest of the pulmonary parenchyma. The bacillæmia may just as well be a consequence, as a cause, of the caseous pneumonia. In any event, we know that they are almost invariably associated, and this is in marked contrast with what we find in other forms of pulmonary tuberculosis. It would seem, says M. Jousset, that bacillæmia has more to do with the extent than with the severity of the lesions.

With regard to the prognosis, I can only say that it is of the gravest. With such a lesion death is inevitable, and the only point we might discuss would be its probable duration

The treatment is purely palliative, but should the temperature fall and the course of the disease become less rapid, it would be our duty to employ the methods of treatment applicable to chronic phthisis. In the present state of our knowledge that is the most we are justified in hoping.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Dr. Robt. Alex. Fleming, F.R.C.P., Lecturer on the Principles and Practice of Medicine in the Edinburgh Medical School, Assistant Physician to the Edinburgh Royal Infirmary, the subject being "Optic Neuritis and Its Relationship to Intercranial Tumours."*

CLINICAL LECTURES FOR 1907.

In addition to the list of "Clinical Lectures" promised us during the current year, which we were privileged to publish in our last issue, we have since received the following :—

HY. GILBERT BARLING, M.B., B.S.Lond., F.R.C.S., Dean of the Faculty of Medicine, Professor of Surgery, and Ingleby Lecturer in Birmingham University.

G. W. SCOTT CARMICHAEL, M.B., C.M.Edin., F.R.C.S., Surgical Registrar to the Royal Infirmary, Edinburgh, Surgeon to the Royal Infirmary for Sick Children.

ARTHUR C. LATHAM, M.D.Oxon, F.R.C.P.Lond., Physician to and Lecturer on Medicine, St. George's Hospital, London, Asst. Physician to the Brompton Hospital for Consumption.

E. PERCY PATON, M.D.Lond., M.S., F.R.C.S.Eng., Dean of Westminster Hospital Medical School, Asst. Surgeon to and Lecturer on Surgical Pathology, Westminster Hospital.

(a) "Rein et Bacille de Koch," *Arch. de Med. Experimen.*, Oct. 1904 No. 5.

ORIGINAL PAPERS.

SOME NOTES ON EXAMINATIONS FOR LIFE ASSURANCE.

By R. SHINGLETON SMITH, M.D.Lond., F.R.C P.,
Consulting Physician to the Bristol Royal Infirmary and Emeritus Professor of Medicine, University College, Bristol.

It is commonly supposed that any qualified medical man is competent to undertake life insurance examinations, and many no doubt undertake them with little sense of the nature of their duty to the office by whom they are employed, often with no previous training, and with little knowledge of the problems which they may be called upon to solve. Of late, however, a tendency has been growing in favour of the idea that a life insurance examiner must be a universal specialist, and that no report can be considered complete unless the physical examination of the applicant has included the use of pretty well all the special methods of diagnosis known to the specialists in the various departments of medicine and surgery. When we read that "no means of investigation which would demonstrate the truth, by any diagnostic device whatever, should be omitted, no instrument of precision should be left unused, no matter how troublesome that use might be to the examiner, no diagnostic device should be passed untried, if by aid of instrument or art *one single fact* could be established with certainty which otherwise was only probable," (*a*), &c., we cannot but wonder who will be competent for these things.

We all recognise the fact that the examination of a candidate for insurance is a problem in diagnosis, and often by no means an easy one, even after many years of experience; it is also a problem in prognosis, a still less easy one, demanding the most careful consideration; it involves also the recognition not only of disease which is, but of disease which is to be in the future, and these forecasts demand the highest knowledge and the highest intellectual faculties. To make such an examination and to solve the problem which may arise must take time, and must weary the patience not only of the examiner, but of the examined; accordingly we cannot but think that an intermediate course is the only one possible, and that special examinations—microscopic, ophthalmoscopic, laryngoscopic, otologic, sphygmographic, hæmatoscopic, endoscopic, bacteriologic, and so on—must be left to the judgment of the individual examiner, who will apply them in case of need. However this may be, I read (*b*) "that the time is coming, nay, the hour is already sounded by the clock, when those men who cannot, from lack of training, or from lack of perception of need, and duty, be brought to use every means and method of diagnosis in making examinations will cease to be medical examiners." Such views as these will not commend themselves, and will not conduce to the increase of insurance, inasmuch as few candidates will be found ready to submit to such an inquisition.

Now, as regards the examination itself, the insurance offices provide forms for the guidance of the medical examiner. We sometimes wish that the form provided might be a blank sheet of paper; the experienced examiner would often give a better report in this way than by answering a long series of questions, many of which have no bearing on the case in hand. We must not, however, forget that there can be no uniformity in the results unless the various examiners have some such form for their guidance, and that the principal function of the examiner is to ascertain the facts and report the same to the medical officer-in-chief at the head office. It is true he is commonly asked to do more than this, as his opinion on the risk is also desired when he is asked to advise the actuary who knows much better; but the summing up of the whole evidence on the case and the adjudication thereon can only be done by the central authority from an examination of the collected reports of the medical examiner, the agents, the reports of confidential friends, and the opinion of the chief medical adviser.

The forms commonly provide that the essential points shall not be overlooked: they are as follows:—

(*a*)—The family history—heredity.

(*b*)—The past medical history of the proposer.

(*c*)—The results of the physical examination at present.

(*d*)—The general appearance of the candidate.

(*e*)—The occupation, habits, residence and general environment.

It is scarcely needful to observe that as a rule an ordinary case presents no difficulty. The first-class life on the one hand, and the manifestly uninsurable on the other hand, are easily determined; but the intermediate cases are those which will tax all the powers of the examiner. Here we have a great variety of problems to solve—those relating to heredity, the effects of previous illnesses, the probability of their recurrence, diminishing or increasing risks as well as present ones, and the exact value of a personal defect with its results in the future. On all those points the examiner has to give information to the actuary, who alone is qualified to determine what is the money equivalent of the defects reported. It is obvious that even with the first-class life no one is spotless; there is always some risk that the possibility of attaining the age of 98—the limit when, according to the British Life Offices, everyone ought to be dead—may be shortened in some unforeseen way. The contract for assurance payable at 98 or at previous death is accepted by the offices on their own conditions.

These conditions are grounded on the duration of life of the normal man, of good parentage, and with a healthy environment. This is the requisite standard, but how few of us attain to it. The risk accepted by the office is a great one, for who can predict the accidents of contagion, who can forecast a fatal attack of pneumonia? Many years ago I was asked to examine a spare man with a family history of phthisis. In spite of my recommendation to accept the risk, it was declined. Fifteen years later the proposal was renewed, the applicant being quite well, and having had no illness during the interval. The risk was then accepted, the first premium paid, death occurred from pneumonia a few months later, and the widow derived much benefit from the two thousand pounds on which one premium only had been paid. It should be generally admitted that every person should be allowed the privilege of insurance unless good cause to the contrary can be shown. The object of the medical examiner is not to endeavour to reject an applicant, but whilst safeguarding the company for which he acts, he should not decline the risk without very good reason, and should not expect that every candidate for insurance should attain the standard of the first-class life both by heredity and environment. The vital stamina may be deficient or the environment adverse, and yet that particular person may attain a good age and prove to be a profitable client. I was once told by a robust-looking gentleman of over 70 years of age that he was the only surviving member of a family of seven, who had died from phthisis, and that he was in early life declined insurance because of his family history.

The most important questions of heredity relate to cancer and tuberculosis. On these two points much information is given in the most recent data of the Scottish Widows' Fund, (*a*) from which the following conclusions seem to be justified:—

1. The registered increase in the number of deaths from cancer is undoubted.

2. After allowing that this increase is not wholly real, but may be accounted for, to some extent, on the assumption that the true nature of obscure cases of malignant disease has been recognised with ever-increasing certainty in recent years, and that as a consequence, the statement of death has been made

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(*a*) "Med. Exam. and Pract.," 1904, xiv., 459.

(*b*) *Ibid.*

(*a*) "The Causes of Death among the Assured in the Scottish Widows' Fund, 1874-1894," reported by Claud Muirhead, M.D.

with greater precision than had been formerly the case, there remains a large real increase to account for the large and progressive mortality from this disease.

3. The age period at which death from cancer is most frequent is gradually declining according to the Scottish Widows' Fund returns.

4. The average age at death from cancer among our members declined by two years from 1874–80 to 1888–94, as contrasted with a rise in the average age at death from all causes of a little over two years.

5. The office returns mark an *decrease* in deaths from *internal* cancer of 7.70 per cent., and an *increase* in deaths from *external* cancer of 18.89 per cent., of the percentages in the first septennium as contrasted with the third.

Dr. Muirhead further remarks that "during the twenty-one years under observation, cancer as a cause of death among our members aged from 45 to 65 has made rapid and startling progress."

As regards hereditary predisposition to phthisis, it has been sought of late years to deny that such a factor exists at all, and that all cases of phthisis should be attributed to direct infection. From an examination of the data it is stated that "the logical conclusion is that, in the adjudication of a proposal with a family history of phthisis, while we cannot discard from our minds altogether such history as a predisposing cause of the disease, we must attach a much less degree of importance to it than has been the practice in former years," prior to the discovery of tubercle bacillus. Not more than 35 per cent. of the consumptives exhibited any family predisposition to phthisis.

A history of pleurisy, as suggestive of tuberculosis, has recently assumed a grave importance, and the latest dictum is that of Dr. William Osler, (*a*) at Oxford, who states that "during the last twenty-five years the evidence has been accumulating in favour of the tuberculous nature of a large proportion of all cases of simple sero-fibrinous pleurisy. The exact percentage is hard to determine, but, in the absence of pneumonia or sepsis, the very existence of a pleural exudate is in itself sufficient to raise a suspicion of tuberculosis."

Hæmoptysis is a non-infrequent occurrence in those who have no other evidence of lung disease, but it is rightly regarded with much apprehension, and it is usually safe to act upon the assumption that there must be more or less active disease in the lung as its cause. Of course the spitting of blood may not be hæmoptysis of the graver kind, but it is usual to decline any proposer until there has been no return of the hæmorrhage for seven or ten years, after which period, the applicant having reached the age of 35 or 40 and being in good health, he may be accepted as a good life.

Other questions of heredity relate to insanity, diabetes, gout, cardiac conditions, and so on. Of these I remember a notable case of a young lady who after having been a diabetic for some years, was accepted by an insurance examiner as a first-class life: within a very few weeks, she died after a few hours of coma. This lady's father had died of tubercular phthisis after some ten years of diabetes, and a brother has since died from acetonæmic coma as a sequel of diabetes.

Concerning the heart, it is only to be expected that such hereditary maladies as rheumatism and gout should be frequent antecedents of heart disease. It is commonly understood that rheumatic fever in a parent predisposes not only to the same disease in the offspring, but to chronic defects of the heart, even although there may be no history of an attack of acute rheumatism. Hence the insurance offices very rightly attach great importance to the question relating to rheumatic fever.

Diseases of the nervous system must be regarded as likely to be of influence in the offspring. With a family history of well-marked neuroses it would not be safe to accept the risk unless the proposer had reached middle life and had not developed previously any indications of a neurotic tendency. The subject of insanity and epilepsy in relation to life insurance has recently been very exhaustively summarised by Sir W. R. Gowers. (*a*)

As regards the physical examination of the applicant, the most important and obvious questions relate to the height and weight. The men of moderate stature, ranging from 5 ft. 6 in. to 5 ft. 9 in., are considered to be the most capable, with an average weight of 10 st. 4 lb. to 11 st. 10 lb. As regards the practical estimation of these, it is interesting to note that the heels of the boots are considered to approximately counterbalance the weight of the clothing, so that the person may be measured and weighed in the usual garments in which he appears. It is commonly the rule to allow a margin of 15 or 20 per cent. on either side of the normal average as consistent with good health and good constitution, but anything over this margin suggests the perils of obesity, and a marked underweight suggests the possibility of phthisis. Any difficulty arising from over-weight, all other points being good, may be arranged by the recommendation of an endowment policy payable at a certain age, the insurance being then for a short term of fifteen or ten years. This gets rid of the fact that those of over weight tend to die prematurely of apoplexy, heart disease, atheromatous degeneration of the blood vessels, and having poor resisting power, do not throw off the effects of serious ailments as well as those of normal weight.

Dr. Muirhead (*b*) remarks that "light-weights are looked upon as undesirable risks, because, being usually of a nervous constitution, they take affairs of life more seriously than others, and are predisposed to early death from nervous breakdown and tubercular complaints . . ." The investigation of 524 schedules of males who had died of phthisis, when compared with 502 schedules of those who had died of apoplexy, "corroborates the popular opinion that men of light weight exhibit a special proclivity to phthisis, and that over-weight, while not excluding the possibility of the individual falling a victim to lung disease, is much more commonly associated with disease of the nervous system than with phthisis; so that very light weight in a candidate for assurance must always be regarded by the medical examiner as a danger signal, warning him to be more than usually vigilant in his investigation of the condition of the respiratory organs."

The same author also directs attention to the fact that the prevalence of consumption is by no means confined to persons under middle life, inasmuch as phthisis is a potent cause of death amongst the older members. The statistics of the Scottish Widows' Fund directly contradict the popular belief that this disease belongs to the period of youth and young manhood, and is rarely encountered after 45 years of age.

I well remember a case illustrating this point some years ago. The wife died from phthisis at early middle age, one after another of her children followed, then the wife's sister living in the same house, and last of all the father developed an attack of tubercular pleurisy at about the age of 70, from which he died after a comparatively short illness.

It has been remarked (*c*) that "there is more certainty about the result of examination of middle-aged and elderly applicants whose habits are formed, and who have passed through the dangers and risks of early adult life. There are, however, some special difficulties and pitfalls to be avoided in the examination of these lives."

The question is commonly asked whether the apparent age is in agreement with the ages stated. Now this appears to be one of the superfluous questions which might well be deleted from the form. The answers to it must be absolutely unreliable and vitiated by the common experience that some look old whilst young and never look older, some appear to be born looking

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(*a*) "Brit. Med. Journ.,, 1904, ii. 999.

(*a*) "Lancet," 1904, ii., 1061.

(*b*) *Op. cit.*, p. 44.

(*c*) Havilland Hall, "Life Assurance," 3rd edition, 1903, p. 43.

old, and others grow old but still look young. The question as to resemblance to which parent is another which cannot be of any reliable assistance, and must commonly depend upon the statement of the proposer, unverified by the medical examiner.

The chest measurement is usually asked for, but there must be many fallacious measurements in the case of women applicants encumbered with much clothing and often considerable collections of loose fat. Tables of these measurements (*a*) show that the medium circumference of the chest varies from 33½ inches in a man of 5 feet up to 40½ inches in a man of 6 feet. Approximately the chest measurement should not be less than half the height; that is to say, a man of 5ft. 6 in. should measure not less than 33 inches. "A good chest expansion is a great safeguard against pulmonary tuberculosis, and a range of expansion from forced expiration to forced inspiration of 2 inches at 5 feet height and 3 inches at 6 feet height respectively should be the minimum." Women commonly weigh less than men up to a height of 5 ft. 7 in., but over this they may be more.

The problems associated with the examination of the heart are many and of the greatest importance. On the one hand, there can be no doubt that many applicants are rejected on account of supposed heart disease, and *vice versa* some heart defects may escape observation. Ephemeral murmurs may be mistaken for those of organic disease, and organic murmurs are not always indicative of serious defect. The absence of a bruit is not sufficient evidence that there is no organic defect, and the presence of a bruit does not necessarily render the proposer ineligible. Commonly the mere existence of a cardiac murmur has been considered sufficient to exclude an applicant from insurance, but of late years it has been argued that even well-marked examples of valvular disease may be accepted at an increased premium. The large variety of murmurs of varying intensity and diffusion commonly classed as hæmic would obviously suggest the postponement of the application for three or six months pending the results of treatment. A cardio-respiratory murmur at or outside the apex may be easily mistaken for that of organic disease, and has frequently been the reason for rejection of a candidate. Neither of these murmurs should be a sufficient reason for a definite refusal of the proposal. But on the other hand, if there exists a definite systolic murmur at the apex believed to be of organic origin, and even if there should be no other evidence of heart defect or of weakness of circulation, the uncertainty of prognosis in such cases must render the applicant ineligible for insurance. It must be impossible for the medical examiner to advise the office to accept the risk when a sudden heart failure is at any time a by no means remote possibility. The presence of a murmur of mitral or aortic stenosis or one of aortic regurgitation will be still more emphatic in causing rejection. In spite of the fact that cases of aortic regurgitation and of mitral regurgitation with good compensation have been known to continue for very many years, and the patients sometimes survive to a good old age, yet the uncertainty of such conditions, and the facility with which failure of the compensatory conditions may arise must give no hesitation in absolutely declining to entertain an acceptance of such risks. A diagnosis of hypertrophy, indicated by a supposed displacement of the apex beat, has often given rise to a difficulty. Here there are many fallacies due to obliquity of ribs and other causes which may lead the examiner into error. There are many conditions where, in the absence of a murmur, the position of the apex beat, its character, and that of the sounds, the rhythm and regularity or otherwise of the heart-beat, may be such that the integrity of the heart muscle may be gravely questioned; in all such a rejection of the proposal is inevitable. The cases in which fatty heart may be suspected give much ground for question, for if all cases are rejected in which the impulse is feeble and irregular, it will lead to the loss to the company of many good lives.

Of the pulse-rate there can be no rigid limit. Nervousness is not confined to women, and a quick pulse is often the result of many trivial and temporary causes. Cases of persistent tachycardia or bradycardia should lead to enquiry as regards the possibility of brain lesions, of arterio-sclerosis, fatty heart, Graves' disease, or excess of alcohol and smoke.

In connection with diseases of the arteries and aneurism it is well to remember that arterial murmurs of an ephemeral character may be due to the pressure of unusually well-developed muscles. It was once my duty to report on an eminent cricketer who had been declined insurance in consequence of a murmur below the clavicle, which was no doubt due to this cause. There was no other defect, and the risk was duly accepted.

The state of the genito-urinary organs presents many questions. Syphilis and gonorrhœa appear to be remarkably rare in applicants for insurance, and hence the need for critical clinical observation on the part of the observer, and especially as to the veracity of the applicant. Of course, no case can ever be accepted so long as sugar or albumen is found in the urine, but a temporary glycosuria or a temporary albuminuria would not permanently exclude the candidate from insurance. A passing glycosuria in middle life is quite as common as what is called cyclic albuminuria in the youth, and although it cannot be discreet to accept the risk in the presence of either, the disability may be only temporary and need postponement of the proposal for three or six months.

The general appearance of the proposer presents many points for observation; anæmia, or cyanosis, injected capillaries of the cheek, œdema of eyelids, an icteric tint, or contracted pupils, the condition of the tongue, throat, gums and teeth, the proportion of muscle to fat, and the patient's bearing under examination, as unusual reticence and sometimes a craving for morbid accuracy may give information of an important character. All these points should be passed in mental review and noted when needful.

The older forms commonly make an inquiry as to the temperament of the proposer. Now the modern medical man is not educated in the classical temperaments, and has little regard for them. If he attempts an answer to the question he does so in a casual kind of way, deeming it of no importance. Dr. Stillman (*a*) has the audacity to devise a new series of temperaments of his own. He cuts down the classical four—lymphatic, sanguine, bilious and nervous—to three, and those he designates on an anatomical basis—motive, vital and mental. He remarks that "when either of the temperaments exists in excess, the result is necessarily a departure from symmetry and harmony both of mind and body, the one always affecting the character and action of the other. Perfection of constitution consists in a proper balance of temperaments, and whatever tends to destroy this balance should be avoided." We are told that in this country diverse nationality and parentage render it more and more difficult to find typical specimens of the normal temperaments, and that the same individual at different ages may be classified under different headings. According to age, the child approximates the sanguine or vital temperament; the mature adult the bilious; while advancing age produces a tendency either to excess of the nervous or phlegmatic elements. We think that the whole question of temperaments, and the supposed liability to particular forms of disease associated therewith is so beset with fallacies that they are of little use in estimating the probable duration of life or liability to disease.

The words diathesis and cachexia are also of little use from the insurance standpoint. Few cases with such chronic ill-health as would justify the appellation "cachectic" are likely to apply for insurance, and these would be at once recognised as ineligible. As regards the strumous, gouty and rheumatic diatheses,

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(*a*) Havilland Hall. *Op. cit.*, p. 46.

(*a*) Stillman, "Life Assurance Examiner," 1888.

there will be information derived from the family history.

The information as regards the vital statistics of the family is at all times a little difficult to obtain; the want of knowledge and the fallacies of memory greatly test the patience and the tact of the examiner. It is not surprising that people know so little of the causes of death of their grandparents, whom often they have never seen and of whom they have rarely heard; beyond the father and mother the information can only be approximate, but it becomes of importance when either parent has died in early life. It is also not to be wondered at that many applicants know very little of the cause of death of elder brothers and sisters whom they may have never seen, and of whose diseases they can personally know nothing. Any person of intelligence should be able to state the cause of death of brothers and sisters who have been known to them, but it is not surprising that the non-medical mind should often fail in giving anything like an accurate statement of events which may have occurred many years previously. The examiner has to be cautious in the acceptance of these statements, and especially when there is method in the want of knowledge and apparent want of memory, which may be more feigned than real.

We often hear of insurance without medical examination, and of the alleged uselessness of medical selection. No doubt there are many fallacies into which the most careful examiner may fall, and the most honest judgment may be neutralised by the unavoidable accidents and uncertainties of life, but it has been shown by the statistics of the Scottish Widows' Fund(*a*) that an enormous disproportion is observed between the rates of mortality from consumption of those insured and those recorded by the Registrar-General. The deaths from consumption at all ages amongst the selected lives were 81.15 per 10,000, as compared with 178.29 during the ten years 1881-90, as given by the Registrar-General. This disproportion is clearly due to the medical examination which each candidate has to undergo before being admitted to the benefits of insurance. It is also scarcely necessary to remark that the mere presence of a medical examination prevents the application of the large body of persons who are known to have organic and other defects which would render their acceptance improbable. No one likes to be rejected, and few will make any overtures if they have any suspicion that they may not be acceptable.

Much disputation has existed from time to time as regards the fee which the offices should pay for the medical service rendered. It has always appeared to me that there can be no rational excuse for the practice of cutting down the fee to one-half because the amount to be insured is small. The examination is the same whatever the amount of the insurance may be. No honest medical examiner can proportion his examination to the size of the fee or to the sum insured. This will always take a considerable time and require the same careful consideration, and it is not necessary that the medical examiner should know whether the proposal is for one hundred or ten thousand pounds. So also as there is no reason for cutting down the fee for the smaller sums, neither is there any for doubling it in the case of the larger amount. It is true the responsibility appears to be greater; but this should have no influence in the examination, which is presumed to be in all cases complete, thorough and honest.

CASE OF CEREBRAL ABSCESS FOLLOWING ACUTE MASTOIDITIS.

PEYTON T. B. BEALE, F.R.C.S.(*b*)

THE patient, a man æt. 22, was admitted to the Great Northern Central Hospital, at 11 p.m., on October 20th, 1906.

He complained of pain in the left ear, slight headache, vomiting after food, and at times rigors. There was a small amount of pus in the left external auditory meatus, and a very slight amount of pain on firm pressure over the mastoid antrum, but no redness or œdema in this region. There was no bulging or drooping of the auricle. On the pus being cleared from the meatus, numerous granulations were seen in the floor. The membrana tympani was slightly congested and perforated at the lower and back part, from which pus exuded. There was very slight tenderness on pressure over the left jugular vein. There was no sign of intracranial mischief. The pupils were equal, and reacted normally, and there was no squint. The knee jerks were normal and equal; the plantar reflex was flexor. No paralysis of muscle anywhere. The temperature was 102, pulse 104 respiration 24. The other organs were all healthy; urine normal. The history of the case was as follows:—

A month previous to admission patient had a painless discharge from the left ear which lasted five days and passed off. The discharge began again six days before admission, and at first was painless, but after the first day pain began and became very severe. Three days previous to admission pain in the ear became very severe, patient had a rigor, and the temperature rose to 103 degrees, and he began to vomit his food. From this time until date of admission the temperature kept up, rigors recurring at intervals and vomiting continued. Previous illnesses, none.

Mr. Beale was at once called to the case, and on his suggestion the antrum was opened in the usual way by Mr. Clark, senior house surgeon. The bone here was hard and like ivory, and the antrum lay deep, but when opened creamy pus came out with considerable force. The outer wall of the cavity was completely removed by mallet and chisel, and the middle ear washed out but not opened. The cavity was packed with gauze, and the wound partly stitched up.

Next morning (October 21st) the temperature was normal, and the patient felt better than he had done for days. The plug was removed, and the cavity washed out with lysoform (1 in 20), the lotion passing through the middle ear and out through the external auditory meatus. In the evening he had two slight rigors, and the temperature rose to 103.6 degrees. Slight weakness of muscles of left side of face was noticed.

As the temperature kept up, the patient was again anæsthetised, and Mr. Beale exposed the lateral sinus, but found it healthy, so the cavity was plugged, and the wound closed again. In the night patient had two rigors, but next morning (October 22nd), the temperature was normal, and the patient felt very well.

After this there were no more rigors, the weakness of the left side of the face disappeared, the discharge from the wound became less, and the patient was able to walk about the ward.

On the morning of November 4th patient had a right-sided convulsion. The twitching began in the right hand and arm, and spread to the right side of the face and the right leg, but did not spread to the left side. He did not lose consciousness, and there was no squint or aphasia. The convulsion lasted about two minutes, and afterwards there was paresis of the affected muscles, which slowly passed off. The temperature remained normal and the patient took his food well, did not complain of headache, and there was no vomiting.

The patient remained perfectly well until next afternoon (November 5th), when he had a second epileptiform attack, much less severe than the last, and beginning in the right hand in the same way. After this there was complete right hemiplegia. The ocular muscles were unaffected, but the orbicularis palpebrarum was paralysed. Sensation on the right side was perfectly normal. There was no aphasia or hemianopia. The right knee jerk was increased, and the plantar reflex was extensor. There was slight ankle clonus present. The pupils were equal, medium, and reacted normally. There were no retinal changes present. The patient's mental condition was perfectly clear. The temperature remained normal, and the pulse varied between 90 and 100 per minute. A

(*a*) *Op. cit.*, p. 39.

(*b*) For the notes of this case we are indebted to Mr. Clark, Senior House Surgeon.

diagnosis of cerebral abscess in the middle of the left Rolandic area was made.

On November 6th the patient was trephined by Mr. Beale. A horseshoe-shaped incision was made, and the scalp turned down from the parietal eminence on the left side. The pericranium being turned back, a piece of skull was removed by a crown trephine over the middle of the fissure of Rolando. The dura mater when exposed looked healthy, did not bulge, and the normal pulsation was visible. A small incision was made in the dura and the brain explored in every direction with a small grooved director, but no pus found. Then an exploring syringe was used in the same way, and some of the ventricular fluid drawn off which was perfectly clear. The dura mater was separated from the skull down to the base, but no pus was found anywhere. The scalp was sutured in position, a small gauze drain being left leading down to trephine hole. The patient suffered a good deal from shock after the operation.

After this the temperature rose steadily to 101.4, and the patient vomited several times. The pulse was never under 80 per minute. He developed aphasia and gradually became more and more drowsy, though never unconscious. The right knee jerk was lost, and the plantar reflex remained extensor. There were no more convulsions.

On November 9th patient was again trephined by Mr. Beale about 1½ inches below and behind the previous opening, over the posterior end of the fissure of Sylvius. The brain was explored here in the same way as before, but nothing found. On pressure being made over the scalp in the region of the former opening some suspicious-looking fluid was found to exude from the edge of the scalp flap, so the trephine hole was again exposed. A bead of pus was found exuding from the centre of the opening, and when a sinus forceps was introduced, about half an ounce of thin greenish yellow, foul-smelling pus escaped. The abscess lay at least ½ inch below the cortex in the middle of the Rolandic area, as previously diagnosed. The cavity was found to have a fairly definite wall and was syringed out, a rubber drainage tube being left in. The scalp was now sutured in position, a hole being cut in the flap to admit the drainage tube. The patient stood the operation very well.

Next morning the temperature was normal, and the patient began to take notice of things, though he was unable to speak. There was still complete right hemiplegia.

November 13th.—The temperature keeps normal. No change in the paralysis. Patient is perfectly intelligent, and can now say "Yes." There is still a large quantity of pus draining from abscess cavity.

November 20th.—Patient now talks fairly well, but slowly, and at times seems at a loss for words. Right side of face still weak, but power returning rapidly. Arm and leg still paralysed. General health excellent.

November 25th.—There is now slight movement of thigh muscles, and the arm seems less limp than before. Right side of face recovered. There is still a fair-sized cavity in the brain, but less pus being discharged. The drainage tube is still in. The mastoid antrum is now practically healed up.

November 30th.—Patient now talks as well as ever. He is able to move the thigh muscles, but not the leg or foot. The arm is still paralysed, but the muscles react to mechanical stimulation. There is now only a small gauze drain leading into the almost closed abscess cavity. The ear is practically cleared up.

The general condition of the patient is now very good, and except for paralysis he is perfectly well.

REMARKS BY MR. BEALE.

Mr. Beale said that the case was an unusual one, because the cerebral abscess could not be said to be directly in continuity with the suppurative process in the middle ear or in the antrum.

At the second operation, when he investigated the lateral sinus, he also made certain that there was no pus near it, or in connection with the brain close to the temporal bone, and the progress of the case during the next 12 or 13 days fully bore this out, for the patient appeared to be getting on perfectly well.

At the first trephining on November 6th Mr. Beale found no abscess. At that time he believed his exploring instruments had passed close to an abscess, but had not perforated its somewhat tough and thick wall. Therefore he employed a needle, but still was unable to get any pus. His opinion now was that the pus was very much deeper than he at first believed, and this opinion was quite justified by the large extent of the paralysis which was present, indicating the presence of damage not in the cortex, but deeper, where the motor fibres were packed closely together. Moreover, the cortex of the Rolandic area appeared quite normal, and not as it ought to have appeared had there been a large abscess within an inch of it.

As regards prognosis, everything now seemed favourable to complete recovery.

NOTE ON ADENOIDS AND NASAL OBSTRUCTION.

By WILLIAM LLOYD, F.R.C.S., L.R.C.P.E.,
Surgeon-in-Charge of the Nose, Ear, and Throat Department, Kensington General Hospital; Aural and Laryngeal Surgeon, St. Pancras and Northern Dispensary, &c.

It is a matter of clinical experience, both to myself and all other throat and nose specialists, that numbers of patients who have been operated on for adenoids return to us after a short time with their symptoms unrelieved.

The explanation of this disappointing fact is that two or more causes of nasal obstruction co-exist, and the mere removal of adenoids improves for a time, then the trouble of general obstruction asserts itself again, and the whole symptoms of adenoids are reproduced.

Causes of Nasal Obstruction.

In considering the causation of nasal obstruction, one is helped by remembering that the nose is bounded by bony and cartilaginous walls, covered with mucous membrane, rich in glands; also that the antrum and other accessory cavities communicate with the nasal cavities, and malignant growths from these sinuses readily find their way into and block up the nose. For practical purposes the following classification is simple, and includes most of the conditions which cause nasal obstruction.

I.—*Conditions originating in the mucous membrane and its glands or in the periosteum.*

Adenoids.
Hypertrophic rhinitis.
Mucous polypi.
Vascular growths and papillomata.
Gummata.
Carcinoma and sarcoma.

II.—*Conditions of the Bones or Cartilages.*

Displacements or the angular projections of fractures of the septum nasi.
Congenital deformity of the septum.
Exotosis or ecchondrosis.

III.—*Other Conditions.*

Congenital smallness of nasal cavities.
Congenital abnormalities.
Hæmatoma.
Abscess.
Foreign bodies and rhinoliths.
Cicatricial contraction of nares.
Synechial.
Enlarged Eustachian cartilages and pterygoid plates.
Meningocele.

It is the aim and object of the present paper to deal with—

(i.) Adenoids.
(ii.) Those cases which have the look and symptoms of adenoids without any being present.

Omitting the effect on the general health and development of the child, the symptoms of adenoids can be conveninetly put under three headings :—

Nasal, Aural, and Pharyngeal.

The symptoms due to adenoids are not dependent merely on the size of the swelling any more than all the symptoms of enlarged tonsils are the result of its overgrowth. Patients are frequently seen with very large tonsils with next to no symptoms, or there may be only small tonsils, which are constantly becoming inflamed.

The same is true of adenoid growth. It may attain a very considerable size, and apparently cause little trouble. Whether it will give rise to trouble depends on the extent to which it is associated with nasal catarrh, and this catarrh causes a chronic hypertrophy of the inferior turbinates. The nasal cavities may be partly blocked by the mere size of the large pad of adenoid tissue, but more frequently as a result of the spreading of the catarrh, which is liable to exacerbations, and the children are described as always catching colds; therefore it is the hypertrophic rhinitis more than the mere lumps of adenoids which give rise to the characteristic nasal obstruction, and when the mouth-breathing has persisted for a long time definite changes are brought about in the face, chest, etc. The facies is so peculiar and distinctive that the condition may be evident at a glance.

2. *Congenital Narrowness of Nasal Passages.*

Hundreds of children are brought or sent to every out-patient department with symptoms exactly simulating adenoids. All the signs are present which make up the complete picture of an adenoid case.

On examination, the nose is small and narrow, and frequently the inferior turbinate body appears jammed in between the septum and outer wall. The naso-pharynx is free of adenoids, but the space is narrow and pinched, barely admitting the tip of your finger; the soft palate and pharynx nearly touch. These cases are as common as cases of real adenoids, and it is impossible to doubt that a large number are subjected to the operation for adenoids who do not require it. What should be done to these cases? The majority should be left alone, as there is nothing more than inconvenience and occasional discomfort. At puberty the nasal cavities, in common with other passages, commonly enlarge. If the obstruction is so bad as to interfere with the general health or causing deafness, then a part of the turbinate must be removed with a spokeshave or cutting forceps.

Conclusions.

With the above formidable list of cases of nasal obstruction, which often co-exist, one can readily understand the causes of failure in the hands of operating practitioners who are not conversant with the technique of anterior and posterior rhinoscopy, whereby any other pathological condition complicating post-nasal growths might be recognised and dealt with if the operation is to be successful.

No surgeon would operate on the abdomen for intestinal obstruction without knowing all its causes and the various methods of dealing with them, yet the same surgeon will operate on nasal obstruction not knowing how to examine the nasal cavities, and takes it for granted it must be adenoids.

I have met with patients who have been subjected to two and three operations for the removal of adenoids with no benefit, the reason being, as I have pointed out, other causes being associated and overlooked depending upon imperfect examination.

All this meddling tends to discredit nasal surgery.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

Charcot's Joint.

By Joseph Cunning, B.S., F.R.C.S.

Among the out-patients was a man æt. 52, who complained of pain and swelling in his right knee; this had lasted on and off for nine years. There was no history of injury, and the symptoms were stated to have begun gradually. On examination the right leg was seen to be markedly deflected outwards; in fact, there was one-sided knock-knee. This, the man said, had slowly developed during the last nine years. There was a swelling occupying the upper part of the synovial pouch of the knee-joint, and obliterating the grooves on either side of the patella. The sign of fluctuation proved this to be fluid; during examination tenderness was elicited. Proceeding further, it was found that there was great overgrowth of the tuberosities of the tibia, laterally and posteriorly, and that the synovial membrane was studded with tough villous processes.

The movements of flexion and extension of the joint were unimpaired, but were accompanied by grating, which was not only palpable, but audible. Abnormal lateral mobility was also present.

Mr. Cunning pointed out that this case was either one of osteo-arthritis or Charcot's disease, two diseases which belonged to the same type, in which the changes in the joint structures were similar, but these were carried to a further degree in the case of Charcot's disease. He thought that the slow onset of the malady, and the amount of pain from which this patient had suffered rather suggested he was the subject of osteo-arthritis, but on the other hand, the exaggerated changes in the shape of the limb, the amount of wearing away of the external condyle, and the overgrowth in the head of the tibia, all pointed to Charcot's disease.

The patient was further examined,and found to have an Argyll-Robertson pupil; there was also absence of knee-jerks. With reference to the former, Mr. Cunning pointed out that the best way to examine for absence of the light reflex was to cover one eye, and at the same time watch the other. If a light reflex is present the observed pupil dilates when the other eye is covered, contracts when it is uncovered. He considered that this method averts a fallacy which may creep in when other methods are used: if both eyes are covered, and then uncovered, contraction due to accommodation may occur, and deceive the examiner, for the patient involuntarily accommodates to the surgeon's face or the light he may be holding.

The conclusion arrived at was that this was clearly a case of Charcot's disease.

Mr. Cunning was asked what was the ultimate fate of these joints, and said that the fluid in them subsided from time to time, and if an apparatus were worn which prevented abnormal mobility, a fairly useful joint resulted, though the patients were liable to exacerbations in the way of swelling.

Then very marked changes occurred in some of them in the formation of bony plates in the synovial membrane, so that the joint became more or less ankylosed by a sort of protective armour.

Mr. Cunning also pointed out that a Charcot's joint may be the very first sign discovered in a case of locomotor ataxia, preceding the lightning pains, absence of knee-jerks and Argyll-Robertson pupil.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

Injury to Skull, Trephining, Œdema of the Brain.—Mr. Edred Corner said the case he was going to operate on was that of a boy who with several others was standing under a tree throwing stones at birds, when a stone thrown by another boy came down and hit him on the head. He had sustained a compound fracture of the vault of his skull over his left parietal region. A week had now passed since the accident, during which the scalp wound had suppurated, and the boy had become drowsier and more unconscious. He had had little or no fever, and the pulse was not rapid—84. The question of diagnosis lay between an extradural or cerebellar abscess and meningitis. The history and the onset, the absence of fever and the quickening of the pulse seemed to indicate the abscess. The absence of localising symptoms indicated the meningitis. It was obvious that if left alone the boy would die, so that it had been decided to trephine over the wound in the skull, because if an abscess was found and opened the boy might live. Whilst the scalp was being shaved and cleansed, Mr. Corner pointed out that practically no anæsthetic was required. The wound in the skull was more or less punctured, and a probe was easily passed right through. Cerebro-spinal fluid escaped at first through it, but soon none came away, probably because the swelling of the subjacent brain had blocked the aperture. To expose the field of operation a flap of the scalp was turned down with its base directed towards the ear. This flap was made large to give full exposure. The knife cut down to bone at once, so that the flap was reflected before any vessels were secured. The hole in the skull was seen to be irregularly punctured. The pericranium was reflected after being incised in a cruciform manner. An inch trephine was used to take away the bone in a disc, the centre of which was the wound in the skull. Now that the disc was removed, it could be seen that there was no extradural abscess, and that the dura mater had been perforated by the falling stone. The dura mater was next incised crucially and the brain bulged. The bulging part presented a curious appearance. It was very pale, œdematous, and marbled by blue veins. There was no fluid or pus worthy of note within the cavity of the dura mater. There was a small ragged tear on the surface of the brain where it had been wounded by the stone. The brain was explored with trocar and cannula. A cerebral abscess of traumatic origin, was, he said, always formed just under the seat of injury, so that the trocar was plunged straight into the brain. Unfortunately for the boy there was no result. Further explorations failed to find any abscess. And there was nothing left but to suture the flap of scalp in its place. In pointing out the reason of the failure and why the boy must die, Mr. Corner said—Firstly, the alternative and provisional diagnosis of extradural or cerebral abscess was wrong. Secondly, the alternative diagnosis of meningitis, in the ordinarily accepted sense of the word was also wrong. Thirdly, there was found. what he did not expect, a wound of the brain, accompanied by a pale and œdematous, rather than an inflamed, brain. This condition was one which many do not believe in, and to which has been given the name of "spreading œdema." It was doubtless of a septic or infective origin in this case, though not necessarily so in others. At its commencement, it was probably inflammatory. But, as was seen, the brain was pale and œdematous, not red and hyperæmic, as ordinary inflamed tissues. Probably the "spreading œdema" in the brain represents what would be a cellulitis in other tissues. This cannot be treated in the brain, and the boy must die.

Apollinaris Water.—We are asked to announce that the Grand Prix has been awarded to Apollinaris Water at the Exposition Coloniale, Marseille.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Obstetrics.

President—R. D. Purefoy, M.D., F.R.C.S.I.
Sectional Secretary—H. Jellett, M.D., F.R.C.P.I.

Meeting held Friday, December 14th, 1906.

Dr. R. D. Purefoy, President of the Section, in the chair.

NEW FORM OF PESSARY FOR USE IN UTERINE PROLAPSE.

Dr. **Seymour Stritch** said he had been obliged to devise a pessary which would support the uterus, in a patient æt. 80, without pressing on an ulcerated cervix. He accordingly had a pessary made in the form of a ring, supported by a vaginal stem, from the vulvar end of which tapes are attached, for fixation, to a waistband. The ring (made by Down Bros.) can be hinged against its stem to facilitate its insertion, and when in position can be locked at the required angle to the stem. The uterus hangs within the ring free of pressure irritation.

Dr. **Hastings Tweedy** said they should be grateful for any device which would ameliorate the suffering in prolapse of the uterus in the aged when operation was impossible. He thought the pessary should get a fair trial.

Sir W. **Smyly** agreed with Dr. Tweedy. In two very important points—the joint and the waist attachments—Dr. Stritch's pessary was a distinct improvement on former ones.

Dr. **Alfred Smith** expressed his intention of trying the pessary in his own practice.

The **Chairman** also commended the pessary.

UTERUS WITH CANCER OF CERVIX AND FUNDUS.

Dr. **Henry Jellett** showed a uterus with cancer of both cervix and fundus. He said that he showed the specimens rather from their pathological interest than as an operation specimen. One of the indications in the past for supra-vaginal amputation of the cervix was said to be cancer of the cervix, and he thought this specimen showed the untenable nature of such a position. The specimen was also a rare one, and Cullen in his work on cancer of the cervix only recorded half a dozen cases. Cases of cancer occurring at both the fundus and the cervix might be divided into two classes:—First, those in which the two cancers were independent of one another. Such cases were difficult to allocate with certainty, since, unless the two cancers were of a different nature, it was difficult to say that they did arise independently of one another. The mere fact of a cervical and fundal cancer co-existing without macroscopic connection did not afford evidence that the two were dissociated. The second class of case was that before them, in which it was possible to trace definite connection. In the present case, of a patient about fifty-four years of age, he had operated for cervical cancer, and had no reason to suspect fundal cancer. The first thing he saw on opening the abdomen was a slight adhesion of the intestines to the fundus. The operation was a fairly radical one, and he regretted to say the patient was unable to stand it, and died from the shock fourteen hours after. The operation had to be very extensive, on account of the necessity of taking away almost the entire upper third of the vagina. In the specimen before the meeting a fine line of connection could be seen between the two growths, and this presumably followed the lymphatics traversing the muscular wall from one growth to the other.

Dr. **Alfred Smith** said the case reminded him of a recent article on how cancer spread. Cases had been found in which the cancer extended not only through the lymphatics but also by the tiny branching tendrils that seemed to grow out from the primary cancer.

Dr. **Hastings Tweedy** thought it was a great triumph that so much of the vagina had been removed without rupture.

Sir W. **Smyly** said he had seen the operation performed. It was a very radical one, and it was a great pity the patient had not the strength to stand it.

The **Chairman** said the case reminded him of one of his own in which the uterus contained two varieties of cancer, one in the cervix and one deep in the tissue of the fundus, no microscopic or macroscopic connection being between them. The disease in both localities was not very far advanced, and the patient made a good recovery.

Dr. **Jellett**, in reply, said the operation was performed by Werder's method, as described in Cullen's "Cancer of the Uterus." In spite of the fact that it had been abandoned by its originator, it was an excellent operation for the removal of extensive vaginal infiltration. In the case before them the rectum was free, but the bladder was commencing to be involved, and there was considerable difficulty in separating the vaginal wall from the bladder.

OVARIAN CYST.

Sir W. **Smyly** presented a specimen of ovarian cyst. He said the case showed all the characteristics of an ovarian tumour, except that he could not isolate the uterus from the tumour. The uterus moved with the tumour, and, though he thought it was ovarian in origin, he could not make a positive diagnosis. When he opened the abdomen he saw what appeared to be an ordinary ovarian cyst. He incised it, and let out a quantity of pseudo-mucinous fluid. When he had dealt thus with half a dozen cysts, he enlarged the incision, and found the uterus spread out over the front of the tumour, and the round ligament running over the top of it. The pelvic cavity was almost entirely de-peritonealised. When he had almost completely shelled out the tumour he found it impossible to separate it from the uterus, and, even as it was shown, it was impossible to see any line of separation between the tumour and the uterus, so that one would be almost inclined to think—were it not for the characteristics it presented—that it was fibro-cystic tumour.

On the motion of Dr. **Alfred Smith**, seconded by Dr. **Hastings Tweedy**, the specimen was referred to the Reference Committee for a special report.

VESICAL CALCULUS WITH NUCLEUS OF PEDICLE SILK.

Dr. **Alfred Smith** said that about three months after the removal of a large ovarian cyst the patient began to suffer increasing pain during micturition, and her medical adviser was satisfied that she had stone in the bladder. Eventually she came to him. She was so tender that he could not palpate her without an anæsthetic, but when the anæsthetic was administered he found the bladder filled with stone. Having smashed the stone and washed out the fragments he drew out, by the urethra, with the guidance of the finger and forceps, the ligature shown. The natural explanation of how the ligature got into the bladder would be that there was some inflammatory disturbance around the pedicle, but if such were present it would suppose some evidence of pain, but the only pain complained of was that already mentioned.

The **Chairman** recalled a parallel case.

Dr. **Neil** instanced a case in which the patient passed a quantity of pus in the urine some time after the removal of a large myoma, but none of the ligatures came away.

A CASE OF LABOUR OBSTRUCTED BY FIBROID TUMOUR: RED DEGENERATION OF THE TUMOUR.

Dr. **Roulette** read, for Dr. Kinkead and himself, a paper on "A Case of Labour Obstructed by Fibroid Tumour: Red Degeneration of the Tumour." The patient, a multipara, was admitted to the County Galway Hospital, having been thirty hours in labour; a globular tumour, four inches in diameter, was presenting at the vulva, apparently springing from the anterior lip of the os. As the tumour was very vascular, Dr. Kinkead decided to deliver the patient before removing the tumour. Drawing the latter down and forward, he applied forceps and extracted a living child. When the placenta came away he cut the pedicle of the tumour with an écrasure. The patient left hospital quite well on the thirteenth day. The tumour was a typical example of "red degeneration," showing necrosis and congestion. The condition was probably comparatively rare, and was in most cases associated with pregnancy. It usually gave rise to marked constitutional symptoms—pain, weakness, wasting, gastric disturbances. Dr Rowlette believed that the staining was due to a diffusion of the blood pigment consequent on a sudden necrosis of a congested tumour.

Dr. **Henry Jellett** said the Section was indebted to Professor Kinkead not only for his paper, but because he had given Dr. Rowlette, incidentally, an opportunity of making a very important contribution to the pathology of an obscure condition. If the staining in the case was incidental with the staining that would be brought about by the breaking down of the red corpuscles in the blood, by finding a cause for such a breaking down some explanation would be found for the condition. On a former occasion he had suggested that there was possibly some curious bacterial action which brought about the change, but, with or without a previous bacterial invasion of the tumour, some ferment might be found in the tumour that would lead to breaking down of the corpuscles.

Dr. **Hastings Tweedy** congratulated Professor Kinkead on the brilliant way in which he had dealt with the case, and brought it to a successful delivery, notwithstanding the immense difficulties in his way.

Dr. Ashe, Dr. FitzGibbon and the Chairman also spoke.

Dr. **Rowlette**, in reply, said the term "degeneration" as applied to the condition was a bad one; it was not a degeneration, but a necrosis. In none of Fairbairn's cases was any bacterial infection found. If bacteria gained access to the degenerated fibroid it was likely to be quite different from the simple necrosis in the case before them.

The following card specimens were shown:—

Dr. **Spencer Sheill**—Tuberous Sub-chorial Hæmatomata of the Decidua in an early Abortion.

Dr. **Hastings Tweedy**—(*a*) Ovarian Cysts, 2; (*b*) Myoma of Uterus, 5; (*c*) Salpingitis; (*d*) Epithelioma of Vulva.

THE LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, December 20th, 1906.

The President, Mr. **Frank T. Paul**, F.R.C.S., in the Chair.

Mr. G. P. **Newbolt** read notes of a case of PERFORATING DUODENAL ULCER, complicated by abscess of the lung, in a male patient, aged 30 years, who had previously been in robust health. The treatment was by injections of polyvalent serum. Frequent attempts were made to localise the abscess with exploring needles; the abscess eventually emptied itself—on some days, a pint to a pint and a-half of pus being expectorated. Finally the patient made a good recovery. The organism isolated conformed to the type of streptococcus termed S. Salivarius by Andrewes and Horder.

OPERATIONS DURING TYPHOID FEVER.

Mr. W. **Thelwall Thomas** read notes of two cases of surgical operations during the course of typhoid fever—one for perforation and one for appendicitis—both of which had recovered. He drew attention to the fatal character of perforation unless surgically treated, when the recovery rate was 30 per cent. or more. Although in many cases the diagnosis was uncertain—stress would be laid on pain, rigidity, and increased pulse rate; even when in doubt it would be wiser to explore (under local anæsthesia) than to wait until general septic peritonitis had set in. The treatment of the perforation by quick suture or the formation of a fæcal fistula appeared to be the two alternatives; fancy work, such as enterectomy with end to end anastomosis, was not to be recommended; enterostomy had the further advantage of draining and keeping the typhoid intestine at rest. The first patient was a man who had been walking about until a few days before symptoms of perforation occurred; the case was diagnosed as perforative appendicitis and immediately operated upon, with the result that a typhoid perforation was found. The second was a young lady in the third week of typhoid: though a provisional diagnosis of perforation was made, at the operation acute appendicitis was found. Mr. Thomas briefly described two other previous cases in which he had operated for typhoid perforation without being able to save the patients' lives.

The **President** referred to two cases—one illustrating the difficulty of making a certain diagnosis in typhoid perforation; the other, a perforation 12in. from the cæcum three months after the onset of typhoid fever. In the latter case the ulceration was so extensive that the perforation could only be closed by excising it, and the patient died nine days after the operation.

Mr. T. C. **Littler Jones** mentioned a case he had operated upon successfully last July. A Lascar boy was brought to the infirmary at the end of the second day after perforation of a typhoid ulcer. Simple suture of the ulcer was performed and the abdomen cleaned of intestinal contents. The boy was transferred to his ship three weeks afterwards. Perforation was rare in Hindus, and the infection comparatively slight.

The difficulty of diagnosis was illustrated by a case he had seen at Pretoria in a soldier suffering from typhoid and scurvy. The man had taken several strong doses of lime-juice at once, and the consequent colic, rigidity of the abdomen, pain and collapse closely simulated perforation of the intestine. Fortunately the cause was discovered in time.

Mr. Littler Jones agreed with Mr. Thomas that the chances of success depended upon the time that had elapsed since the perforation, and on the speed with which the operation was performed.

Mr. R. W. **Murray** said that better results from operative interference would probably be obtained if as a general rule the bowel at the point of perforation was brought to the surface and a fæcal fistula temporarily established. Such an operation could be quickly performed, and would have the great advantage of allowing the inflamed bowel rest, and affording the ulcerated surface every opportunity of healing.

Drs. W. Carter, T. R. Glynn, R. J. M. Buchanan, T. R. Bradshaw, E. E. Glynn, and J. Hill Abram also spoke.

Dr. R. J. M. **Buchanan** read a paper on

ACUTE LYMPHATIC LEUKÆMIA.

in which he drew attention to the rarity of the disease, and said that in its symptom complex it resembled in many ways an acute specific fever. The blood picture was one quite different from that seen in myeloid leukæmia, and was due to a hyperplasia of definite cell elements. The clinical picture was described and illustrated by an acute case of nine days' duration, in which the symptoms pointed, in the later stages, on the one hand to a morbid blood state, and on the other to an acute abdominal lesion, most probably hæmorrhage into the pancreas. A blood count revealed a lymphocytosis of 528,000 per cubic metre.

The case was under the care of Dr. Schofield, of Southport, to whom Dr. Buchanan expressed his thanks for the notes of the early condition.

The paper was discussed by Drs. E. E. Glynn, W. Carter, and Horter.

Dr. A. **Cassels Brown** read a paper, entitled "Two Forgotten Medical Worthies." The subjects of the paper were Dr. Gabriel Broughton and Dr. William Hamilton, both of whom played somewhat important parts in the early struggles of the "Company" in India.

A most cordial vote of thanks was accorded to Dr. Cassels Brown for his most interesting paper.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY.

Meeting Held Thursday, December 13th, 1906.

The President, Mr. H. Shirley-Jones, M.R.C.S. (Droitwich) in the Chair.

The **President** and Dr. **Bagshawe** (St. Leonard's) spoke of the great loss which had recently been sustained by the Society through the death of Dr. Symes Thompson and of Dr. Douglas Kerr (Bath) both of whom had been Presidents of the Society.

A paper was read by Dr. **Leonard Williams**, on the

TREATMENT OF GOUT BY THE INGESTION OF COMMON SALT-CONTAINING WATERS.

The author contended that Widal's work on the subject of common salt and its effect in cases of renal inadequacy should cause us to review the probable effects of common salt waters, which are given by the mouth in the treatment of gout. After a brief résumé of the salient points of Widal's work in reference to this question, he went on to say that inasmuch as gouty people were for the most part potentially inadequate in the matter of renal excretion, it seemed to him to be an unwise proceeding to continue to send gouty patients to salt water spas. He had made out a table showing the contents in common salt of some of the more popular spas, and he held that certain spas, notably in Germany, such as Kissingen, Homburg, and Wiesbaden, were unsuited to the treatment of gout when regarded from this point of view. He further expressed the opinion that inasmuch as the bowels were only accessory excretory organs where the products of nitrogenous metabolism were concerned, the wiser course was to advise gouty patients to those spas such as Contrexeville, Vittel, and more especially, Evian, whose waters were known to exercise a stimulating effect upon the kidneys, which constituted, after all, the normal physiological route for the discharge of nitrogenous waste.

The **President** remarked that simple waters, given in large quantities, and without sufficient intervals, do not give the diuretic effect produced by moderate quantities, and he believed this to be all the more true in cases of waters containing large quantities of sodium chloride. Therefore, it was necessary to watch carefully the action of the kidneys in treating gouty cases with saline waters. With due care in prescribing saline baths and waters an early increase in the flow of urine and a corresponding decrease in the gouty manifestations were usually found. There were no cases so hopeful as these which showed this early diuretic action.

Dr. **Solly** (Harrogate) said that whatever theoretical objection there might be to the use of salt-containing waters in gout, there was no doubt that the practical experience of a multitude, both of medical men and patients, went to prove that these waters were beneficial in gout. It was true that they must be administered with discretion, and with due regard to all ascertainable factors in the patient's case—of which the condition of the kidneys was very important. His own experience was that, leaving out acute cases, for which Harrogate waters were never recommended, all ordinary cases of gout were benefited by the strongest saline water of Harrogate, if only precautions were taken to secure from the first a thorough, though not drastic aperient action—this being often most satisfactorily obtained by a preliminary dose of euonymin or some other simple hepatic stimulant, and by the administration of sufficiently copious doses of the water.

Dr. A. P. **Luff** said that he could not agree that all gouty patients should be debarred from taking mineral waters containing sodium chloride. In those cases in which gross renal inadequacy existed it was right to forbid the use of such waters, but in other cases the waters were of great value to gouty patients as stimulants of hepatic metabolism.

Dr. C. W. **Buckley** (Buxton) considered it probable that the chloride radicle of common salt is of much importance in the therapeutic effect of these waters in gout, in view of the value of ammonium chloride, and also nitro-hydrochloric acid, in functional disorders of the liver. Hydrochloric acid has been used as a remedy for gout with success, a fact which also supports this view. He was quite in agreement with Dr. Luff that the kidneys were not the only organs to be considered, and that the function of common salt-containing waters was to act upon the liver, but held that any renal inadequacy contra-indicated them, no matter how slight it might be.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris Jan. 6th, 1907.

Biliary Cirrhosis.

From an anatomical and clinical point of view, two types of biliary cirrhosis are admitted by clinicians—biliary hypertrophic cirrhosis and biliary cirrhosis from obstruction by calculi.

Clearly isolated by Hanot in 1875, from the confused group of hypertrophic cirrhosis, biliary cirrhosis is essentially characterised by a considerable increase in volume of the liver, the spleen, chronic icterus, absence of ascites, and of complementary circulation.

Its cause is almost unknown. Alcoholism, paludism, syphilis, have been incriminated, but the affection seems to be somewhat hereditary. It is observed generally in young subjects of 25 to 35 years; it is more frequent in men, while children have been known to be affected.

The lesion consists in angiocholitis followed by peri-angiocholitis; the sclerosis invades the spaces, producing obliteration of the biliary ducts. The hepatic cells remain healthy, although hypertrophied, and do not undergo fatty degeneration, as in other forms of cirrhosis.

The liver and spleen are enormously increased in volume, in which also the abdominal ganglions participate.

As to the cause of the malady, only presumptions can be made. For Kiener, Hanot, Hayem, and Ascoli, the theory of general infection is considered sound. Chauffard believes in its splenic origin. According to him, the infection first attacks the spleen and the lymphatic ganglions, and secondly the liver.

The first symptoms of biliary cirrhosis are very obscure. The patient complains of *malaise*, inappetence, weight in the gastric region, flatulence after meals, tardy digestion. The patient loses flesh and strength, and sometimes epistaxis is observed.

Jaundice is sometimes the initial sign, appearing without any known cause or attributed to an access of grief, depressing emotions, alcoholic or alimentary excesses. The tongue is furred, and the hepatic region a little tender. With the usual treatment of rest, purgatives, and alkaline waters, the jaundice disappears, but returns in a short time; the liver becomes congested again, epistaxis and purpuric spots on the skin are observed and the patient gets weaker and weaker.

The jaundice is this time permanent, but varies in intensity from pale yellow to dark green. The urine is scanty and dark-coloured as with bile.

The liver is enormously enlarged, constituting with the icterus the fundamental symptom of the malady, completed, however, by the hypertrophy of the spleen. As negative symptoms may be mentioned absence of ascites and dilatation of the abdominal subcutaneous veins.

Repeated hæmorrhage is frequently observed as well as cutaneous purpura, itching, acne, &c. Towards the end œdema of the extremities sets in, with pulmonary congestion from cardiac insufficiency, and finally cachexia, to which the patient succumbs.

The duration of the affection may vary between several months and three or four years, according to the treatment and the resistance of the subject.

The prognosis is necessarily fatal, but some relief and extension of life may be obtained from treatment, which consists mainly in hygienic principles and régime.

The patient should avoid all alcoholic excess, all fatigue and overwork or mental strain. The lacto-vegetarian diet should alone be allowed, while antisepsis of the intestine will be realised by salol, salicilate of soda, or calomel in fractional doses; saline purgatives may be ordered periodically.

Biliary cirrhosis from obstruction by calculi differs from the former affection by the fact that the hepatic organ is atrophied. The biliary canals or ducts are greatly dilated from mechanical retention of the bile, which itself is modified and becomes a cause of irritation for the cells, which finally perish; atrophy of the organ is the result.

The symptoms consist in the presence of jaundice, varying in colour, and discoloration of the fæces; the urine contains biliary pigment, the patient complains of a distaste of fatty foods, of constipation, vomiting, itching, &c.

The diagnosis of biliary obstruction is very difficult, and even impossible if the history of the case does not reveal the existence of hepatic colic.

The treatment is purely surgical, and the only question to be studied is the best moment to operate. According to Schwartz, the operation should be done at the end of three or four months, especially if the patient is getting thin. Mongour believes that as long as the liver is able to defend itself nothing should be done; that medical treatment often succeeds. A liver subject to variations in form resists and defends itself for an indeterminate time; a liver, on the other hand, which remains definitely fixed in its dimensions (atrophy or hypertrophy) is a liver which has lost all functional adaptation, and places the life of the patient in immediate danger.

GERMANY.

Berlin, Jan 6th, 1907.

Typhoid Bacilli Carriers.

From work carried out in the Kaiserl. Gesundheitsanit we learn that during twenty-one months twenty-three carriers of typhoid bacilli were met with. Amongst the carriers were people ranging from sixty years of age down to one and a-half years. Out of the twenty-three cases a group of eleven was distinguished, inasmuch as no observable signs of illness of any kind were discoverable in its members. Seventeen hundred healthy individuals were examined during the period in which the investigation was being made, and the eleven were amongst this number. The period of bacilli excretion in this group was only of short duration. In contrast with the group of "acute" bacilli carriers was that of the "chronic" carriers. This group consisted of convalescents from typhoid fever, and in them the bacilli were met with in all stages after defervescence from six weeks up to eleven months. Some of the persons examined had had typhoid some years before, and occasionally examination revealed some bacilli in these. These latter cases have led to a belief that after the disease has run its course certain of the bacilli may continue a saprophytic existence in the gall bladder, and from there many find their way into the bowel. A definite disappearance of the bacilli in the chronic carrier was determined with certainty in one case only.

In practice it is of the highest importance to realise that typhoid bacilli may be excreted from healthy individuals, and that, passing into others they may set up typhoid fever; theoretically, such a thing might take place, although no actual observation of such an occurrence has yet been made. The so-called acute bacillus carrier, the writer, Dr. Klinger, thinks tolerably harmless, but the danger in the chronic cases is great so long as they are allowed out into the world, and especially when they themselves are ignorant of their condition and when they are uncleanly in their habits.

The rules for preventing mischief arising are cleansing of the anus and hands after every defæcation, and the strict forbidding of defæcation in unsuitable places Of course, disinfection of stools when the carrier is going about is not practicable, as supervision is impossible. Perhaps the discovery of some means of rapid evacuation of all bacilli when the disease has subsided will lead the way to greater security than the public have at present.

Milk and Typhoid.

From the same institution we have an instructive paper on this subject.

In Strassburg five people living in different streets in the same part of the town were attacked with typhoid fever one after the other. All had drunk milk uncooked from the same milkman. The milk came originally, as was proved, from two dairies of one village in the Landkreise Strassburg. Investigation showed that no one in the village was ill of the disease, but that about six months before a schoolboy had lain ill of cough, and that large quantities of typhoid bacilli had been present in his stools, and that it was possible that the water of a well adjoining or near to the privy had become contaminated.

In Strassburg also there were at another time eight cases of fever in different parts of the city, to which others were added some weeks later on. Each sufferer from the disease had drunk, as was proved, unboiled milk from the same milkhouse, which distributed only mixed milk from various dairies. More detailed examination showed, at one of the dairies from which the general supply was obtained, that a woman lived there who was apparently healthy, but whose stools contained typhoid bacilli.

The interesting cases were similar to a number observed by the writer, Dr. Kayser. During the years 1904 and 1905 two hundred and sixty cases of typhoid were observed in Strassburg, and in sixty of these a connection was discovered between the disease and the consumption of unboiled milk. The total percentage of cases then brought about of twenty-three was much increased in the latter year, when of one hundred and twenty-six cases this connection was discovered in fifty-one, *i.e.* forty per cent. Another interesting and striking fact was the number of servant girls who were affected, and also people employed in cooking in shops.

The moral of all this is that more exact supervision must be exercised in the case of all suspected persons, but herein lies a serious difficulty, as pointed out by Dr. Liebetieu, of Treves, in the *Zeitch. f. Med. Beambe*, November, 1906. The carriers of the bacilli and even the disseminators of the disease have not always been ill themselves; they cannot be classed as "ill," nor as "suspected of being ill," or of being "suspected of carrying infection." The disseminators of the disease have in many instances been in apparent perfect health, and there is no law in Germany or anywhere else that can get hold of such persons, dangerous as they certainly are. One cannot expect that the stools of all individuals shall be examined for typhoid bacilli, the most that can be done is to look carefully after all suspected individuals, and these will naturally be all engaged in some department of the milk trade, whether as milkers, washers out of pails and cans, or distributors. The matter is not a savoury one, but it must be faced. When a case of the disease is notified it will be the duty of the medical officer of health for the district to at once look up the milk supply that comes under suspicion, and then institute a searching inquiry into the constituents of the dejecta of all engaged in that particular supply of milk.

AUSTRIA.

Vienna, Jan. 6th, 1907.

Diuretic Medicines.

Löwi read a long paper to the Gesellschaft on the action of diuresis and the varied actions of the "Purin-derivatives" such as diuretin, caffein and digitalis. His opinion of the action of diuretin was that it increased the circulation of the vascular in the kidneys themselves, thus increasing blood changes, which was the opposite of digitalis, which increased the work of the heart by constricting the vessels.

There was an apparent anomaly in the action of digitalis which rendered explanation difficult. In a healthy individual no rise of pressure was observed, but if a morbid condition existed the blood pressure rose and produced a favourable result. Diuretin had also a beneficial effect on stenosis, which could not be attributed to the diuretic action where no œdema exists; we must therefore attribute this action to another property of the drug.

Schur was inclined to agree with Löwi on the action of diuretin in general, but when he tells us that it relieves pain in arterio-sclerosis he hesitated to believe it; neither was he supported by experiments, as none of them admitted, nor can it be demonstrated that dilatation of the vessel takes place under the action of diuretin.

Federn thought the congestion of the organ and increase of blood pressure was due to the peripheral irritation of the splanchnic nerve.

Braun thought that digitalis acted on the vascular system, and particularly on the central nervous system The increase of blood pressure plays a very insignificant part in arterio-sclerosis, which is contrary to the usual orthodox teaching.

Grossmann said the views put forward were quite contradictory, as we could not have excessive cardiac action and congestion as the true explanation. We have undeniable proof that increased cardiac pressure removes the congested state of the kidneys; we also know that digitalis has little or no effect on the healthy as a fact, but to speculate further is dangerous.

Bier's Congestion Treatment.

Eiselsberg gave a few examples of his method of applying Bier's treatment in acute inflammation. He has obtained wonderful results and speaks in high praise of this form of treatment. The chronic cases rapidly improve, the pain ceasing, and the natural secretions returning.

Bier's congestion treatment consists in checking or reducing the flow of blood through any inflamed part of the body.

Jerusalem showed several cases of phlegmonous lymphangitis which he had treated with the very best results by Bier's hyperæmic treatment. He showed three of "Bier-Klapp's" suction apparatus which he applied in the treatment of stiff joints.

Cystadenoma Mammæ.

Saar showed diagrams of this disease which might also be called mastitis chronica cystica. It was a genuine neoplasm arising from the epithelial cell, which forms the principal substance of the growth.

Trichonodosis.

Riehl showed a few cases of this disease, as well as preparation of others, that he had preserved. This is the trichorhexis nodosa of Kaposi, of which he concluded no ætiology could be given. Riehl now affirms that it is not a disease in the true sense, but is the outcome of mechanical irritation or neglect. Burning the hair or applying large quantities of fat are potent factors in the production of this anomalous condition.

Intestinal Infection.

The ideal disinfectant, according to Moro, is the regular changing of the contents of the bowel to allow of the active development of the normal bacteria. Feeding with the mother's milk is an excellent germicide for infants where the pathogenic type threatens to exist. In breast-fed children the bacillus bifidus is the mormal germ, which will attack and destroy every other pathogenic microbe present in the canal.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Health of Edinburgh during 1906.—The death rate during the year was 14.26 per 1,000. Of the 4,868 deaths, diseases of the chest accounted for 1,074, phthisis and other forms of tuberculosis for 611, and zymotic diseases 293, measles being the most fatal with 129. The births were 7,042, of which 617 were illegitimate; this gives a birth-rate of 24.41 per 1,000. During the year 2,147 cases were notified under the Infectious Diseases Act, comprising 987 scarlatina, 667 diphtheria, 337 erysipelas, 144 typhoid, 11 puerperal fever, and 1 relapsing fever. The admissions to the fever hospital were 3,079, the excess over the number of notifications being due to the number of cases of measles, etc., which are not scheduled for notification.

The Cost of Scottish Asylums.—The *Scotsman* of January 2nd gave prominence to a contributed article by an expert on this subject, which affords considerable food for reflection. The writer's text is Lord Rosebery's pronouncement at the opening of Bangour Asylum in which he dwelt on the enormous cost of erection and maintenance of asylums—"sepulchres for the living dead." From the article in question it seems that during the past half century the approximate cost for construction of asylums in Scotland has been four and a half millions, and the annual maintenance bill approximates to £450,000. Some of the Scottish asylums have been erected at a cost per head of £400, £500, and even £600—sums that would build villas for families of eight. What has contributed to this cost? Not the necessary heating, lighting and laundry plants, etc., nor the furnishings, nor the mural decorations, but the palatial masonry, the towers, domes, and minarets, the carving and sculpture, the massive wrought iron gates, the byres and piggeries befitting the palaces of millionaires, the parquet rout flooring, the tiled bathrooms, and the recreation rooms in their get up equal to any modern fashionable playhouse. These are not needed for the treatment of the 35 per cent. of curable cases, and are not justified for the housing of the 65 per cent. of chronic dements, chronic maniacs, inebriates, and epileptics who form the permanent pouplation of the asylum. The responsibility for this extravagance is variously laid on architects, and on local authorities, each anxious to go one better than its neighbour, yet there are Boards and architects who have shown how the thing can be done at less than half the cost. In the Kingseat Villa Asylum, Aberdeen, the cost has been £220 per patient, and at Ayr the erection of a hospital (the costliest part of an asylum) has been completed at £150 per bed. A table is given showing the annual cost of maintenance per patient, and the annual assessment per patient for buildings, lands, etc., in fifteen of the large asylums. The average is £28 for maintenance, £20 for assessment—a total of £48. Bangour Asylum heads the list with £37 10s. and £60 19s. respectively, while Ayr is at the foot with £26 and £6 16s. Woodilee, Glasgow, Midlothian, Lanark, Roxburgh, and Dundee, are near the average. In the year 1905, the amount of unpaid borrowed money for Scottish district asylums stood at £1,721,760, of which £199,000 stood to the debit of Gartloch, £195,300 to Govan, £183,400 to Lanark, £173,500 to Edinburgh, £122,690 to Aberdeen, and £91,000 to Dundee. Various remedies have been proposed for a state of matters loudly calling for reform. It has been proposed that Parish Councils, who provide all the patients and the entire maintenance bills, should have some say in administration. The Town Councils of Edinburgh and Glasgow already object to rate for institutions in the erection of which they have no say. A plan could easily be found to effect a combination of the three authorities—Town Council, Parish Council, and District Lunacy Board, which would be a step forward in local government.

Complimentary Dinner to Dr. Norman Walker.—Dr. Norman Walker was entertained to dinner at Kirkcaldy on December 28th, on the occasion of his election as direct representative for Scotland. The dinner was held under the auspices of the Fifeshire branch of the British Medical Association, and was presided over by Dr. Graham, Leven, who gave the toast of The Guest. The dinner was attended by a large company, many of whom came from a distance; a number of apologies from those who had been storm-stayed were read. The Lord Provost of Edinburgh, the Provost of Kirkcaldy, Mr. Munro Ferguson, M.P., and others were unavoidably prevented from being present.

BELFAST.

Public Health.—At a meeting of the Belfast Corporation held on New Year's Day, Dr. Bailie, the new Medical Officer of Health, made a brave show as a medical reformer. He is, of course, on his metal, and is naturally anxious to prove that he is better qualified for the post he holds than his professional brethren thought. He presented reports on the inspection of dairies, and on the prevention of tuberculosis, which were excellent as far as they went; but it remains to be seen whether he will have sufficient weight to enforce his reforms on the Corporation, which contains a solid body of property-owners and "property-developers" whose interests are strongly opposed to reforms. Meantime Dr. Bailie will no doubt be preparing his annual report, and we should like to remind him of some of the items for which we have looked in vain in his predecessor's reports for years back. We want some information as to inspection of dairies and slaughter-houses, inspection of meat and fish, milk, fruit, and vegetables. How many prosecutions were instituted, and how many convictions obtained? Typhoid and tuberculosis have received a fair amount of attention in recent reports; what about alcoholism and cancer? How are the female sanitary inspectors employed and what is the general result of their work? Is the refuse destructor working well or is it an expensive failure, only kept going to save some members of the Corporation from awkward questions as to why that particular make of destructor was chosen, and why the contractors were not kept up to the mark, before it was paid for? And, finally, if all these questions seem too trivial to Dr. Bailie, as they did to his predecessor, and he wants one worthy of a master mind, let him tell us a little about the main drainage of the city, whether it is working satisfactorily, and, if not, why not?

Case of Arsenical Poisoning at Antrim: Censure of Medical Man.—At an inquest held on January 4th, on the body of a farmer who died lately at Antrim, the evidence showed that there was a considerable quantity of arsenic present in the body. It was also proved that the deceased had made attempts to procure arsenic at several shops, and, having failed in these, finally got half an ounce of arsenic from Dr. Gawn, of Antrim, "for treating a horse." The arsenic was labelled "For external use only," and Dr. Gawn said that he did not charge for it, as he did not sell poisons or keep a poisons book. The jury returned a verdict of suicide from taking arsenic, adding that they were of the opinion that Dr. Gawn had been negligent in not visiting the deceased when told that he had taken some of the contents of the bottle. Dr. Gawn protested against the findings, and said that there was no evidence whatever that he had been told so, and that it was merely hearsay. As the evidence in question has not been published, it is impossible to express any opinion on it, but from various reports there is clearly a good deal of local feeling on the subject, and more may possibly be heard of it.

LETTERS TO THE EDITOR.

ANTI-VIVISECTION AND SPORT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Will you allow me to say a word in reply to the letter signed "S." in your last issue. Your correspondent, referring to me, says "Can this Christian Minister not take the trouble to ascertain at first hand the facts about experiments upon animals, and in the meantime direct his further energies to the gross and unjustifiable forms of wholesale cruelty he rightly denounces?"

As regards the latter part of this question, the writer's suggestion is rather belated, inasmuch as I have devoted a great deal of my time, during the last fifteen years, to exposing and denouncing the horrors of "sport."

His advice is equally inapplicable to me on the subject of vivisection. My abomination of that practice is not founded on mere hearsay: I go, for my information, to accounts which the vivisectors themselves give of their proceedings. For instance, I take up Volume 46 of the "Transactions of the Pathological Society of London," and read at page 236 all about the kidney-slicing experiments on dogs, conducted by a well-known London doctor, and I rise from the perusal with the feeling that I had rather die a hundred deaths than blacken my soul by consenting that such deeds should be done for *my* benefit.

What I stand for is the demolition of cruelty in every sphere where it shows its hideous face.

I am, Sir, yours truly,
(Rev.) J. STRATTON.

Wokingham, January 7th.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—From a communication to the *Field* of December 22nd, I see that Lord Ribblesdale has joined Mr. Peter Ormrod in establishing a pack of hounds to hunt deer in Lancashire and Yorks. These animals will be chased under conditions which will make the sport a cross between the carted-staghunt and the wild-deer-hunt of Exmoor. This is the plan suggested by the *Field* of September 3rd, 1892, in order to meet the possible fall of the Royal Buckhounds. Lord Ribblesdale, I presume, foreseeing the probable enactment of Mr. Luttrell's Spurious Sports Bill, which would make it illegal to hunt deer that have not had a month's freedom, is anxious to provide against the evil day, and so sets up a Hunt which he thinks the Bill would not touch.

All humanitarians, I am sure, will be extremely sorry that his lordship has taken this line. We live in times when education is rife, and one might legitimately expect that persons of position, instead of promoting a new form of sport, bearing more or less resemblance to the universally reprobated carted-deerhunt, would feel that the time has come for questioning the justifiability of hunting even really wild creatures.

I am, Sir, yours truly,
ONE OF THE PEOPLE.

December 29th, 1906.

OBITUARY.

FRANCIS ROBERTSON MACDONALD, M.D.EDIN., J.P.

THE death took place on January 2nd of Dr. F. Robertson MacDonald. He was a J.P. and an Hon. Sheriff-Substitute of Argyllshire. Dr. MacDonald went to Inverary about fifty years ago as a medical practitioner, and resigned his medical appointments to be medical attendant to the late Duchess of Argyll. On her death he was appointed private secretary to the late Duke, continuing in this office until the Duke's death. Deceased was a lineal descendant of the MacIans, Chiefs of Glencoe. He was proprietor of an estate in the neighbourhood of Aberdeen. His medical education was at Edinburgh University, where he took the degree of M.D. in 1853.

EDWARD ASHBY FARDON, L.R.C.P., M.R.C.S.Eng.

The death is announced of Mr. E. A. Fardon, who filled the post of resident medical officer of the Middlesex Hospital for a period of thirty years. The funeral took place at Ventnor on Saturday, and a memorial service was held on the same day in the chapel of the hospital with which he was so long connected. Mr. Fardon qualified in 1879, and after filling the junior resident post at the Middlesex Hospital, was appointed medical officer. His death will be regretted by many friends who knew him in that capacity.

THOMAS GEORGE O'SULLIVAN, L.R.C.P.LOND., L.R.C.S.I.

The announcement will be received with very deep regret of the death of Dr. T. G. O'Sullivan, Limerick, which occurred on the last day of 1906, after an illness of some months. Dr. O'Sullivan had been connected with many institutions in Limerick, and at one period took a large part in public life, and was elected mayor of the city in 1881. He was held in the highest esteem in Limerick, and was particularly appreciated by the poorer classes, to whose interest he devoted a large share of his professional ability. His medical education was received at the Carmichael School, Dublin, whence he qualified as L.R.C.P. of London in 1866.

BENJAMIN PITT JOHNSON, L.S.A.

We regret to announce the death of Dr. Benjamin Pitt Johnson, surgeon of the Cunard liner "Caronia," at the early age of 45. The sad event took place on Sunday at the Royal Infirmary. Dr. Johnson, during his sixteen years' service with the company, gained the esteem of the officers and crews of the various steamers in which he sailed, and many passengers who yearly travel between England and the States will regret to hear of his death. Dr. Johnson was a native of Ludlow, and was educated at Liverpool.

REVIEWS OF BOOKS.

ARTIFICIAL FEEDING AND FOOD DISORDERS. (a)

THE feeding of infants, though coæval with the beginning of the world, is evidently only a finite science. It has taken six editions (with six prefaces) to bring this work to its present pitch of perfection, the finishing touches having been given by a younger colleague who may be supposed to be "in the swim."

It is a regrettable fact that the information on the artificial alimentation of children so laboriously acquired is by no means of general knowledge, and many duly qualified men will be well advised to refresh their memories from time to time by a draught at the fountain head.

This standard treatise not only deals exhaustively with the artificial feeding of infants from a practical point of view with the authority begotten of extensive experience, but the reader is taken over the principal departures from health in infants dependent upon improper or inadequate alimentation.

The various categories of artificial foods are discussed, and analyses given of their alimentary values, the utility or otherwise of employing them being explained on a scientific basis. Altogether it will be seen that the joint work covers the whole ground, and it well maintains the authors' reputations.

(a) "Artificial Feeding and Food Disorders of Infants." By W. B. Cheadle, M.A., M.D.Cantab., F.R.C.S. Sixth Edition, edited by F. J. Poynton, M.D.Lond., F.R.C.S., Assistant Physician to University College Hospital, &c. London: Smith, Elder and Co. 1906. Price 5s.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Case of Supplementary Lobe of the Liver causing Symptoms of Pyloric Obstruction.—Adams (*Glasgow Med. Journ.*, December, 1906) reports an operation undertaken by him with a view to relieving pyloric obstruction. The patient's emaciation and prostration were so marked that his intentions were directed more to palliative procedure rather than to radical measures. The history is as follows: The patient, a man of 28, suffered for eight years with pain in the stomach, followed by vomiting of blood. Liver dulness was normal. To the right of the middle line, midway between the xiphoid cartilage and the umbilicus, there was a thickening, but no definite tumour. There was no pain on palpation, succussion was unduly marked, and the patient was habitually constipated. Patient had lost a stone in weight during the three months before admission. The stomach was enlarged down to the umbilicus and 3½ inches to the right of the middle line. Patient complained of a dull pain over most of the epigastrium, and of another distinct pain of a stabbing character below the ribs 3 inches to the left of the middle line. On opening the abdomen a pedunculated lobe of the liver was found in such a position as to press on the pyloric end of the stomach. The lobule, which measured 3 inches by 2 inches, was covered by peritoneum, which was continuous with the broad, flat pedicle, the attachment of the latter being on the under surface of the liver to the left of the gall bladder. The pedicle of the abnormal lobe was ligatured prior to removal. The stomach revealed no thickening or tumour. No vomiting occurred after 24 hours, and the after history was uneventful. The author points out that even after investigation into the literature of the subject, it is difficult to know how a differential diagnosis could be made in this case prior to operation. But when the true nature of the case was recognised on opening the abdomen, the removal of the tumour was effected without much difficulty, and resulted in an absolute cessation of most of the symptoms. S.

Present Views on Diseases of the Joints.—Marsh (*Brit. Med. Journ.*, December 8th, 1906) classifies disease of joints into three groups. 1. Acute arthritis following wounds, or occurring in the course of acute infective osteomyelitis of pyæmia. 2. Arthritis following specific fevers, as acute rheumatism, typhoid, etc., the origin of which is usually obvious. 3. A group which is discussed somewhat fully, as the cases it includes are apt to lead to serious oversights and mistakes. It is composed of examples in which infection is produced by such everyday agents as streptococcus, staphylococcus, and gonococcus, but in which the symptoms differ so widely from those which we are in the habit of associating with these several infections, that the connection is apt to remain undetected. Taking the gonococcus, for instance. Arthritis developed in the course of an acute attack of gonorrhœa, the organism being of full virulence, produces the symptoms of an acute affection. But in a case of slight gleet of long standing, the joint infection by the gonococcus may present an entirely different picture. Such a case may bear a very close resemblance, from a clinical point of view, to tuberculous disease. The likeness is due to the fact that, under the influence of environment, the gonococcus has been deprived of so much of its original virulence, and is in such small quantities that the degree of irritation it produces is practically identical with that to which the Bacillus tuberculosis gives rise. The author cites several cases. In one case, a man aged 27 was admitted to hospital, and was believed to be suffering from tuberculous disease of the right knee, of five months' duration. All the symptoms fitted in exactly with this view. But it was ascertained that the patient had a very slight gleet, remaining after gonorrhœa contracted nine months previously. The urethral condition was set right by treatment, and in three months, under passive movement, massage, douching, and later, gradually increasing exercises, the knee completely recovered. The generalisation may be made that wherever, in any organ or any part of the body, a septic process exists, joint infection may result. The parts played by the tonsils and lymphatics of the pharynx in harbouring agents by which joints may be infected has only recently been fully appreciated. The author reports one or more cases in which the primary septic focus leading to joint disease was connected with each of the following conditions: (*a*) necrosed teeth, (*b*) septic cavities in the lungs, (*c*) empyema, (*d*) infective processes in the skin, (*e*) secondary to vaginal and uterine discharge (other than gonorrhœal). When the primary focus was cured in these cases, the arthritis disappeared, sometimes leaving an almost unimpaired joint, in other instances with resulting stiff joints. An obvious preliminary regarding treatment is that every effort must be used to find out the source of infection. The life history of the bacteria concerned must be remembered. The chief characteristic of the tubercle bacillus is its prolonged vitality and the manner in which it is able to resist destruction by phagocytes and kindred agencies. Streptococcus, staphylococcus, and gonococcus are much more easily eliminated by incision, drainage, disinfection, and phagocytosis. If arthritis is tuberculous, the joint must be kept for many months at complete rest, and the patient must, if possible, be treated on the open-air system; while in the other group the nurpose of treatment, when the supply of infective material has been cut off, will be the removal of coagulable lymph, the separation of adhesions, the restoration of movement, and the repair of atrophied muscles. These several results are best obtained by hot douching, massage, and often by manipulation under an anæsthetic. S.

On Sprains, and their Treatment.—Sir Wm. Bennett (*Brit. Med. Journ.*, December 8th, 1906) divides sprains into three classes. 1. Simple sprains, involving the soft parts only. 2. Sprains complicated by a fracture, the symptoms of the latter being so slight as to make it undiagnosable under ordinary circumstances, the symptoms of sprain being altogether predominant. 3. Sprains with gross nerve injury. In sprains without swelling, firm compression by strapping is most effectual in relieving pain. Massage cannot be commenced too soon, but passive movements are better deferred for six or seven days. Very hot fomentations are most serviceable when swelling is increasing after a sprain. This should be followed by pressure by means of a porous bandage. Slight voluntary movements cannot be commenced too soon. Massage should not be delayed more than twenty-four to thirty-six hours after the cessation of increase in local swelling. Passive movements should follow freely as soon as all heat has left the damaged part, whether the swelling be tense or not. In the case of sprain with fracture, the order of treatment should be massage, passive movement, voluntary movement. The reason for the early use of passive movement under these conditions is that, if the treatment is properly carried out, the detached piece of bone is not disturbed; whereas if voluntary movement were allowed, imperfect or faulty union would not improbably follow, with the usual imperfect recovery. The nerve injuries in sprains are of two kinds. In one, where the evidence of nerve lesion is pain along the line of distribution of the nerve, rest, and rest only, will bring about a complete and permanent cure. Massage does nothing but harm in the early stages of this type of case. In the other variety, numbness is the indication of nerve lesion. If this symptom has not disappeared in twenty-four hours, the only hope of cure lies in the skilful use of massage, supplemented after two or three days by galvanism. S.

The Surgical Treatment of Malignant Disease of the Stomach.—R. T. Morris (*Post Graduate*, December, 1906) gives his views on operating in cases of gastric carcinoma. They may be classified in the following way:—That operation for the removal of the stomach in cases of extensive malignant disease is almost never allowable; that operation for the relief of obstruction in cases where the disease is beyond the point of eradication is a questionable operation, that we may do on presenting the facts to the patient, and giving the patient a clear understanding of the condition. Some cases will get relief, but many will fail. We are seldom justified in operating for relief after the disease has gone beyond the point where eradication of the affection is possible. In those cases where the disease is limited to the pylorus, in the early stages where the diagnosis can be made, it is better to operate early, and without preliminary treatment, except for a very few days. As soon as we can make the diagnosis in these cases we should do the radical operation for eradication. G.

Isolated Omentum for Plastic Operations.—Girgolaff calls attention (*Zentralblatt für Chir.*, November 17, 1906) to the use of isolated portions of the great omentum for plastic work in abdominal operations. He finds that the stomach or large intestine may be experimentally injured, sutured loosely, and then covered over by a piece of omentum taken from the same animal. As a rule, within twenty-four hours the transplanted piece of omentum forms adhesions, containing blood-vessels, with the organ to which it was attached, and covers the wound perfectly, without forming any adhesions with the parietal peritonæum. The vitality of such isolated pieces of omentum is so great that the author has used them experimentally upon injuries of the liver as living tampons with excellent results. Numerous attempts have been made to implant omentum in a similar way upon the small intestine. The results obtained from this have not been so uniformly successful, and omentum cannot be considered quite trustworthy for this purpose. G.

Operation for Prolapsus Ani and Internal Piles.—D. Newman describes (*Lancet*, December 22nd, 1906) an operation he has devised for this affection. It consists in cauterising the mucous membrane of the rectum in six narrow strips from above downwards, each strip being four inches long by a quarter of an inch broad. This procedure is carried out by means of a special rectal speculum, whose sides being cut with long slits, allow the mucous membrane of the bowel to bulge through into the lumen of the speculum, where it is cauterised in the usual manner with the actual cautery. The following advantages are claimed for this operation:—1. The very sensitive area of the anus not being included in the operation, the patient suffers no shock, and little or no pain after the operation is over. 2. The cautery is applied while the mucous membrane and the muscular wall are as nearly as possible in their normal relationship. The adhesions which form are widespread, also, being in the form of longitudinal bands with uninjured mucous membrane between them, rather than as transverse rings, the danger of subsequent stricture is avoided. 3. The anus being uninjured, the sphincter acts normally at once after the operation. 4. In no case was there the slightest indication of sepsis after this operation; there was no case of suppression of urine, the after sickness was slight, and when the bowels were moved for the first time after the cauterisation, no great pain was suffered. 5. There has been no case of recurrence of prolapse or hæmorrhoids after this operation. G.

Pyelonephritis.—F. F. Smith (*New York Med. Jour.*, December 8th, 1906), recognising that in the large majority of cases pyelonephritis is an ascending affection from the urinary bladder, calls special attention to the ætiology of inflammation of the bladder, and draws the following conclusions as the result of an elaborate bacteriological study. 1. Every cystitis is due to microbes, with the rare exception of cases caused by chemical irritation. 2. Ordinarily we find one pure culture in enormous quantities. 3. The bacillus most frequently found, and described by other authors under different names, is identical with the ordinary intestinal parasite, the bacterium coli communis; it is pyogenic and infectious, of very variable virulence. 4. In the urethra and prepuce of males, and in the vagina of females, are frequently found these pathogenic bacteria which, introduced into the bladder, can provoke a cystitis. 5. The microbe alone does not produce cystitis, except in certain cases where the proteus vulgaris is present, which is a determining cause by virtue of its decomposing action in connection with urea. 6. The microbe does not cause cystitis until the bladder has been rendered vulnerable by the influence of certain predisposing agents, like retention and traumatism. 7. Retention or traumatism alone are insufficient; a microbe is always the cause. 8. In every cystitis pus will be found in varying quantities; the existence of a catarrhal cystitis is very doubtful. G.

Congenital Word Blindness.—S. Stephenson (*British Journal of Child. Disease*, 1905) writes on this subject, which has been becoming more familiar of recent years, although the reported cases are few. Yet he believes there are good reasons for supposing that it is far from uncommon among the children of the lower classes. From the nature of the cases most of them are met by ophthalmic surgeons in the first instance. An otherwise intelligent child experiences difficulty in learning how to read, although numbers present little trouble. A child who cannot learn how to read "dog" will quickly solve small arithmetical sums. It is thought that the condition is probably due to a congenital defect in the visual memory centre for words and letters. Most of the patients would appear to have their auditory memory highly developed. A patient of Hinshelwood concealed his difficulty in reading by learning his book off by heart. The other centres seem to compensate for the loss of the visual memory, for patients can help themselves by repeating sentences with the lips or tracing the words with their finger. Some of the cases had a parent who never learnt how to read. M.

Chronic Aural Discharges.—F. C. Hotz (*Ann. Ot., Rhin. and Laryngology*, December, 1905) considers that these cases do not receive sufficient personal attention from the surgeon; that there is too much indiscriminate ordering of lotions and drops for the patient to use at home, which do little more than cleanse the meatus, and fail to reach the causes of the discharge, which may be so various. After a lengthened period of this home treatment, perhaps carried out most conscientiously, the discharge continues, and the patient is advised and submitted to a "radical" operation. Hotz maintains that with a limited number of instruments, patience, and amount of time many of these cases can be cured. He uses probes, applicators, and curettes with flexible stems, so that they may be curved to suit the necessities of each case. With these inspissated masses, granulations, polypi, carious or necrosed spots can be reached and scraped, débris being removed by an attic syringe. Granulations and small polypi can be removed by repeated applications of chromic acid. After an apparent cure Hotz recommends that the case should be re-examined at intervals of several weeks to see if the cavity keeps clean and dry and free from smell. M.

MEDICAL NEWS IN BRIEF.

Government Stamps on Patent Medicines.—Coroner's Strong Remarks.

Dr. Frederick J. Waldo, the Southwark Coroner, held an inquest on January 1st with reference to the death of Alfred A. Cushing, aged 42 years, an engineer's labourer. The widow said that her husband used to doctor himself, as he said doctors did him no good. The Coroner: What did he take? The Witness: Anything he was told, and he also used an inhaler for the nose. Continuing, she said that on Friday she found him ill, and she sent for a doctor, who pronounced him dead. He had not previously seen a medical man for twelve months.

Dr. Paton testified death was due to consumption. He produced a pamphlet relating to the inhaler used by Cushing, an instrument for which the widow said he paid £3 3s., in addition to 8s. an ounce for the fluid to be used with it.

The Coroner (examining it): It is recommended for asthma, hay fever, and catarrh, and I see "Ohio. U.S.A.," on it. Did it give relief?

The Widow: He reckoned it did.

The Coroner: I have had a number of cases of quack medicines in connection with which credulous people are deceived by seeing the Government proprietary article stamp on them, and are deluded into believing that the Government guarantee the contents. They get a rich harvest out of the sale of the stamps, but I think the sooner the Government do away with the stamps the better. so that the public may be undeceived. What does this fluid consist of?

The Doctor: I have no idea, but I presume it is some harmless liquid. These things usually are.

The Coroner: Then that must be a fraud on the public if it is of no service, though harmless.

Dr. Paton: I know this, that it is a good stroke of business, for while they charge £3 3s. for the inhaler and 8s. an ounce for the fluid, the whole lot could be got for 3s. or 4s.

The Coroner: Can you say if the using of this hastened the man's death?

Dr. Paton: I am not prepared to speak as to that, as the man had been using it for a long time, and was in an advanced state of consumption.

The Coroner: Under the circumstances nothing can be done, as we do not know whether this was harmless or not.

The jury returned a verdict of death from natural causes.

Medical Training for Missionaries.

The Committee of Livingstone College, in their recent annual report, announce that a similar school of medical training for missionaries is about to be established in Germany. This is the result of a visit paid to Great Britain by Herr Oberlehrer Kammerer, Secretary of the Stuttgart Medical Missionary Association, who carefully investigated the work of Livingstone College and of the London and Edinburgh Medical Missionary Societies, and who on his return called a conference of the chief German and German-Swiss missionary societies, and laid before them the plan of an institute both for the training of medical missionaries and for the instruction of ordinary missionaries in the elements of medicine and surgery. Livingstone College has now been at work for 13 years. Before that time young missionaries who wanted a little of the medical knowledge that practically all their fraternity need, had to pick up information as best they could at the general hospitals, chiefly in the out-patients' departments, without any systematic lectures or any preliminary training in anatomy and physiology. Careful steps are taken to prevent the Livingstone College students from attempting to treat cases which are clearly beyond their powers, or competing with fully-qualified practitioners. During the past year 24 students—Anglican, Congregationalist, Methodist, Moravian, French Protestant, and of other denominations—have been trained at the college. The accounts show a deficit of £522, in addition to a mortgage of £3,500 on the college property at Leyton; but the Committee chiefly desire to increase the number of students, whose fees would largely meet the financial need.

Slaughter of Tuberculous Pigs.

IN the House of Commons on the 12th inst., Mr. Ffrench asked the President of the Local Government Board whether he is aware that the value of pigs seized and destroyed weekly in Birmingham for tuberculosis has been estimated at £100, and that it has been admitted by the Town Clerk of Birmingham that the approximate value of pigs destroyed each week for the four weeks ended November 17 was £31 18s.; and whether he will take steps to have those dealers recompensed whose pigs have been destroyed in the interest of the public. Mr. Burns said he was not aware of any authority for the first statement. Its accuracy was denied by the Town Clerk on behalf of the Corporation. He was informed that the value of pigs destroyed for the four weeks ended November 17 was as stated, but that the number was considerably above the average of the year. He had no authority to cause the dealers to be recompensed. Mr. Ffrench: Are not these pigs slaughtered in Birmingham inspected, and passed free of disease, by your inspectors? What are the special qualifications of the Birmingham inspectors which enable them to discover tuberculosis more than the Government inspector? Mr. Burns did not doubt the qualifications of the Birmingham inspectors to discharge their duties thoroughly. (Cheers.)—Mr. Will Thorne: Can the right hon. gentleman say what becomes of the condemned pigs? (Laughter).—Mr. Burns: I hope by means of a Bill I have before the House to ensure that these pigs are not sold as food for human consumption. (Cheers.)

Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society, was held on the 28th ult. There were present Dr. de Havilland-Hall, in the Chair; Dr. J. Brindley James, Dr. W. Knowsley Sibley, Mr. F. Swinford Edwards, Dr. F. J. Allan, Dr. St. Clair B. Shadwell, Mr. H. P. Symonds, Dr. Fredk. S. Palmer, and Dr. J. B. Ball. The accounts presented to the Committee showed that the business of the society was satisfactorily progressing, although the large number of influenza claims received during the last few weeks will make the margin in favour of the funds somewhat smaller than was anticipated. A considerable number of members are now on the half-pay list, and this practically permanent provision for those who cannot again perform professional work is looked upon as one of the most useful features of the society's operations.

BELGIAN PARLIAMENTARY GROUP.—The medical members of the Belgian Parliament have, in a petition addressed to the Minister of the Interior and of Public Instruction, asked him to consider the expediency of creating a clinic of dentistry in each of the State Universities. They express the opinion that such a step is desirable. The Minister has agreed to look into the matter. The Parliamentary Group has further decided to press forward as much as possible the debate on the proposed law on the practice of medicine, and that on compulsory vaccination.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

POPE AND DOCTOR.

Our Rome Correspondent writes: "The Momento" of Turin tells the following tale about Leo XIII. and the lately-deceased Dr. Lapponi. The Holy Father was about to give a long and important audience to some pilgrims, although he had a very bad cold Lapponi carefully provided the Pope with a box of pastilles, begging him to take one from time to time. The doctor then took his place in the audience chamber in a corner from which he would be able to catch the Pope's eye.

After he had spoken for some time Leo XIII. became very hoarse, but the doctor noticed that he did not take the pastilles. To attract the Pope's attention Lapponi coughed loudly. The Pope looked up, and then said to an attendant, "Call the doctor." Naturally there was some alarm among the bystanders, who thought the Pontiff felt ill. But as Lapponi approached, Leo XIII. drew the box of pastilles from his pocket, and holding it out to him said: "Doctor, we heard you cough. Will you take one."—*Tribune.*

Xeres.—The first attempt to use the abdominal route for hysterectomy for cancer was made as long ago as 1878 by Freund. Wertheim's work, published in 1900 and 1901, will give the facts required.

Dr. L.—After forcible delivery rupture of the liver does occur, and not very infrequently.

Fibroma.—We cannot recommend the institution named. It may be properly conducted, but it is not under any definite medical supervision. You would be wise not to patronise it without very careful enquiry.

A DOCTOR'S "DIPLOMACIES."

At the annual meeting of the Flint Female Friendly Society last week Mr. W. A. F. Twemlow, M.R.C.S.Eng., and L.R.C.P.Lond., who has recently commenced practice in Flint, was, with one exception, unanimously elected to be medical officer. An objector proposed that the election be deferred for a month, in order that the doctor might show his "diplomacies."

L. R. M.—The preparation has rather a misleading name. It is not an anæsthetic proper, but rather a drug to paralyse the nerve terminals in the stomach, and has been used to check or prevent vomiting.

Scrutator.—You do not say if you have sent your account to the address stated. The gentleman you name is well-known at the institution mentioned; at least he held the appointment there at one time to our own knowledge. If no reply is returned to your letter, a *closed* note to him addressed care of the Secretary would be almost sure to be forwarded.

Meetings of the Societies, Lectures, &c.

Wednesday, January 9th.

Dermatological Society of London (11 Chandos Street, Cavendish Square, W.).—5.15 p.m.: Meeting.

Hunterian Society (St. Bartholomew's Hospital).—4 p.m.: Clinical Afternoon.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Clarke: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. H. Campbell: The Rôle of Blood Pressure in Disease.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Dermatological (Dr. Meachen), Ophthalmological (Mr. Brooks), Medical (Dr. Whipham).

Thursday, January 10th.

British Gynæcological Society (20 Hanover Square, W.).—8 p.m.: Annual General Meeting. Valedictory Address: The President.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Mr. M. Yearsley: General Disease in Relation to the Ear.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Gynæcological (Dr. Giles), Medical (Dr. Whiting), Surgical (Mr. Carson). 3 p.m.: Clinique:—Medical In-patient (Dr. Chappel). 4.30 p.m. Lecture:—Mr. H. W. Carson: Peritonitis, its Pathology, Diagnosis, and Treatment.

Friday, January 11th.

Wimbledon and District Medical Society (Worple Hall, Worple Road, Wimbledon).—9 p.m.: Clinical Evening.

Clinical Society of London (20 Hanover Square, W.)—8.30 p.m.: Papers:—Dr. F. H. Hawkins: A Case of Acute Pneumonia with Abscess of the Lung and Acute Endocarditis. Dr. Forsyth: A Fatal Case of Myxœdema with Changes in the Parathyroid. Dr. Langmead (introduced by Dr. Garrod): The Association of Tetany with Dilatation of the Large Intestine.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. W. Stuart-Low: Clinique. (Ear.)

Vacancies.

Newport Borough Asylum, Caerleon, Mon.—Assistant Medical Officer. Salary £125 per annum, with board, apartments, and attendance. Applications to the Medical Superintendent.

Bath Royal United Hospital.—Resident Medical Officer. Salary £100 per annum, with board, lodging, and washing. Applications to J. M. Sheppard, F.C.I.S., Secretary

Liverpool Dispensaries.—Head Surgeon. Salary £200 per annum, with board and apartments. Applications to K. Stretch, Auditor, 56 Vauxhall-road, Liverpool.

Liverpool Dispensaries.—Assistant Surgeon. Salary £100 per annum, with board and apartments. Applications to K. Stretch, Auditor, 56 Vauxhall Road, Liverpool.

Royal National Hospital for Consumption. Ventnor.—Senior Resident Medical Officer. Salary £200 per annum, with board and lodging. Applications to the Secretary, 34 Craven Street, Charing Cross, London.

Stroud General Hospital.—House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the Hon. Secretary.

London Open-Air Sanatorium, Linewood, Wokingham, Berks.—Assistant Medical Officer. Salary £100 per annum, all found. Applications to the Medical Superintendent.

Carmarthen, Cardigan, and Pembroke Joint Counties Lunatic Asylum, Carmarthen.—Junior Assistant Medical Officer. Salary £150 per annum, with furnished rooms, board, washing, and attendance. Applications to W. Morgan Griffiths, Clerk to the Asylum Visitors, Carmarthen.

Royal South Hants and Southampton Hospital.—House Physician. Salary £100 per annum, with rooms, board, and washing. Applications to T. A. Fisher Hall, Secretary.

Down District Asylum, Downpatrick.—Junior Assistant Medical Officer. Salary £130 per annum, with board, residence, and laundry. Applications to M. J. Nolan, Resident Medical Superintendent.

Appointments.

Champtaloup, Sydney T., M.B., Ch.B., House Surgeon at the Cardiff Infirmary.

Coates, Charles Joseph Adams, L.R.C.P. and S.Edin., L.F.P.S. Glasg., Medical Officer for the Fourth District by the Shepton Mallett (Somerset) Board of Guardians.

Finch, Alexander Henry, L.R.C.P.Lond., M.R.C.S., Public Vaccinator for the First District by the Shepton Mallet (Somerset) Board of Guardians.

Kynoch, J. A. C., M.B., F.R.C.P., F.R.C.S.Edin., Extern Examiner in Midwifery at the University of Durham.

MacKinnon, Murdoch, M.B., Ch.B.Edin., House Surgeon at the Cardiff Infirmary.

Sheppard, Amy, M.B.Lond., D.P.H.Camb., Ophthalmic Surgeon to the Canning Town Hospital.

Watkins, William Richard Spencer, M.B., Ch.B.Edin., Resident Medical Officer at the Cardiff Infirmary.

Watson, G. W., M.D.Lond., M.R.C.P.Lond., Pathologist to the Leeds Public Dispensary and Honorary Assistant Physician to the Association for the Prevention and Cure of Tuberculosis.

Births.

Carpenter.—On Jan. 3rd, at St. John's House, Blackheath, the wife of Sidney M. Carpenter, L.D.S., R.C.S.Eng. (and of 62 Queen Anne Street, London), of a daughter.

Hutcheson.—On Dec. 14, at Bijnor, United Provinces, India, the wife of Captain G. Hutcheson, Indian Medical Service, of a son.

Steel.—On Jan. 2nd, at Stirling House, Alexandra Road, South Farnborough, Hants, the wife of Major E. B. Steel, R.A.M.C., of a son.

Marriages.

Dittmar—Wilkins.—On Jan. 2nd, at Hartley Witney Church, Winchfield, Hants, Frederick Dittmar, M.A., M.D., D.P.H., Medical Inspector to the Local Government Board for Scotland, eldest son of the late Professor Dittmar, LL.D., F.R.S., to Catherine Beatrice Wilkins, M.A.Lond., of St. Hilary's, Winchfield, Hants, daughter of Thomas Wilkins, of Cheltenham.

Gilchrist—Osmond.—On Jan. 5th, at St. James's Church, Weybridge, James Gilchrist, M.A., M.D., Ch.B., Farnboro House, Sydenham, to Constance Lilian, youngest daughter of the late James Osmond and of Mrs. Osmond, Casita, Weybridge.

Scott—Jelf-Reveley.—On Jan. 3rd, at St. John's Church, Torquay, Herbert Bodley Scott, I.M.S., son of Mr. and Mrs. Scott, Aldington, Bournemouth, to Sybil Claudia Jane, eldest daughter of Mr. and Mrs. E. P. Jelf-Reveley, of Brynygwinucha, Dolgelley.

Deaths.

Austin-Robinson.—On Jan. 3rd, at Hastings, of acute meningitis, Gwenllian Rogers (Gwenylw), aged four years, only daughter of the late Frederic Austin-Robinson, M.R.C.S.Eng., L.R.C.P.Lond., of Nottingham Road, Natal.

Tuke.—On Jan. 5th, at Chiswick House, Chiswick, Sophia Jane Tuke, widow of the late T. Harrington Tuke, M.D., F.R.C.P., and daughter of the late John Conolly, M.D., F.R.C.P., aged 82.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, JANUARY 16, 1907. No. 3

NOTES AND COMMENTS.

Surgical Resurrection.

THINGS are apt to be a little dull and stagnant after the excitements of Christmas and New Year, but this has not been the case during the first few weeks of 1907. The usual monotony has been staved off by a number of wonderful achievements in surgery, which have been unearthed by the ubiquitous reporter ere ever they had the chance of finding their way into the recognised organs of the profession. For instance, there is the case which is described by several papers under such lurid headings as "Farnham Hospital Miracle," "Child Raised from the Dead," "Snatched from Death," and so on. Happily, the names of the medical men concerned in this latter-day miracle are not given, and the circumstances seem to have been related by some inexperienced underling to whom they presented all the elements of novelty and surprise. The child who was so sensationally resurrected, it appears, was taken to the hospital in a condition of partial asphyxia from laryngeal diphtheria, and was, of course, promptly subjected to tracheotomy by the medical man in attendance. By the aid of artificial respiration, strychnine and brandy injections, and other routine measures, breathing, which had been in abeyance, was resumed, and the child gradually came round. Such a result is very satisfactory, but fortunately it is by no means unusual, as every house-surgeon in the country can testify. The ignorance of people with regard to commonplace surgical "miracles" is pathetic, but the stuff on which they are fed is rather more miraculous than the "miracles" themselves.

Further Marvels.

OTHER marvellous triumphs recently announced in leading daily newspapers are "Transplanting an Eye" and "Possibility of a Severed Head being Replaced." The former of these feats is whittled down to very small dimensions when one comes to look into it; in fact, the "cure" consisted in certain grafts of the "cornea lobe" of an eye removed from one patient being placed in the defective "cornea lobe" of another. The cure was far from successful in one eye, as the grafts caused painful swelling, and had to be removed, but in the other eye they are said to have taken. The size of the grafts is not mentioned. But if we pass from this anti-climax to the "severed head" we find that this yet-to-be event is only one of a "perspective of possibilities . . . enough to make one dizzy." We fancy that any "perspective of possibilities" is calculated to have that effect, except perhaps in the case of one whose head had been severed. It is highly probable that he would be unable to feel dizzy again, even with the recently detached member fixed on his shoulders *secundem artem.*

Faith and Strychnine.

THERE is, we all know, a faith that removes mountains, but there is also a faith, so we are assured, that is prepared to swallow strychnine. The latter quality animates the Rev. Staple Desmones, who, it need hardly be added, lives, moves, and has his being in the U.S.A. But let us not be uncharitable to Mr. Desmones, for the faith that promotes the strychnine-swallowing proposal is faith in the medical faculty, and he is prepared to drink *liquor strychninæ* against any Christian Scientist, he himself to be treated by an ethically-practising physician, while his opponent is to be left to the tender mercies of the Eddyites. Of the legality of this proceeding we are not quite satisfied, for in the eye of the English law it is a crime to compass the death of a fellow-creature, but in America there may be more freedom, and a man may, for aught we know, be allowed to incite another to swallow strychnine if he thinks it will serve a good purpose. But we can hardly advise Mr. Staple Desmones to rely too exclusively on the medical art, for it has yet to discover a trustworthy antidote for strychnine-poisoning. If he would oblige by swallowing half-a-crown, we might attempt to recover it with better promise of success.

Medicine and Sex.

PROFESSOR VON BERGMANN, at the recent celebration of his seventieth birthday, let himself go a little and gave his views on many professional questions of the day. To the Editor of *Medicin für Alle*—a rather curious paper to choose for the purpose—he has explained that he is decidedly against women studying medicine, "for," said he, "they are neither physically nor mentally capable of it." If, he argued, they have shown themselves unable to retain the monopolies of cooking and sewing, which once were theirs, how can they compete with male doctors? "Were it possible to obliterate sex distinctions, women might become good doctors, but that is not to be thought of." Few will be disposed to disagree with the distinguished surgeon when he says that the obliteration of sex distinctions is not to be thought of; it would be something of a waste of time to indulge in such speculations until biological science is considerably more advanced than it is at the present day. Perhaps some unborn Mendel may arise to teach us how to divine the aptitudes of the embryo for the career of medicine or for public life, and how to shape its sex accordingly. Till then let us suffer suffragettes gladly.

Medicine and Marriage.

SUCH in effect would seem the view of Professor Lassar, who in the *Frauen Zeitung* vigorously combats the view that women are not worthy to sacrifice in the temple of Hippocrates. They have proved themselves capable of practising medicine with credit in England, Russia, America, India, and—of all places—Bosnia, says that authority, and why not therefore in Germany? Because, he avers, German women have so long toiled in bondage to the male that they cannot at a moment's notice rise to the "immeasurably higher level dedicated to science." It will be news to most people, it certainly is to us, that the German frau is inferior in intellectual culture to the ladies of Bosnia, but perhaps if the masculine fetters are removed, she too may rise to their immeasurably higher level, and leave her husband grumping for his dinner. That is, if she is to have a husband at all, for Professor Lassar asks "To whom would it occur to let his mind occupy itself with personal thoughts of a base kind in the serious atmosphere of a university hall or in a hospital ward? Who would think, while working for the betterment of the sick patient, of sex distinctions?" We might be suspected of a pun of a base kind if we suggested that Professor Lassar was "laying it on thick," but how little can he know of the gallantries of Anglo-Saxon medical co-education where the base thought of marriage engendered in the Outpatients or by the sick bed is brought to fruition under the most regular ecclesiastical auspices, with a repetition that has grown almost monotonous!

'Liza and the Students.

ONE argument the co-educationalists are fond of using is that the gentle feminine would smooth down the rude, uncouth young medical male. But does he really need such influence? Has not the medical student of the day reacted too far from the Bob Sawyer ideal, and would he not be somewhat better for a little admixture of that gentleman's knowledge of the world and of human nature? Thoughts such as these are suggested by the perusal of the account of an inquest held last week on a Lambeth infant. The mother, it would appear, had engaged the services of charity for help in her confinement, and was supplied at the appropriate time with two medical students. Whether through gratitude for the help thus afforded, or through spontaneous attachment to the young gentlemen, or merely through following the picturesque habit of Lambeth, the labouring mother and her "lidy friend" persisted, much to the annoyance of the youths, in calling them "old dear," and "old darling." Now this would have suited Bob Sawyer to the ground, and he would probably have retorted by calling the ladies "mother," and "auntie." Not so the modern product of the aseptic theatre and the bacteriological laboratory. The medical students pointed out the grave indecorum of the ladies' behaviour, and announced that they could not consent to be made the subjects of such indignities. But the 'Lizas of Lambeth are not easily snubbed, and these ladies continuing the affectionate attentions, the gentlemen left the case. No further medical assistance was sought, and the child died a few hours after birth of some accidental cause.

LEADING ARTICLE.

THE EDALJI CASE.

THE notorious case of Mr. Edalji has been brought once again pointedly before the attention of the public. This time the challenge has been made in the *Daily Telegraph* by Sir A. Conan Doyle. In two long articles published on the 11th and 12th of the current month, he deals exhaustively with the whole case in his usual clever, concise, and powerful manner. One of his strongest grounds may be attributed to his early medical experiences, when, it is matter of common knowledge, he was specially interested in the study of diseases of the eye. With that part of his argument we shall deal later. As regards the main portion of this most interesting document we are in complete accord. Our readers for 1903 need not be reminded that in that year we drew up a petition to the then Home Secretary, Mr. Akers-Douglas. The nature of our views may be gathered from a special editorial notice in our issue of November 11th, 1903, under the title of "The Wyrley Cattle Maiming Outrage." "We feel it a public duty," the notice ran, "to call urgent attention to the cattle maiming case at Wyrley. A young Birmingham solicitor lies in prison condemned to penal servitude as the perpetrator of a number of senseless and absolutely brutal and wanton outrages on cattle. The evidence on which he has been convicted was purely circumstantial, and, as such, open to the fallacies that must necessarily accompany that class of evidence. During his imprisonment, and while awaiting trial, a further cattle maiming outrage was committed at Wyrley, the village where accused lived. Since his conviction still other cattle have been maimed and killed. On this ground alone, therefore, we submit that his sentence demands revision. But if an educated solicitor killed cattle in the senseless and purposeless manner under which the Wyrley outrages were comitted, we submit, unhesitatingly, that he was, on conviction, fitted for a lunatic asylum rather than a prison. There has been a grave miscarriage of justice, and we appeal to the Home Office for immediate action by way of revision of the sentence in this case. If necessary, we are prepared to nominate the necessary scientific body of investigation as to the state of mind of a cattle maimer of the kind involved in the assumption of the recent sentence." This petition was signed by many medical men, including such eminent authorities on mental disease as Dr. Savage, Professor Clouston, Dr. Bevan Lewis, Dr. Younger, and by such prominent men as Dr. F. J. Waldo, Dr. Ward Cousins, Dr. F. J. Smith, Dr. Danford Thomas, Dr. H. Jellett, and Mr. E. H. Tweedy. The petition was formally acknowledged by the Home Secretary, but no official reference has been since made as to any official investigation of the state of mind of Edalji. From time to time we have referred to the case of this unhappy man. In February, 1905, we noticed the review of the affair published by *Truth*, and joined in the emphatic demand that it should be reinvestigated. We then said: "It is difficult to escape the conclusion that either Mr. Edalji is an innocent man, as the continuance of the outrages after his imprisonment suggests, or that he is a poor madman who should be cared for in an asylum." Since then a new Home Secretary, Mr. Herbert Gladstone, has appeared upon the scene, and a few months ago Mr. Edalji was released. That event means presumably that his innocence was at length officially recognised. Now comes the demand from many parts of the country that he should be given a free pardon—that formal warrant of innocence which is ironically granted by the Crown in the case of subjects convicted of offences they have not committed. It is to be hoped that this timely act of grace will be performed in order to minimise as far as possible the far-reaching moral disturbances arising from so palpable a miscarriage of justice. One point insisted upon by Sir Conan Doyle is that owing to the physical defect of vision created by severe astigmatism, Mr. Edalji was physically unable to roam about at night, and cover the distance requisite to encompass the evil deeds of which he was found guilty. The argument is so highly technical that it is hardly possible to deal with it off-hand on general grounds. We have accordingly referred it to Mr. Sydney Stephenson, the editor of the *Ophthalmoscope*, whose remarks will be found following the present article. We may perhaps venture to make a slight criticism upon Sir Conan Doyle's challenge to any police constable to cover the same ground at night within the requisite period of time if provided with spectacles made so as to astigmatise his vision to a degree corresponding to that of Mr. Edalji's. It seems to us fairly evident that the conditions of experiment would not be identical enough to warrant sound conclusions therefrom. In the one case we have a man who has had his astigmatism from birth, and who has learned to interpret more or less correctly the distorted world in which he lives; while in the other the constable is plunged suddenly into a topsy-turvey environment. But, apart from that particular theory, Sir Conan Doyle has presented the world with a convincing case of the innocence of Mr. Edalji. We welcome his contribution, not only as coming from a medical man, but also as a vindication of the strong attitude taken up from the first by the Medical Press and Circular. It has always seemed to us that the public must look to the medical profession for much of the future advance in criminal law reform, of which so much has been heard of late years. We hope in the course of a few days or weeks to be able to announce a free pardon from the King for one whom we cannot but regard as the hapless victim of a prolonged storm of adversity.

[The following note has been kindly sent by Mr. Sydney Stephenson. It is in answer to an editorial request for an opinion on Sir A. Conan Doyle's theory that Edalji's astigmatism was of such an extreme kind as to have precluded the possibility of his committing the Wyrley cattle maiming outrages in the darkness of night-time. We have, further, the express assurance of Sir A. Conan Doyle that Mr. Edalji did not wear glasses, but that information did not reach us in time to communicate with Mr. Stephenson before going to press.—Ed. "M. P. and C."

To the Editor of The Medical Press and Circular.

Dear Sir,—Sir Arthur Conan Doyle's question, conveyed in his letter of January 13th last, raises wide issues. He inquires whether it is possible for anybody with, roughly, about nine diopters of myopia, together with 1.75 diopters of astigmatism in the right eye, to do what the police allege the convict George Edalji accomplished—namely, to have set forth on a pitch dark night, to have crossed the country for half a mile, climbing fences, finding gaps in hedges, and passing over a railway line, to have found and mutilated a pony which was loose in a large field, to have returned half a mile, and to have accomplished it all under thirty-five minutes, the limit of the possible time at his disposal. Assuming that Edalji was familiar with the countryside, and active in his movements, it seems to me that the short-sight from which he suffered would handicap him but little in his errand. Indeed, if the error of refraction were compensated by means of proper glasses, Edalji would probably be much in the position of a man with natural sight. It is known that some short-sighted persons are liable to a degree of so-called night blindness, and it is possible that Edalji suffered in this way. I do not gather from Sir Conan Doyle's letter whether this was or was not the case.

Yours faithfully,
Sydney Stephenson
(Editor, *Ophthalmoscope*).

January 14th, 1907.

To the Editor of The Medical Press and Circular.

Dear Sir,—Might I ask you in the cause of justice to permit me to put the following question to those of your readers who are engaged in eye practice:—

"Do you consider it physically possible for Mr. George Edalji, whose degree of myopic astigmatism as determined by retinoscopy under homatropine is—

Left eye ... ... – 8.25 Diop. spher.
– 1.75 Diop. cylindaxis 90°
Right eye ... ... – 8.75 Diop. spher.

to have set forth upon a pitch dark night with neither moon nor stars, to have crossed country for half a mile, climbing fences, finding gaps in hedges, and passing over a broad railway line, to have found and mutilated a pony which was loose in a large field, to have returned half a mile, and to have accomplished it all under thirty-five minutes—the limit of the possible time at his disposal?"

A consensus of scientific opinion upon this point would greatly aid me in getting justice for this young professional man condemned for an offence which, in my opinion, he could not possibly have committed.

I am, Sir, yours faithfully,
Arthur Conan Doyle.

Undershaw, Hindhead, Surrey,
January 13th, 1907.

CURRENT TOPICS.

Liverpool School Children.

The Education Bill of last session, thanks to the liberal degree of *odium theologicum* evinced by partisans, was successfully killed, and it can hardly be expected that the Government will attempt another settlement of the religious difficulty, at present at all events. Is it too much to plead that the non-contentious clauses of the bill, especially the one dealing with medical inspection, may be embodied in a short measure for passage through Parliament next session? The utmost unanimity in every part of the House of Commons prevails on the question of the necessity of medical supervision, and if any fillip were needed none more emphatic could be given than the revelations made by Dr. Arkle of Liverpool, in a paper read before the recent North of England Education Conference at Bradford. This gentleman was appointed by Liverpool City Council to make a thorough examination of the children of three typical Council schools and to compare his results with those obtained from the examination of well-to-do children. Dr. Arkle has taken twelve months to complete his investigations, and has produced a report which would be sensational if it were not scientifically and scrupulously exact. He examined all children in three Council schools, one in a good class district, one in a quarter where labour was fairly steady and regularly paid, and one in the poorest part of the city, and with them he compared the result of similar examinations conducted in secondary schools, where the children of the leading citizens of Liverpool are educated. After detailing his methods of research, weighing, measuring, examining sense organs, and so on, Dr. Arkle says: " One cannot fail to be startled—I had almost said appalled —at the unanimity of results, and the clearness with which they indicate a very terrible state of affairs. It is not only that they show deterioration as between the different schools, which one might naturally expect, but it is the mathematical precision with which the result is shown, and the extent to which the deterioration has gone, which makes the tables such gruesome reading." And such indeed they are. Without exception, the tables show that there is progressive want of development according to whether the parents are wealthy, well-paid, badly off, or very poor, the standard of physique in the children of the latter class being deplorable. Not only were the height and weight of the poorer children far below those of the better-off ones, but in eyesight and brainpower they were lamentably deficient, no less than 30 per cent. of the boys and 46 per cent. of the girls having defective vision. Inadequate feeding is shown to be the main cause, but insufficient clothing, want of tending, and deficiency of house room all contribute to produce a scathing indictment on latter-day civilisation.

Anti-Suicide Bureau.

THE saddest feature of rich and prosperous countries is that, side-by-side with luxury and happiness, there are many whose lives are so miserable that sooner or later they destroy themselves. The more complex the civilisation and the higher the level of education in a general way, the larger the proportion of suicides. In most European countries and in America during the last century the rate of suicide has risen alarmingly, and it is one of the problems to which preventive medicine must sooner or later turn its attention. It is no answer to the question of possibility of effective repression to say that most suicides are committed during attacks of insanity. That doubtless is true, but it merely means that such attacks should be prevented. It is well within the knowledge of all experienced practitioners that, especially in the case of young people, suicidal impulses which have appeared at certain junctures have been repressed by judicious treatment, and there are not a few people now living who after being frustrated in attempts to take their own lives have lived long and worked usefully. It is not possible for most educated and scientific people to support the Salvation Army in all its methods, but it is possible to regard that organisation as expressing a want in the community for some method of dealing with social wrongs and misfortunes, and " General " Booth's latest scheme, the opening of an Anti-Suicide Bureau, cannot fail to interest medical men, if only as a daring experiment. We may be prepared for startling figures, and indeed they have come already, for the officers announce that they have saved a hundred and four lives as the result of one week's work, but even discounting such announcements liberally, it is quite reasonable to suppose that some agency to which people under the influence of impulse can apply for help and protection, may be able to tide them over their period of mental aberration or place them under such restraint as will prevent them destroying themselves. It is, however, greatly to be hoped that the Salvation Army will take wise medical guidance in the formation and fashioning of their scheme, as their enthusiasm is notoriously apt to outrun their discretion.

The Union of London Medical Societies.

WE are glad to learn that the steps to promote a union of the various London societies are leading to a successful end. Only one society of primary importance—the Medical Society—has decided to remain out. Twelve have agreed to join the Union :—the British Electro-Therapeutic, British Gynæcological, British Laryngological, Rhinological and Otological, Clinical, Dermatological of Great Britain and Ireland, Dermatological of London, Epidemiological, Neurological, Odontological of Great Britain, Obstetrical, Pathological of London, Royal Medico-Chirurgical. Their energies should cover a fairly wide field, and in union the societies should constitute a representative academy of London medical science. There is always, however, a certain danger in overgrown societies of any sort, unless the sense of individual responsibility can be maintained. The members of a small group have a sense of responsibility and an *esprit de corps* unknown to the units of a crowd. It will be well, therefore, if the members of the various societies which soon will form a union see to it that they exert themselves as keenly under the new circumstances as they did under the old.

The Trypsin Treatment of Cancer.

IN the issue of *Nature* for January 10th, 1907, appears a letter from Dr. J. Beard. The writer quotes from the MEDICAL PRESS AND CIRCULAR of December 19th last, the following passage :—"Every medical man must deplore the frequent attempts which are made in the lay press to induce the public to believe that a cure for cancer has been discovered." Mr. Beard then proceeds :—"This is clear enough. Against it, I, a scientific man, now affirm not only that a cure has been found, but that my own work and discoveries have revealed *the cure*" (the italics are not our own). This clears the grounds so far as Dr. Beard's claims are concerned. As he is not a medical man, we own to having felt some curiosity as to the evidence on which a "scientific man" has seen fit to announce with such profound conviction a momentous medical discovery to the world. It appears that his evidence comes from New York in the shape of an article on trypsin treatment by Prof. W. J. Morton. That gentleman obtained apparent cure in two cases out of thirty, but as in one case the relief has so far lasted only one month, and in the other only four months, he who would conclude he had found a specific on such evidence must indeed be ignorant of the course of malignant disease in the human body. Dr. Beard, indeed, shows by his methods that he lacks the elementary principles of correct scientific observation. His claims to priority in the trypsin treatment fail to bear any close examination. After due enquiry, we ourselves are convinced that any credit that may be claimed in the matter belongs to Dr. Shaw-Mackenzie, who was the first to use trypsin upon a patient. In point of fact, Dr. Beard appears to have adopted the very preparation of the drug originally made up from Dr. Shaw-Mackenzie's formula. So far trypsin has failed to fulfil the claims that have been advanced in its favour, and its usefulness has not been confirmed by the Cancer Research Fund.

The King Edward's Hospital Fund Bill.

THE text of the King Edward's Hospital Fund Bill, published during the past week, will surprise even the most stolid. The Bill proposes in all seriousness to commit the entire administration of the Fund, lock, stock and barrel, into the hands of one person—the president of the Fund for the time being. He is to have power over capital and interest, to give or to withhold as he "in his uncontrolled discretion may from time to time think fit." In fact, the only limit imposed on his absolute power is the direction of the funds to hospitals in London ; inside this limit he can dispose of the funds without check, even handing them all to one hospital if he wish. The function of the General Council is to be purely advisory, and the members of it, as of all committees, and also the officers of the Fund, are to hold office at the pleasure of the president, who is himself to be the nominee of the Sovereign. In announcing his consent to the Bill now put forward, the present distinguished president, H.R.H. the Prince of Wales, stated that he acted on the advice of those most closely connected with the matter. We can only regret that they should have been so injudicious.

PERSONAL.

ON the 10th inst. H.R.H. the Duchess of Albany opened a new Infirmary for Children in Liverpool.

PROFESSOR RONALD ROSS, Sir Rupert Boyce, and Dr. John L. Todd, have received His Majesty's authority to accept and wear the Cross of the Commander of the Order of Leopold II., lately conferred on them by the King of the Belgians.

BY the will of M. Andrac, a wealthy landed proprietor, the Pasteur Institute is about to benefit to the extent of some £30,000 or £40,000.

DR. J. B. MCKENZIE ANDERSON has been appointed Visiting Physician to the Glasgow Royal Infirmary. Dr. Patrick King has been appointed anæsthetist to the same institution.

DR. SAMUEL EDGERLEY has been appointed Medical Superintendent of Menston Asylum, in place of the late Dr. J. G. McDowall, at a salary of £500 per annum, with furnished house, board and attendance. Dr. Edgerley has served on the medical staff continuously since 1897.

SURGEON-LIEUT.-COLONEL DAVID LENNOX, M.D., Surgeon-Major David Greig, M.A., M.B., F.R.C.S. Edin., and Surgeon-Captain George Halley, M.A., M.B., F.R.C.S.Edin., have been enrolled as Honorary Associates of the Grand Priory of the Hospital of St. John of Jerusalem.

MR. JOHN H. DEANE, L.R.C.S., L.R.C.P.Ed., was recently presented with a silver service by his friends on leaving Weston-super-Mare.

DR. COLIN HEYNSBERG, assistant Colonial Surgeon, Puttalam, Ceylon, is to succeed Dr. W. H. Meier, who is retiring, as Superintendent of the Leper Asylum, Hendala, Ceylon. The latter has occupied the office for the past twenty-seven years.

AT a meeting of the Board of Management of the Cardiff Infirmary on December 21st, the post of resident medical officer was obtained by Dr. W. R. Spencer Watkins. Dr. Sydney T. Champtaloup and Dr. Murdo M'Kinnon were appointed house surgeons.

A BUST of Dr. James Gregory, at one time Regius Professor of Physic at Edinburgh, has been presented to the University by Lord Leith of Fyvie.

DR. H. J. PALMER, of the Gamlingay District of the Caxton and Arrington Union, has been awarded the Government grant for successful vaccinations.

COLONEL LAMBKIN has been appointed lecturer on Syphilology at the Royal Army Medical College.

DR. A. H. FREELAND BARBOUR has been elected to the newly-instituted Lecturership in Systematic Clinical Gynæcology at Edinburgh University.

MR. H. T. BUTLIN will give the Hunterian Oration at the Royal College of Surgeons of England, at 4 o'clock, on February 14th.

MR. HENSLOWE WELLINGTON, M.R.C.S., L.R.C.P., Lecturer on Forensic Medicine at Westminster Hospital, Barrister-at-Law, has been elected a Corresponding Member of the French Medico-Legal Society.

DR. ALONZO GARCELON, a former Governor of the State of Maine and a past-President of the American Medical Association, has died at the patriarchal age of 93.

DR. A. S. GUBB, of Mustapha Supérieur, has been appointed Honorary Physician to the British Consulate at Algiers.

A Clinical Lecture
ON
OPTIC NEURITIS AND ITS RELATIONSHIP TO INTRACRANIAL TUMOURS.

By Dr. ROBERT A. FLEMING, F.R.C.P.E.,

Lecturer on the Principles and Practice of Medicine in the Edinburgh Medical School; Assistant Physician to the Edinburgh Royal Infirmary.

You have seen in these wards (*a*) not a few cases of intracranial tumour, and your attention has been directed to the significance both of the general clinical features common to most, if not all, cases, and also of those which localise more or less accurately the probable position of the tumour.

I wish to-day to discuss one of the chief general clinical features, namely, optic neuritis. While it is true that optic neuritis is found in a large proportion of cases of intracranial tumour, yet we must admit that our present knowledge of the precise nature of the neuritis and of the *modus operandi* of the tumour in producing it, is most unsatisfactory.

I purpose (1) discussing with you the ophthalmoscopic and microscopic appearances of optic neuritis as found in cases of intracranial tumour, and referring to the pathological appearances noted in a number of cases examined by myself. Under this head I shall also mention briefly the pathology of optic neuritis and the chief theories put forward. (2) We shall consider the nature of the tumours with which optic neuritis is most commonly associated, and—what is of much greater moment—the bearing of the site of the tumour on the incidence of optic neuritis. (3) Lastly, I shall refer, very briefly to treatment.

1. The optic neuritis met with in a case of intracranial tumour is generally double, although it may be more advanced in one eye, and sometimes this indicates the side on which the neoplasm is situated. The old name given to that optic neuritis which we are at present discussing, was "choked disc," or stauungspapille, because there is generally great pressure in the inter-sheath space or, at least, at the back of the eyeball, causing difficulty in the way of the blood returning by the retinal veins. This interference with the retinal vessels adds to, if it does not entirely cause, the choking of the disc or papilla.

The ophthalmoscopic appearances are easily recognised. The retinal arteries are small, the veins engorged, swollen and tortuous, and many small venous branches which are not noticeable normally are large enough to give the impression that these veins are unusually numerous, while the arteries have decreased in number as well as in size. The disc as a whole is red, the edges blurred, and to such an extent may the vessels project on the surface of the swollen papilla that they may require a +7D lens to focus them when the direct method of examination is used. At the edge of the disc the vessels bend backwards towards the retina; in front they are covered by exudation. There are usually numerous flame-shaped hæmorrhages in or near the disc, and the retina at the periphery of the disc shows evidence of exudation.

In cases where there is less pressure, the nerve head does not become so markedly "choked," but it has been conclusively proved that pressure in the inter-sheath space or at the back of the eyeball is not essential for the production of optic neuritis. In fact, an intense optic neuritis may be present without any pressure in either lymph spaces or vessels. It remains true, however, that "choked disc," is most marked where there is increased pressure in the inter-sheath space.

The optic neuritis may disappear, the inflammatory exudation and hæmorrhages being gradually absorbed, or else it may go on to a consecutive atrophy in which connective tissue replaces inflammatory exudation, the result being inevitable and permanent blindness. An attempt has been made to divide optic neuritis into stages, of which the first consists in congestion of the disc with some swelling, but such divisions are unnecessary and quite useless from a clinical standpoint. It is sufficient to know that early optic neuritis may never go on any further and that simple swelling of the papilla may be due to pressure behind the lamina cribrosa without sight being affected at all. Actual inflammation—in other words, true neuritis—must interfere sooner or later with vision.

Sight may fail early, even within twenty-four hours, or a wonderful preservation of visual acuity may persist with a high degree of "choked disc." The atrophic stage invariably leads sooner or later to blindness. In most cases of optic neuritis the common visual changes are an impairment of visual acuity and interference with the vision fields for colour, and especially a narrowing of the fields for green and red. The scotoma due normally to the optic disc is also often much enlarged.

Microscopically, I have never failed, in a case showing marked optic neuritis during life, to find definite changes in the optic nerves. Comparing a normal optic nerve (Fig. 1) with any of the other three figures, all of which are taken from photographs of optic nerves from cases of intracranial tumour in which well-defined optic neuritis was present, a marked nuclear increase is noted, and the nature of the increase is important. It is the neuroglial cells which chiefly undergo this increase in number, and the hyper-nucleation is largely due to proliferation of their nuclei. Ford Robertson has demonstrated the dual nature of so-called neuroglia, and that, cells he calls mesoglial, and which h

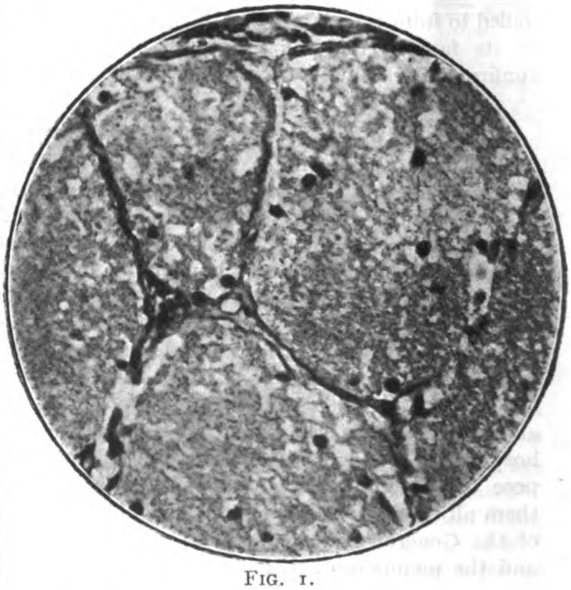

FIG. 1.

(*a*) Delivered to the lady medical students attending Dr. Bruce's wards in the Edinburgh Royal Infirmary.

has differentiated by the platinum method of staining, are distinct from the other cells to which the old name, neuroglia should be applied. These mesoglial cells do proliferate in optic neuritis, but not markedly, and they do not undergo the distinctive changes which are noted in the neuroglial cells. The normal neuroglial cells are branched cells, which vary greatly in size and in number and arrangement of their processes. The nuclei are oval or rounded, and the protoplasm, originally large in amount, is differentiated into fine, branching fibres. In optic neuritis these neuroglial cells, as distinct from the mesoglial, undergo the following changes, most of which are well seen in Figs. 2, 3, and 4. :—

(1.) They proliferate, and the proliferation studied in longitudinal sections shows that these cells are arranged in rows which aid the trabeculæ in supporting the optic nerve fibres.

(2.) The protoplasm of the cell is enormously increased and the processes become much more visible, extending quite obviously for long distances among the nerve fibres.

(3.) Many of the larger cells have a distinctly granular cytoplasm, and the periphery is often blurred; while in a few cells vacuolation of the protoplasm may be seen.

(4.) The nuclei of the cells become much larger, show definite karyokinetic figures, and, as a whole, stain more faintly than the normal neuroglial cells do. The nuclei are usually eccentrically placed, but this is a feature of many, if not most, normal neuroglial cells, and is merely enhanced by the great enlargement of the cells.

These neuroglial changes are best marked near the outer portion of the optic nerve, although in an advanced case they may be seen in any part of the transverse section, and appear to extend all along the optic nerve.

In a considerable series of cases of intracranial tumour in which I have examined the optic nerves after death, these changes were uniformly present, less marked, it is true, where sight was but little affected and the optic neuritis less advanced, and more definite where neuritis was giving place to atrophy. A few leucocytes were found, especially where meningitis was present; but the chief hypernucleation was accounted for by the proliferated neuroglial nuclei.

Some of the chief theories of optic neuritis demand a brief description, and I quote from a paper I wrote for the *Review of Neurology and Psychiatry* in 1904.

"The first theory, Von Graefe's, was that venous obstruction from increased intracranial pressure, especially affecting the cavernous sinus, might account for the optic neuritis. Needless to remark, the free anastomosis with facial and orbital veins renders this theory untenable. Broadbent, Manx, and others believed that the great pressure of lymph in the inter-sheath space might cause the optic neuritis. While it is true that a post-bulbar distension of the inter-sheath space is not uncommon, it may be slight even in extreme cases of optic neuritis. Schmidt included the lymph spaces, which form such an important means of communication between the inter-sheath space and the lymphatic channels in the nerve and pial sheath.

"It is usually pointed out in referring to these three theories, that while a very small tumour may produce the most intense optic neuritis, a very large one may cause none at all.

"Leber believes that there is an irritant of some kind in the cerebro-spinal fluid.

"Galezowski, Brailey, Edmonds, Juler, and others, hold that the irritant is not in the cerebro-spinal fluid, but in the brain tissue itself, by which it is directly conducted downwards to the optic nerve.

"Schweller and Hughlings Jackson suggest that the papillar inflammation is due to a reflex stimulation of the vaso-motor nerves of the disc.

"Deutschmann closely associates meningitis with optic neuritis, partly as the result of experiments on rabbits, in which he found that injecting staphylococci or tubercle bacilli into the subarachnoid space produced a more or less definite optic neuritis, and partly because in most cases of optic neuritis due to intracranial tumour, he describes a perineuritis with not infrequently a certain amount of localised meningitis in the neighbourhood of the tumour. Gowers believes that it is a descending neuritis which is present in intracranial tumour cases, and often associated with meningitis; the nuclear increase in the optic nerve and inter-sheath space he believes to be mostly of inflammatory origin."

It is difficult to say where the inflammation, unquestionably present, begins—whether at the papilla and ascending from there, or descending from the brain to the papilla. There is no evidence that optic neuritis is an ascending neuritis, and everything points to the correctness of a toxic theory, and, arguing by the hypertrophy of neuroglial cells which occurs in general paralysis of the insane, and other diseases which are certainly toxic, the changes just described favour a toxic hypothesis.

I cannot enter at greater length into this neuroglial hypertrophy, which certainly in not a few of my specimens suggests rather a condensation of neuroglial processes than a true hypertrophy; but I may be permitted to add that this hypertrophy differs from the neuroglial changes found in an optic atrophy not due to intracranial tumour, and that in albuminuric papillitis a somewhat similar, although less advanced, neuroglial change is present in numerous specimens I have examined.

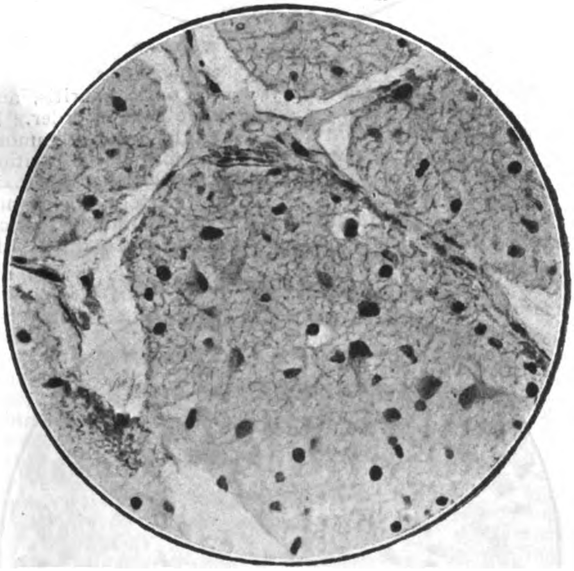

FIG. 2.

Fig. 2 is the photograph of a transverse section of an optic nerve from a case of gumma occurring in a female æt. 44. The gumma involved the left occipital lobe, extending into the brain from the membranes.

Fig. 3 is also a transverse section from a case of cerebellar tumour—or glioma—occurring in a man, æt. 40. There is marked optic atrophy present.

Fig. 4 is from a case of cerebellar tumour—a glioma—occurring in a girl, æt. 22.

The ghost-like appearance of some of the proliferated neuroglial nuclei is very well seen in these photographs.

There are therefore three kinds of so-called optic neuritis associated with intracranial tumour. There is (1) "choked disc," due to great intracranial pressure and in which sight may be long retained. There is (2) true inflammatory optic neuritis without much swelling of the papilla, and there is (3) an extreme degree of papillitis not due to mere choking of the disc. The second and third varieties are, I believe, of toxic origin, and in these sight usually suffers early and often severely. Figs. 2, 3, and 4 are taken from cases of (2) and (3), and are not merely instances of choked disc.

2. The nature and site of tumours causing optic neuritis. There is no question that a glioma, of all tumours, most constantly causes optic neuritis, and probably cysts and gummata come next in order. If we could assert that some particular type of tumour *always* produced optic neuritis, no matter the position in the brain in which it might chance to be, the toxic theory would be proved. Unfortunately, we cannot make this assertion and a tubercular tumour, which is perhaps least frequently associated with optic neuritis, will inevitably cause it should the tumour be situated in, for example, the cerebellum. Fully four-fifths of all cases of intracranial tumour are accompanied by optic neuritis, and this including tumours in regions with which optic neuritis is rarely associated. The cerebellum, I believe, is almost never the site of tumour without a coincident optic neuritis. I have collected nearly twenty cases of cerebellar neoplasm of different kinds, and in all definite optic neuritis was present after death. I am therefore disposed to consider the figure of 90 per cent. often given as being too low; optic neuritis is common in tumours involving the corpora quadrigemina.

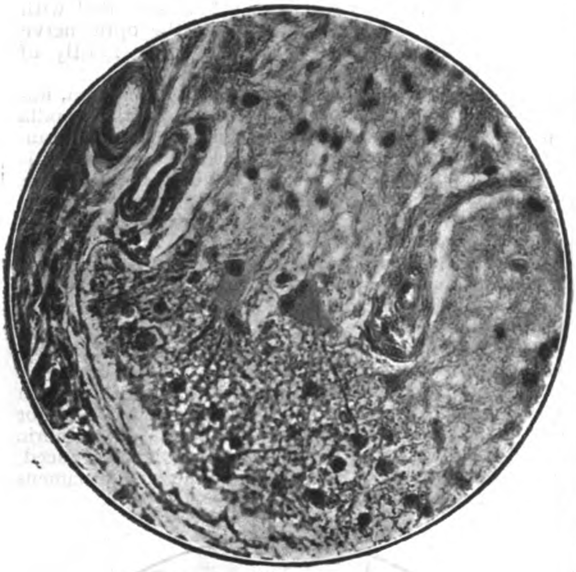

Fig. 3.

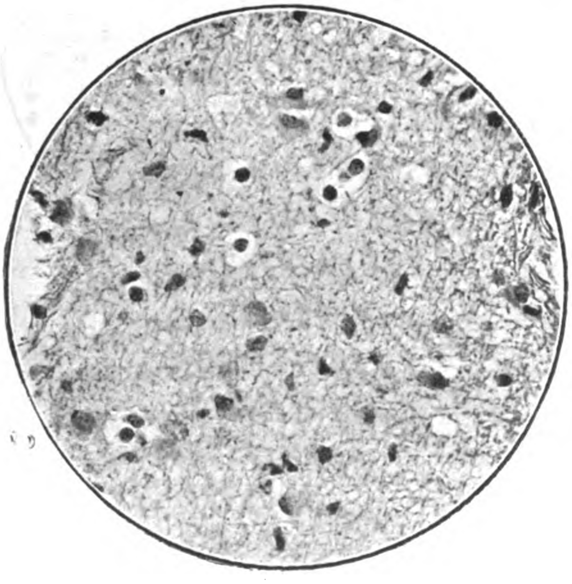

Fig. 4.

Tumours of the cerebral hemispheres generally cause optic neuritis, and especially if the frontal lobe is involved. According to Knies (who holds that choked disc is commonly the result of intracranial tumour, as distinct from a true optic neuritis resulting in atrophy) tumours in the anterior part of the frontal lobe may cause a true optic neuritis, which he thinks is due to a direct involvement of the nerve, and is therefore a descending neuritis. In this connection he points to the significance of the neuritis being unilateral and confined to the side of the tumour, a statement with which my experience of four cases does not agree. Meningeal tumours more rarely produce optic neuritis, and it is rare to find it in tumours of the medulla, pons, and corpus callosum.

3. What can be said with regard to treatment? I am and have been working for some years collecting and examining optic nerves from cases of intracranial tumours as well as optic nerves from other forms of intracranial disease, and I regret that my results are not yet available for this lecture. I have endeavoured to show that mere mechanical choking of the disc is not the only result of cerebral tumour, and that many cases have no such increased pressure in the lymph spaces or blood-vessels behind the eyeball, and yet the best treatment is unquestionably to attempt an operation which relieves any pressure which may be present.

Trephining the skull is, and should be, carried out in all cases of intracranial tumour where sight is threatened, whether we can localise the tumour or not, and it is a more satisfactory operation than trying to tap the inter-sheath space behind the eyeball. Lumbar puncture might in certain cases replace the more dangerous operation of trephining, where there is no interference with the lymph-channels in the brain. I cannot believe that relief of pressure is always necessary, and it is possible that the trephining operation and oozing of cerebro-spinal fluid may, as Horsley thinks, help in blighting the tumour. We know it does not always improve visual acuity, but it does so in more cases than can be explained by the choked disc theory. How it does so I cannot say. If the toxic theory of optic neuritis in cases of intracranial tumour is a correct one, we know as yet no remedy to apply which can do any good as an antagonising agent.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Thos. Smith Clouston, M.D., F.R.C.P., Physician Superintendent, Royal Asylum, Edinburgh, Lecturer on Mental Diseases, University of Edinburgh, the subject being "The Mental Risks of Adolescence."*

ORIGINAL PAPERS.

SOME ASPECTS OF PRURITUS. (*a*)

By FRANK H. BARENDT, M.D.Lond., F.R.C.S.

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In choosing the subject, "Some Aspects of Pruritus," I am influenced by the importance of this at all times distressing condition. For, of the three chief plaintive symptoms—pain, disfigurement, and itching—that induce a patient to seek advice, pruritus is the one that is most frequently complained of in cutaneous diseases. Indeed, a patient states, often apologetically,

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(*a*) Read before the Southport Medical Society, 1906.

that it is not so much that he is ill and in pain, as that he is compelled to seek relief from the intolerable itching, which, he assures us, is far worse than pain.

Disfigurement is largely a question of æstheticism and comeliness, depending as it does on the exposure to view of all those regions of the integument, viz., face, neck, and hands, that are usually uncovered by clothing. Thus, when these sites are free from eruption, and pain and itching elsewhere are absent, a patient is frequently unconscious of any skin-disease, and consequently his medical adviser remains also in ignorance, unless he examines the whole skin. This circumstance may account for the denial in good faith of any previous skin trouble by a patient who is suffering from some affection pointing indubitably to antecedent syphilis; and further, it explains how a medical man may misinterpret the nature of a local lesion in venereal diseases, unless he regularly and systematically insists upon inspection of the entire integument.

Syphilographers have rightly drawn attention to the absence of itching in cutaneous syphilides. This negative aspect of pruritus should ever be borne in mind, as slight maculo-papular syphilides do not generally obtrude themselves visually unless carefully sought for in daylight. Especially is this the case when they are sparsely scattered and confined to the dorsum and flanks.

Again, many psoriatics do not trouble themselves about their skin-disease so long as it does not attack the face or hands, or draw attention to the scalp. They feel well, have no pain, neither do they itch, thus confirming the dictum of Hebra that psoriasis is a disease of the healthy. In fact, if pruritus is at all present in such cases, I think we may with reason revise the diagnosis of psoriasis, or admit the presence of a concomitant disease.

Young ladies suffering from acne of the face and shoulders complain at times of itching; but no scratch effects are discernible, and I imagine that pruritus is put forward as a plaintive symptom to cloak the real reason, fearing lest the medical man belittling it should not give the affection that attention they so anxiously demand.

Leaving the negative aspect of pruritus, let me pass at once to the consideration of some of the positive aspects.

Itching, like most neuroses, is intimately associated with the borderland between health, *i.e.*, ease, and disease, and varies in intensity, not only with individuals, but also periodically in the individual and with the sex of the individual. That some people are more senstive, *i.e* itch more readily, than others, and *vice versa*, is a truism. Indeed, the mere mention of a flea, or the sight of any crawling creature, *e.g.*, an ant (*formica*), is sufficient to start an impulse to scratch —an example of pruritus (*formication*) where the cause is obviously psychical. On the other hand, how often do we see the skin of hospital patients bespotted with flea-bites, and not a sign of scratching, plainly showing how little sensitive their skin is, and therefore the absence of pruritus!

Between the normal cutaneous sensation, with its sense of well-being, and the most intolerable itching, stated to be the cause even of self-destruction, the difference is one of degree and not of kind. It is well known that, owing to the impinging hair of woollen underclothing, there are many who cannot wear it; and contrariwise, there are those whose personal comfort is best obtained by wearing the coarsest woollen underwear, and who cannot rest at night except between blankets. Neither of these conditions transgresses the limits of normal health: they afford an example of the personal equation which we must not forget in treatment. We speak of thin-skinned and thick-skinned persons frequently metaphorically, but the literal truth holds good, and the sensitive, highly-strung individual has a corresponding cutis, and similarly the lethargic and atrabilarian type. Temperament—in other words, the character of the nervous system—largely conditions the degree of pruritus, and explains how the graphic results on the skin differ so much in extent and in severity in different patients.

The causes of pruritus fall manifestly in two groups: (I.) those without, and (II.) those within the skin. Both, however, may graduate insensibly into one another. It is mainly those without, *i.e.*, the extra-dermal group, especially their effects, that I desire to dwell upon, although the time at my disposal is insufficient to take a complete purview of their complexity, ever made more intricate by the structural changes that accompany them. Itching causes scratching, the results of which vary as much in type as the efflorescences of skin-diseases do. Scratch lesions caused by finger-nails are not the sole distinctive objective signs of pruritus. Macules, papules, wheals, vesicles, open sores, and pigmented areæ—as final stages—are called into being by scratching, and the predominance of one or more of these eruptions affords frequently an indication of the severity and duration of the pruritus.

The extra-dermal group comprises mechanical irritation, *e.g.* pressure of clothes; chemical irritants, *e.g.* sweat, soap, and water, etc.; and the various animal and vegetable parasites.

The intra-dermal group includes variations in blood-pressure, hyperæmia and stasis, vascular alterations, *e.g.* varix in all degrees, and toxic states of the blood, *e.g.* icterus and diabetes mellitus, arsenic, etc.

In many diseases, pruritus as *cause* and scratched skin as *effect* become so intimately associated that a vicious circle is established, and clinically it may be impossible from the skin affection to diagnose whether the pruritus preceded or followed its evolution. I may illustrate this by referring to eczema of the lower third of the leg in a patient who has varicose veins. Does the stagnant blood pressing on the terminal fibrils produce the pruritus which causes the scratching, and this latter in turn the eczema? Or has some external irritant caused a small breach of the elevated epidermis, leading to exposure of nerve endings, which results in pruritus and subsequent scratching? Whatever the exciting cause may be, we know that scratching, beyond all doubt, increases and extends the area in which pruritus is felt. The relief that scratching often brings to a pruriginous area is a result of the numbing of the cutaneous nerves produced by capillary distension and exudation. When these subside, the nerves regain their function, and a repetition of the clinical phenomena takes place. As is well known, pruritus increases and decreases in intensity, and, if unrelieved by scratching, may disappear for varying periods. On the other hand, local pruritus may diffuse itself, so to speak, over areæ *far* from the original site. Consciousness is not necessary to pruritus, and patients may continue to scratch whilst asleep; it is only in intense pruritus, *e.g.* that accompanying scabies, that the act of scratching, being irresistible, hinders repose. Pruritus being determined both in extent and in severity by the amount of scratching that is done, as well as by the environment of the patient, accessibility of the scratching hand, or heel and toes, to the pruriginous area explains how certain areæ are more scratched than others. Furthermore, the method of dress may account for this. I may cite as an illustration the presence of pediculi on the pubes. The itching produced by these pests is most pronounced in males, and the scratching is sometimes so severe that in killing the pediculi by mercurial ointment the scratched skin passes simultaneously into acute dermatitis. The scratching here is clearly dependent on the accessibility of the scratching hand to the seat of irritation. In the female, however, pruritus vulvæ due to pediculi does not often come under observation, although I have seen the mons veneris teeming with pediculi in a case where the itching complained of was due to pediculi in the axillæ, no itching of the vulva was admitted by the patient, and no scratched skin was to be detected on examination. In the cases that have come under my observation, the intense itching has nearly always been in the axillæ, and the scratched skin plainly proved the truth of the statement. Here the accessibility of the scratching hand was determined by the method of dress, and apparently the intensity of the pruritus depended on the severity of the scratching. In men, pediculi attacking the axillary regions are of much less frequent occurrence.

Owing to the difference of buttoning the dress, I have noticed that in man more *maculæ cæruleæ* are present on the left inguinal region than on the right, and in women the right axilla showed similar superabundance over the left. I may mention in passing that these blue spots, pea in size, are pathognomonic of the presence of the crab-louse. They are produced by the salivary secretion of the insect. In left-handed patients I have noticed that in pruriginous eruptions, where universal, the scratched regions that are most typical are on the opposite side to those seen in right-handed patients; and more than once, from the extent and severity of the eruption being more developed over the right half of the trunk, I have correctly inferred the left-handedness of the individual.

Pruritus and Age-Incidence.—I believe for practical purposes we can surmise within certain limits the nature of the pruritus from its relation to age-incidence.

In *children*, the most frequent cause is urticaria papulosa or lichen urticatus or prurigo mitis. I may point out that this skin affection not infrequently supervenes upon the exanthemata. I have seen it after measles, scarlet fever, and especially after varicella. Jonathan Hutchinson, whose clinical observations have earned such well-merited fame, was the first to draw attention to this relationship with chicken-pox. Unfortunately, he gave the disease another name, varicella-prurigo, quite unnecessary from a dermatological point of view.

By way of parenthesis, let me say, the fewer the names we have to connote diseases which have a common pathology, the better it is for progress in cutaneous medicine. Indeed, terminology—especially the doublebarrelled kind so frequently indulged in in times past, and not even desisted from nowadays—I venture to think, has rather retarded our progress and rendered the study of skin-diseases, to the practitioner as well as to the student, more difficult than any other department of medicine.

This pruriginous eruption, passing successively through the stages of hyperæmia (like a red-ink smudge), of exudation (a small wheal and papule), is always most troublesome at night. The intense pruritus is revealed objectively by the scratched papules, which may become through inoculation of micro-organisms pustular; and this final stage, if pronounced, may lead to errors in diagnosis. Ecthyma was the term used to designate such pustular eruptions. Its distribution is general, with the exception of the mid-third of the trunk. Here little, if any, evidence of scratched papules is forthcoming, and the reason for this is the presence of the clothes, which prevent access of the scratching hand to the region. The exudate forming the wheals undergoes gradual absorption and leaves no trace of eruption behind. Elsewhere, the sites of the former scratched efflorescences are marked by pigment stains which are intermingled with successive crops of new efflorescences. The amount of pigment is an indication of the duration of the disease. Apart from a previous exanthem, the ætiology of this skin trouble is still a *questio vexata*. Gastro-intestinal disturbance, a labile nervous system, overclothing, abuse of soap and water, the presence of fleas and bugs, have severally been regarded as exciting causes. There is no doubt that a vulnerability of the skin must be present as well as any exciting cause, be it within or without the skin, and in treatment neither view must be overlooked to bring a troublesome case to a speedy and successful issue.

In *adults*, intense pruritus should always make us suspect the presence of scabies. This disease, of which our knowledge is complete—in striking contrast to other skin affections, for we know its ætiology, its pathology, its treatment—is one which, experienced clinicians state, sooner or later we are apt to overlook or misinterpret. Such a contingency is more likely to occur with patients who are more regularly clean than those who only are so spasmodically. The *primary* eruption consists of the familiar burrows with vesicles; the *secondary* eruption is due to the results of the vehement scratching, and insemination of pus organisms into the skin lesions thus produced; hence the term scabies pustulosa applied to the severe and always chronic form of the affection. The universal scratching originating in the local sites of the primary eruption is a good illustration of the diffusion of the sensation of itching all over the integument. For not only at the site, but in ever widening circles, does the scratching hand roam, so that in typical scabies there is scarcely a region of the body which does not plainly show scratch-marks and other efflorescences. In obscure cases, especially where the webs of the fingers fail to yield evidence, the nipple area in the female, and the penis in the male, should never be overlooked. The soft, delicate skin of these regions is a particularly favourite site for the burrows of the itch-mite, and scratch lesions in the vicinity, even if elsewhere ill-defined, should at once lead to the diagnosis of, and tratment for, itch. It is the neglect to examine these regions in obscure cases that so frequently leads to wrong diagnosis, for as it sometimes happens scabies is seen in those in whom we *prima facie* would not expect to find it. Furthermore, I may remind you that syphilis and scabies are from time to time to be seen in the same patient. Kaposi would scarcely admit any other method of conveyance of scabies except by actual skin-contact in bed. Careful attention to the favourite sites of the burrows, along with the presence of other accompanying signs of syphilis, will clench the diagnosis of the disease. The skin of scabietics is drier than normal; the secretion of the oil glands is diminished, due to reflex inhibition of the nerves regulating perspiration, as a result of the pruritus. This condition of the skin (*scabrities*) accounts not only for the statement of patients, who often persist that their blood is out of order, because, although treated successfully, they still complain of discomfort, if not of itching; but it also accounts for physicians, long after the discovery of the sarcoptes. admitting the presence of an itch diathesis, which, so to speak, permitted the development of the acarus. It is therefore important to treat the skin as well as kill the itch-mite, and to bear in mind that, in encompassing the destruction of the cause of the pruritus, its results as shown by the secondary eruption require equally as much attention. The parasiticide applications may even aggravate the skin lesions and actually increase the pruritus, which may mislead the medical adviser into thinking that the cause has not been removed. It is this irritability of the integument that demands allaying and not continued anti-scabietic treatment. This circumstance explains how it is that patients complain of itching long after the acarus has been destroyed; it, however, soon vanishes with emollient medication.

In *middle-aged* individuals, pruritus—be it general or local—should always induce us to examine carefully the urine for sugar, especially where the skin is dry and harsh to the touch. In women, pruritus vulvæ has, as a rule, produced through scratching intense dermatitis, and it is frequently the skin lesion that necessitates their seeking our advice. The itching is so intense that the severest form of eczema I have seen affecting the genital and femoral regions in women, has always been due to diabetes. At times, the pruritus may be general, and the ensuing dermatitis has been regarded as eczema; it is only after examination of the urine that the true cause has been discovered. I am of the opinion that pruritus is one of the earliest indications of diabetes mellitus, and for that very reason we should regularly examine the urine for sugar. For the onset of diabetes is always insidious at this age-period; indeed, it is notorious how difficult—nay, impossible—it is for us to say how long the patient has been a diabetic when he first seeks our advice for symptoms already plain to the practitioner, although he may have previously sought our advice for evanescent pruritus which we referred to some other cause, and relieved by some emollient. Pruritus has been stated to be symptomatic of gout and the gouty diathesis, and examination of the urine has been said to confirm such a nexus. Now, without disputing such ideas—for in every case where normal metabolism is deranged the skin as well as other organs must suffer—nevertheless, I believe that such pruritus originates in external causes and not in vitiated blood-states. Indeed, the most careful examination of the urine in severe cases of skin-disease, *e.g.* universal eczema, dermatitis herpetiformis—where *prima facie* we might expect such changes—has revealed in my experience no such deviation from the normal. The amount of urinary solids has not been diminished, and neither sugar nor albumen has been discovered. I do not say there may not be subtle changes in the urinary secretion, *but*, in the light of our present knowledge, these have not been detected by the tests we have at our command.

In the *aged*, phthiriasis may often be a cause of the intense pruritus that so frequently disturbs rest, so necessary to this period of existence. It is this disturbance that lowers their health out of all proportion to the cause at work. It is well to remember that the body-louse is not always confined to the poor and indigent. It would appear that the dry, furfuraceous, greaseless skin is especially attractive to those pests which live *in* the creases of the body garments and *on* the skin. The distribution of the scratch-marks with the central puncture of the insect is pathognomonic; and the itching, most marked over and below the shoulder-blades, may generalise till it is nigh universal. The pigmented condition of the skin, coupled with the misery of the patient, and the fact that it is often seen in tramps and vagabonds, has led older writers to describe it as the disease of the arraigned (*morbus reorum*). In the late epidemic of arsenical beer poisoning, the skin of many of the habitual drinkers produced the impression that they were suffering from phthiriasis of long standing, and not displaying the effects of chronic arsenic poisoning. The number of cases of morbus reorum admitted to the unions in Lancashire was truly astonishing, until the discovery was made of arsenic in the beer they had taken!

Although we know the cause of the pruritus in phthiriasis, it is curious how patients refer their itching to some blood-state. This very fact, to my mind, shows that the state of the skin is abnormal, being chiefly deficient in grease. The inunction of lanolin alone, and stoving the under-garments, has effected a cure; although, as is well-known, the best remedy is *unguentum Hydrargyri Ammoniati.* As the aged feel the want of heat more than the young and robust, the body vest is frequently not removed at bedtime. It is important to insist upon a change in this respect; for it is surprising how such a point may be overlooked by the medical adviser, and naturally ignored by the patient, who resumes his body vest after treatment, while carefully stoving his flannel shirt.

With regard to treatment, "Remove the cause, and the effect will cease," is a trite saying, and yet in the practice of medicine we soon realise that other matters are of equal importance. I allude to the immediate environment of the skin, the changing conditions to which it is daily exposed, and the ever-varying changes of temperature to which it is subjected. There is no doubt that the character of the underclothing and the continued use of soap and water are *essential* points to be considered in the treatment of pruritus. I have already mentioned the itching that is produced by woollen garments, but mechanical pressure long continued during waking hours may induce pruritus when undressing, which may persist for some time, and so interfere with sleep. It is a familiar fact to most of us, that a sensation akin to itching is experienced when undressing, and we instinctively pass our hands over our body, if not to scratch, at any rate to gratify a sensation of relief from pressure. The pressure of the braces, garters, of the corset in women, of footgear, when removed, often induces one to scratch, due to the flux of blood and concomitant compression of the nerve endings in the skin. In some persons the cold air produces itching, accompanied by the state of the skin known as *cutis anserina.* In such, undressing should be done in a warm room, and the night-gear and bed previously warmed. The old-fashioned copper heating-pan was exceedingly useful for removing the cold sensation of the linen sheets our forefathers so much affected.

That soap and water are injurious in eczema and should be prohibited is well known. But what perhaps is not so well realised, is their *harmfulness* whenever the horny layer of the epidermis is broken, signalled for the first time to the patient's consciousness by itching. He not infrequently ascribes such itching to something on his skin, to his overlooking the region in his ablutions, and forthwith adds fuel to the fire by using more soap and water, and so washing more vigorously. They are good servants but bad masters; and if cleanliness is next to godliness, assuredly over-cleanliness is next to pruritus. It is the daily use of too much soap, and as a result the excessive removal of the natural grease of the skin, that is responsible for the pruritus that patients experience after their morning bath. This excessive washing tends to bring their skin into a condition akin to *xerodermia,* a congenital disease characterised by a deficiency of the natural oil of the skin found in the sweat as well as in the sebaceous glands.

Many cases of that distressing condition, *pruritus ani,* if not caused by the abuse of the bidet, are distinctly aggravated by the over-use of soap and water. If the distended hæmorrhoidal vein has caused a breach in the horny layer of the epidermis, and through nerve exposure started pruritus, soap and water are the very best and surest—because so regularly used—promoters of the continuation of the pruritus. It is therefore of prime importance to decide at the outset in the treatment of pruritus whether soap and water should be used with caution, or absolutely prohibited. But this prohibition does not mean absence of cleanliness; it can be quite well obtained—and, I venture to say, without interfering one whit with treatment—by using olive oil in their place. As a type of soap I take the *sapo durus* B.P.: this is an oleate and palmitate (chiefly the former) of soda, made from olive oil and soda. When used for washing, every soap undergoes partial decomposition, setting free alkali; and this is the ingredient that is so harmful to the broken epidermis. Therefore, if we exclude the alkali altogether from the soap the olive oil remains, and being fluid, we can dispense with water. It is only when we have assured ourselves that the epidermis is intact and the pruritus absent that we should permit the resumption of soap and water. Even then, after a bath and drying, it is a good plan to recommend the application of olive oil to any pruriginous areas. It is in the treatment of pruritus due to diabetes, when the function of the sudoriparous and sebaceous glands is in abeyance, that the use of oil or oil and lanolin is of such signal benefit. In the aged, the shrinking of the panniculus adiposus and the sluggish secretion of perspiration predispose to pruritus senilis; in such patients the value of inunction of emollients (especially after a warm bath) in alleviating the itching is seen. The use of a dusting powder is so beneficial because its particles sink into the crevices of the fissured epidermis, and thus exclude all sources of irritation from the nerve endings.

In conclusion, I may state, my object has been, not to follow the text-book description of pruriginous diseases, but to accentuate the clinical symptom of pruritus, to unravel its graphic effects on the skin, and so working backwards, arrive at a diagnosis of the disease. Then, taking into consideration the manifold conditions that have permitted the evolution of the disease, if not indeed fretted it into persistence, I have endeavoured to work forward to a favourable prognosis, and with it the prevention of its return.

We may not always succeed in ascertaining the cause of the pruritus, but we *do* know how important it is to combat the conditions which favour its development and persistence.

I have cited examples of pruritus in disease most frequently seen in my experience in the four stages of life—childhood, adult life, middle age, and old age. I need not say that pruritus, from the patient's point of view, is in truth a *disease;* his comfort is gone and peace of mind often gravely ruffled. It therefore behoves us to remember *his* view, and in our efforts to restore him to health we should not be so ready to apply the most recent remedy hailing now from Germany, now from America—not that I say it may not be useful—but rather at all times be vigilant of the conditions under which the itching may be produced, and to remember that it is not in the multiplicity of medicaments—old-fangled or new-fangled—but in the method of treatment and attention to detail that success is to be sought.

If the remarks I have made have anything of value, it is because they have been the result of personal experience. I believe that in the practice of medicine, as in other arts, the personal element counts. But it is not in an egoistic spirit that I have ventured to address you to-night. It is simply because I thought that, having honoured me with an invitation, I could not show my appreciation of such honour better than by giving you my views on such an important symptom in cutaneous medicine.

THE MEDICAL INSPECTION OF SCHOOL CHILDREN. (a)

By A. SEPTIMUS ARKLE, M.B.Cantab., M.R.C.S.Eng.

(Liverpool).

This paper is based on the results of an inquiry into the physical and mental condition of children at certain ages in the various grade schools in Liverpool and its neighbourhood, and the subject is one of great importance at the present day, when the feeding of poor children in schools occupies such a prominent position in the minds of all who take an interest in the rising generation.

A total of 2,477 children were medically examined, of whom 366 were from secondary schools. The elementary schools were divided into three groups, A, B, C; A, representing children of well-to-do parents; B representing children of the lower shop-keeping and labouring class, the latter being supposed to be in constant employment; C representing children from a lower stratum, the parents of whom were either out of employment altogether or whose employment was only casual.

The secondary schools were selected in comparison as representing children who enjoy every advantage as regards food and clothing. Class C consists to a considerable extent of children who do not get enough food for their requirements, and who are also frequently insufficiently clad, and it furnishes a very striking contrast to the secondary school class.

The author states that the material as a whole is good, and he has seen none to equal it either in France, Germany, or Italy. "I am sure," he says, "I saw more deformed children in one day in Genoa than in a year's work in the schools of Liverpool, and I have seen more lateral curvature in the streets of Berlin than in all the schools I have examined put together." If, then, the material is as good as it appears to be, there must be serious mismanagement of it somewhere to produce the state of things he met with in actual investigation. He says: "One cannot fail to be startled—I had almost said appalled—at the unanimity (*sic*) of the results, and the clearness with which they indicate a very terrible state of affairs." The picture projected into the imagination by the tables here given is indeed a pitiful one. In the four classes of schools examined there is a distinct lowering of the physique of the children step by step, and this down-grade tendency corresponds to the limitation of the power of the parents to feed and clothe their children.

The lowering of physique in the different schools, from secondary schools to Class A, from Class A to Class B, and from Class B to Class C, cannot fail to attract attention. The comparison was made of children at corresponding ages, the first being made of children at 7 years of age, the next children of 11, and, lastly, children of 14. The tables give the height and weight at the ages named.

Measurement of children at 7 gives:—

	ft.	ins.
Secondary Schools	3	11.8
Council School "A"	3	9.3
,, "B"	3	8.35
,, "C"	3	8

The total difference between the secondary schools and "C" is 3.8 inches. At 11 years of age we find:—

	ft.	ins.
Secondary Schools	4	7.5
Council School "A"	4	5.1
,, "B"	4	3.8
,, "C"	4	1.7

showing a total difference of 5.75 inches. At 14 years of age we get:—

	ft.	ins.
Secondary Schools	5	1.75
Council School "A"	4	10.2
,, "B"	4	8.25
,, "C"	4	7.25

showing that the total difference has increased to 6.5 inches, or more than half a foot.

Taking the weights of the boys, we find the difference even more marked. At 7 years old the boys weigh:—

	st.	lbs.
Secondary Schools	3	7.3
Council School "A"	3	2.1
,, "B"	3	1
,, "C"	3	1

showing a total difference from the secondary schools to "C" of 6.3 pounds. At 11 years of age the weights are:—

	st.	lbs.
Secondary Schools	5	0.26
Council School "A"	4	5.45
,, "B"	4	3.05
,, "C"	3	13.5

showing a difference of 1st. 0.75lbs. Whilst at 14 years of age we get:—

	st.	lbs.
Secondary Schools	6	10.5
Council School "A"	5	5.82
,, "B"	5	5.87
,, "C"	5	1.14

showing that the total difference has reached the magnitude of 1st. 9.25lbs.

There is little need to enlarge on the tale that is here told with such eloquence, but another and much more powerful one might have been told, and we may hear it some day. There can be no doubt there is plenty of material for one, if anyone would only take the trouble to collect it. Supposing, instead of taking the whole of Class C for comparison with secondary schools, the children of the very poor only had been selected; the tables would have shown a wide difference. As they stand many children of Class C would be well fed and well looked after in every way.

Again, if all children taken to workhouses and children's shelters were weighed on admission, as they probably are, and the figures were made available for showing the ravages of starvation and insufficient food in the young, it might be possible to move Government so that in the course of time it might deem legislation on the subject as of almost equal importance to a Constitution for the Orange River Colony, Votes to Women, or the Repatriation of Chinamen.

Her Royal Highness Princess Christian, accompanied by Mrs. Dick-Cunyngham, on Saturday afternoon visited the Crèche at Windsor, and was received by the Rev. F. M. Hargreaves, Mrs. Hargreaves (hon. treasurer), Miss Martin (hon. secretary), Major Martin, Lady Edward Spencer-Churchill, Lady Clementine Walsh, and Mrs. Seymour Corkran. Her Royal Highness, who is the founder and patroness of the institution, received a number of "pound" gifts in aid of the crèche, and distributed to the poor parents of the infants daily catered for in the nursery parcels of warm clothing allotted from the Berks and Bucks Needlework Guild, of which Princess Henry of Battenberg is founder and patroness.

(a) Abstract of paper read at the North of England Educational Conference, held at Bradford, January 9th, 1907.

LETTER TO A YOUNG PRACTITIONER ABOUT TO COMMENCE PRACTICE. (a)

By Dr. G. CORNU

(La Clinique.)

My dear young fellow-practitioner.—Just a month ago you received magisterial sanction and acquired the right, conferred by the State, to intervene between life and death. One is a labyrinth, the other an abyss. You will have to fight your way between two mysteries, with your mind disturbed by the appeals or the remonstrances of human suffering. Your foremost duty is modesty. You have but to glance at the diploma which has just been handed to you. It is written on the skin of an ass, but do not resent the inference, for it is a tacit injunction to be patient, courageous and gentle. You think you are "out of the wood," but a new and tiresome apprenticeship awaits you. You are now entitled to call yourself doctor; it remains for you to become a practitioner.

So far you have practised art for art's sake. Now you will have to practise it for a livelihood, and all your ideas will be upset in the process. At the hospital the patients belonged to you; in future you will belong to the patient who employs and pays you. You will ever have to bear in mind the practical issues of life, your professional reputation and the obligation to please. Your prescriptions will no longer be inspired exclusively by the goddess science, speaking as from a throne. They will have to be modified to suit the whims, the tastes, the indifference or the passions of your "customer," and, as you lack the authority that belongs, perhaps, to superlative diplomas, they will have to fall in with the prejudices of your environment. Before you have thrice listened to the râles of pneumonia you will forswear your masters by ordering a blister in deference to your patient's expectations. You will prescribe useless drugs because you find it necessary to do something and have to justify your attendance. I said just now that your first duty was *modesty*, but your first obligation is cocksureness. *The duty* is your private affair, the obligation is for *show*. One is a scientific duty, the other a trade obligation. You have no right to hesitate in arriving at a diagnosis. Yes, you who, it may be, left the schools with the idea that medicine is a sacred calling, that it would be yours to cure or to console, you, who have so often placed your enquiring hands on that painful vacuum, man, that you have become a sort of sentimental materialist, take my word for it forthwith that in the struggle for existence upon which you are about to enter, sentimentalism is a weakness, and, by contrast, even a psychological danger.

I fancy I see you at the bedside of your first patient! His state is grave, but not past hope, and because everyone is in tears your pity is moved. Imprudent man! You seek to reassure them! Your far-seeing science enables you to relieve their anxiety. Recovery ensues, and the good woman who was the noisiest among the weepers is already muttering that, after all, the malady was not as serious as it seemed, and the convalescent, in view of your fees, will boast to you of his strong constitution, of nature's resources, and discounts his esteem and his bill in proportion to the consolations you have offered him.

Your next patient is incurable. You see that his case is hopeless, and you picture to yourself what would be your own despair were he your brother or your son. As the end is still distant, your delicacy leads you to hide the gravity of the case from his immediate relatives. Six months hence will be quite early enough, you say to yourself, and in the meantime how many anxious days and restless nights you will have spared them. What a mistake! In six months they will reproach you with having disguised the truth at a time when it was conceivably still possible to do something since the papers are full of advertisements of remedies that cure this particular disease. If they called in a doctor it was, of course, to know exactly how matters stood, but very likely you did not know yourself!

Your sentimentalism will hinder you, too, when you limit the number of your visits in order not to scare a nervous patient whose recovery is, moreover, quite certain. If, on the other hand, his exaggerated apprehensions or his vanity oblige you to be constantly in attendance, take heed lest a false conception of honesty make you hesitate to visit him unnecessarily.

Take care not to raise a regrettable misunderstanding between you and humanity at the outset. Never look for gratitude. This flower of evil may raise its head in the shadow of pain, but it fades in the first rays of convalescence, and it will be sent back to you sere and yellow between the leaves of your bill. For the matter of that, what claim have you to gratitude? Whatever service you may have rendered, after all, you were only following your calling, and as you follow it for money, as soon as you have been paid you are quits. If some eccentric person happens to think that something remains due to you after he has handed over the cash, look upon the fact as an anomaly, a purely subjective mistake as to the scope of a social obligation. Do not set it up either as an example or a precedent. Strictly speaking, it is you who ought to be grateful to the patient whose life you have saved, for he has afforded you an opportunity, among the many instances in which your intervention was futile or useless, to show that you and your art are necessary evils. Moreover, he will have flattered your intelligence and renewed your courage.

Lastly, get well into your head that your reputation depends as little as may be on your scientific attainments and your devotion to duty. Your science! Who is to estimate it? The outsiders upon whom you lavish it are more than ignorant of it. You see it through the deforming prism of a thousand false ideas and unsurmountable prejudices. Shall they base their estimate on the results? But to do that they would require to be able to form a sound opinion of the causes and distinguish the starting-points. The ignorant or unscrupulous practitioner who has cured a hysterical patient of epilepsy, will acquire vastly greater renown than the clear-sighted and conscientious physician whose exact diagnosis sets their fears at rest.

Devotion to duty? Do you know what the public understand by this term? Not your personal sacrifice at the bedside of the cholera patient, a merely trade risk, for the man who tiles the roof displays the same sort of heroism. Nor is it the part you directly take in the care of your patient, the first day or two they will thank you, but afterwards they will consider it to be incumbent upon you. No, it is simply the promptness with which you respond to their call. And your haste, especially in country practice, will soon become a snare. You will be expected to put in an appearance immediately for the most trifling thing, or simply because your visit at such an hour will cause less inconvenience than at such another. When the day comes that your gorge rises at seeing your goodness so meanly taken advantage of, vexed at having kept waiting a patient far more seriously ill but less insistent in order to minister to the caprice of one who has a cold in the head and treats you as his domestic; when, I repeat, you decide to put your foot down, you will call down upon yourself more anathemata than a well-established gruffness would ever have excited.

To sum up, practising for the public an art which it is incapable of judging, you must not hope to create an impression by your knowledge of disease, but by your knowledge of men. The more illusions you have brought into your career the more will the reality have bruised your delicacy of intelligence and sentiment, the deeper will be your fall and the more dangerous the depression which experience is holding in wait for you.

Humanity is a landscape that must be looked at as a whole and viewed from the summit of the mountain called disdain. Philanthropy, disdain, they may strike you as a strange contradiction in terms. For those who, like you, have to live face to face with the nakedest reality, one is to the other the only asylum and the indispensable refuge. On the road whither you are summoned by human suffering, through the pitfalls and thorny bushes of foolishness, if your respect for mankind is not protected by the triple armour of which the poet sings, the last vestige will have been carried away before you have been five years in practise. At that stage you will know, not the fugitive, indulgent disdain that smiles and pardons, but the contempt that holds fast, that mocks and extorts.

(a) [The above charming little monologue from the pen of Dr. G. Cornu (La Clinique), appears to us to merit the honour of translation. If we cannot flatter ourselves to have done justice to the literary elegance and sparkling irony of the original, we have at any rate extracted some sound observations and practical wisdom.—Ed. 'M. P. and C."]

I am telling you all this because I credit you with a generous mind. For if Nature has not implanted in your bosom too abstract a conception of science and a troublesome human ideal, all my warnings are idle. You will make your way surely and easily. Offer a cock on the shrine of Esculapius "in settlement of account," and pray the god who bears the twined serpents to maintain you throughout your career in a state of diligent mediocrity. On much the same intellectual level as the public whom you serve you will please without effort. Your object in life will not be to cure your patient, but to pile up visits. Your cures will be slow, and even your mistakes remunerative. More assiduous at the bedside than disease itself, the latter will have vanished without your having ceased to wrestle with it, and the convalescent, finding with satisfaction that you do not neglect him, will hardly venture to be restored to health. Conveniently propped up by books that you have ill-mastered, or bold "lines of practice," you will elaborate for yourself an imperturbable and simple rule of thumb. You will be the trustworthy practitioner who does not allow his rules of conduct to be swayed by that impertinent entity called experience, and without running the risk of losing your way in the chanceful search after causes, you will be the impulsive therapeutist who gives each symptom tit-for-tat, the simple strategist who always rushes to the cannon's mouth, in whose hands polypharmacy provides a liberal supply of shrapnel to make up for any lack of precision in aim. You will be the doctor who gives disquieting diagnoses and guarded prognoses, who daily cures manifold cases of diphtheria and meningitis. No patient will ever leave your consulting-room without being drugged to the full. You will be the blood-purifier, the disperser of tumours, the bone-setter, nay, in deference to the modern trend of ideas, you will squander serums galore. On the other hand, you will shake hands with Dick, Tom and Harry, and when you raise your hat the gesture will be the equivalent of a smile. Masked by the dust of your automobile with its indefatigable horn, the passers-by will celebrate your triumph in dithyrambic and sternutatory fashion, a triumph, moreover, which can be converted into cash. *Aurea mediocritas*, which may be freely translated "wealth to mediocrity." Far more, in the course of time you will acquire a peace of mind that would never have been yours had you taken pure science as your guide. You will be the fly fluttering round the coach sunk in the mud of human health, satisfied with its achievements and proud of its buzzing restlessness.

What! this career has no attractions for you?

Well, I should be sorry for any words of mine to cast discouragement on honest endeavour. I have no doubt inconsiderately laid on the colours too thickly. I only wished to warn you of the perils of the road. But there are concessions that are permissible and honourable, because necessary, between one's principles and the implacable reality. To realise how far you may compromise with your science and your self-respect without betraying one or the other, to know how to capture the esteem of an unenlightened public, is a problem which you may set yourself to solve in perfect honesty of purpose. I could only point to the difficulties, you alone can overcome them, and this is what I meant when I said, "You are now a doctor; it remains for you to become a practitioner."

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

Rheumatic Heart Disease and Blood Pressure.

By Leonard Williams, M.D., M.R.C.P.,
Assistant Physician to the Hospital; Physician to the French Hospital in London.

This woman, whose age is 36, has recently been discharged from the wards, where she was under my care. She was admitted with all the classical signs of uncompensated mitral regurgitation, namely, œdema of the extremities, pulsating liver, orthopnœa, enlarged right ventricle and apical systolic murmur. Her systolic blood pressure on admission was 160 mm. Hg., which is definitely above the normal. This is a very important fact, to which I shall return presently; but before discussing it I want to explain how this woman was treated. Her history showed that she had had chorea as a child, and rheumatic fever in early adult life, so that we were fortunately in no doubt as to whether or not her morbus cardis was of rheumatic origin. Doubts on this point are sometimes very difficult to clear, but it is very necessary that they should be cleared, because the line of treatment to be adopted in a case of rheumatic origin is very different from, one might almost say is diametrically opposed to, that which is proper to a case where the morbus cardis is secondary to arterial or renal disease. In the first case you may give digitalis boldly and with confidence, whereas in the second, if you give it at all, you do so at a risk to your patient's life which is by no means inconsiderable. This woman, then, was given digitalis; but not at first. There is no use in giving digitalis until the path has been prepared for it by brisk and even drastic purgation. If you do not purge your patient, the digitalis will not act; and you may always gauge the efficacy of the purgation by the promptitude with which the digitalis increases the urinary output, and slows and steadies the pulse. Properly employed, digitalis is a soverign remedy in these cases, and if it fails to act as such, then you may be quite sure that the fault lies not with the drug, but with the method of its employment. The drug may be at fault in the sense that the particular preparation used may not be an active one, for there is no drug whose preparations vary more in individual samples than digitalis. The ticture is notoriously unreliable in this respect. A freshly made cold infusion is infinitely more trustworthy.

To return to the question of blood pressure in these cases. On the face of it one would suppose that if ever such a condition as unduly low arterial tension could exist, it would be typically present in a case of uncompensated mitral disease. The systemic arteries are here but partially supplied with blood, the great mass of which is stagnating in the veins and pulmonary system. We found, nevertheless, in this case, and you will find the same in all similar cases, that so far from being reduced, the arterial tension as repeatedly measured by the manometer was not below normal, but definitely and unmistakably above normal. Now, what is the explanation of this fact? If you will ask yourselves a very simple question, the correct answer thereto will supply the solution to this apparent riddle. The question is, "What is the object with which the blood pressure is maintained at or above a certain level?" The answer is, "In order that the periphery, all parts of the periphery, but more especially one part, namely, the medulla, may be adequately supplied with oxygenated blood." Now, if the pressure in the venous system is unduly high, as in cases of uncompensated mitral stenosis it inevitably must be, it follows that if the medulla is to be properly supplied, the pressure in the arteries must rise above that of the veins. If it fails to do so the medulla is starved and the animal dies. In these cases, therefore, so far from finding a low arterial tension we find a high one, and the height of the tension in the arteries is in some degree a measure of the block in the pulmonary circulation: for the arterial tension must rise until it is strong enough to overcome the venous stasis. These considerations supply the solution to another clinical riddle, namely, the phenomenon of orthopnœa. It is a riddle to a good many, that people with a labouring heart should instinctively adopt a position, namely, the sitting position, which imposes an unnecessary amount of work upon the crippled central organ. But we have to remember that this central organ, the heart, is after all only the servant of the medulla, and that consequently if their interests should clash, it is the heart which must yield. Thus it happens that the paramount necessity for arterial blood on the part of the bulb causes the patient to adopt an attitude which, though it may tax the heart, aids the medulla by favouring the return of venous blood from the brain to the heart. He sits up, because by so doing he calls the force of gravity to his assistance in hurrying the venous blood away from the cranial cavity, to make room for the all-essential arterial tide. This patient has passed successfully through her trying ordeal, and she is now well; as well, that is, as she is ever likely to be. She may look forward to the future with a considerable degree of hope. That, unfortunately, is the best we can say; for of all the means of risking disappointment and loss of credit, positive prognosis in heart disease is at once the most dangerous and the least profitable.

OPERATING THEATRES.

NORTH-WEST LONDON HOSPITAL.

Suppuration of the Shoulder-joint Simulating Mammary Abscess.—Mr. Mayo Collier operated on a married woman, æt. 45, who had been admitted with the following history: ten days before she had applied at the out-patient department complaining of pain and tenderness at the lower and inner aspect of the left axilla; she stated that a week before this she had been extremely ill, and had suffered from rheumatism of the left shoulder. There was no history of injury or previous trouble in this region. The house surgeon who first saw the case diagnosed two collections of fluid, one on the lower and inner aspect of the left breast, the other near the anterior border of the latissimus dorsi, about four inches below the axilla. The temperature was normal when the patient was first seen, the lungs, too, were apparently normal; there was no point of suppuration in any part of the body excepting that the patient had several carious and painful stumps. The woman had not recently been parturient, and up to this period her general health had been good. There was no vaginal discharge, but this was not ascertained till her admission into the hospital. At first the patient was not admitted, but was treated as an out-patient. The two collections of fluid, which proved to be pus, were opened and drained antiseptically. Iron and strychnine were administered internally, and instructions were given to the woman to attend daily at the hospital for surgical treatment and supervision. The case not progressing satisfactorily, the discharge still continuing with an elevation of temperature, Mr. Collier, when he first saw the patient and after he had made a careful examination of the breast and of its surrounding parts, said that no cause was apparent for the two foci of suppuration; the breast on this side was soft and elastic and seemed to be quite normal; there was no disease of the ribs or periosteum, no local skin affection which could in any way account for the suppuration. The general condition of the patient, however, he pointed out, was not satisfactory: her face indicated that something was wrong, there was a hectic flush on each cheek, the temperature varied from 99 to 101 at night, and moist sounds could be heard over each base; the pulse was fast and the appetite was fanciful; there was no other focus of suppuration except that the teeth were carious and the surrounding gums inflamed. On movement of the corresponding shoulder no complaint was made, but an area of redness over the bicipital groove about four inches below the shoulder-joint gave a clue to the real condition of things. Mr. Collier incised this area of redness, and found that a probe could be passed in the track of the tendon of the biceps muscle into the shoulder joint. The shoulder was then further manipulated, and still grating could be felt, showing that the head of the humerus and the glenoid cavity were divested of cartilage. Mr. Collier pointed out that it was a common experience to find that in chronic and acute suppuration of the hip-joint abscesses would present themselves in the thigh in various positions, and that the first indication of disease would announce itself in these directions. An abscess in Scarpa's triangle or in front of the ilio-tibial band and posterior to the gluteal region was quite a common experience in connection with hip-joint disease, but an abscess to present itself in the neighbourhood of the shoulder-joint without first directing attention to disease of the articulation was one of the rarest conditions in surgical experience. The shoulder-joint was so placed, so superficial, and so affected by the smallest movements of the upper limb that any pathological condition of the articulation was usually early apparent to the patient or to the attendant. It was quite unusual for acute suppuration causing perforation of the capsule and discharge of its contents into the surrounding tissues to take place without the patient complaining of serious loss of function in this joint. As a matter of fact, the absence of pain and the loss of function in the joint had misguided the medical attendant in his first inspection of the condition. The case was treated in the first place as a mammary abscess; it was not until the patient had been admitted to the hospital that the absence of improvement and the general hectic condition had raised suspicions that something more was present than a mammary abscess. The small area of redness over the bicipital groove gave the clue to the real condition of things. Mr. Collier said that the rarity of this condition was sufficient excuse for the absence of a complete diagnosis before admission to the hospital, but investigation of the shoulder-joint proved beyond doubt that the case was from the first one of septic inflammation of the shoulder-joint, probably following as a direct result of the carious condition of the teeth in a patient whose health was decidedly below par. Mr. Collier passed a probe into the sinus on the bicipital groove, and incised the tissues up to and as far as the acromion process. The joint was entered and opened freely, and irrigated with a solution of 1 in 40 carbolic; a large drainage tube was then inserted and the part dressed antiseptically. The joint as diagnosed before the operation was almost completely divested of cartilage, both the aspects of the head of the humerus and of the glenoid cavity being rough and carious. Mr. Collier felt sure, however, that the case would end satisfactorily, and that fair motion and a useful joint would be obtained. His anticipations have been fully realised; the parts healed, and now (six weeks after operation) there is a fair range of motion in the joint.

It is announced that the fund formed in connection with the candidature of Drs. Langley Browne, Latimer, and McManus for the General Medical Council has been duly audited. The expenses amounted altogether to £79 10s. 8d., towards which general subscriptions to the amount of £43 10s. 8d. were received.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

Meeting held Friday, January 11th, 1907.

The President, Mr. Clutton, in the Chair.

CASE OF ABSCESS OF THE LUNG AND ACUTE ENDOCARDITIS IN ACUTE PNEUMONIA.

Dr. Francis H. Hawkins (Reading) read notes of a case of this nature. The patient was a man, æt. 51, who had pneumonia of the right upper lobe which ended by lysis. After the temperature had been normal for a few days it gradually rose for ten days, then suddenly went up to 105° and fell to 102°, when the patient broke out in a profuse perspiration. The following day he had a rigor and the temperature rose to 104°, then fell to 96°, and he again perspired profusely; two days later the patient became comatose and died. No pus was expectorated throughout. At the necropsy the right upper lobe was in a state of grey hepatisation and contained three abscesses varying in size from a walnut to a hen's egg. All were lined with a distinct lining membrane. At the base of the aortic cusp was a recent fibrous deposit which on being removed showed an ulcerated surface.

Dr. **Hawkins** pointed out the rarity of abscess as a complication in acute pneumonia, and more especially an abscess with a distinct lining membrane. He thought that acute endocarditis was not so common in acute pneumonia as some writers seemed to think. He referred to some cases where the tricuspid valves were affected. He described his case as one of endocarditis pneumonia, mentioning that Weischselbaum had demonstrated the diplococcus pneumoniæ upon the growth of the valve of similar cases as Netter had also done.

Dr. **C. Theodore Williams** had seen four cases of lung abscess in acute pneumonia; two of these were influenzal in origin. He had also seen the combination of abscess and endocarditis in this condition. He did not think the surgical prospect good in these cases, as there was no time to decide on an operation before other abscesses formed. He remarked on the peculiar pleasant cowslip odour of the sputum that in the later stages of the illness replaced the original foulness. Dr. Hawkins' patient had died in coma with symptoms very suggestive of brain abscess, and he inquired whether this had been verified.

Dr. **Hawkins** said that the brain had not been examined.

Dr. **David Forsyth** read a paper on

A FATAL CASE OF MYXŒDEMA WITH CHANGES IN THE PARATHYROID GLANDS.

The patient, a woman, æt. 58, had been gradually developing the symptoms of myxœdema for four years, and at the time she came under observation had lost much of her hair and all her teeth had fallen out. She showed marked dulness and apathy, her mind wandered, and she was noisy. The skin was dry and harsh and the hands spade-like. A fortnight later she died in spite of the administration of dried thyroid gland. *Post mortem* the thyroid presented the sclerotic changes typical of the disease, and the six parathyroid glands which were found all showed certain departures from their wonted structure. These changes consisted in a marked tendency for their cells to form vesicles lined by cubical epithelium, an exceptionally profuse secretion of colloid which not only filled the follicles but lay among the masses of cells, and also distended the lymphatic channels, an abnormal increase in the connective tissue which formed coarse trabeculæ and even penetrated between the cells, and a thickening of the tunics of the arterial walls. The two former changes represented an excessive activity of the glands, and were to be regarded as an attempt on their part to supply the deficiency of colloid left by the atrophy of the thyroid, while the alterations in the stroma and arteries were probably pathological, being allied to the fibroid changes in the thyroid. The case was the first of the kind in which the condition of the parathyroids had been observed.

Mr. **W. L. Harnett** said that he had examined a large number of parathyroids and agreed with Dr. Forsyth in interpreting the presence of colloid as indicating undue activity. He was able always to correlate changes in the oxyphile cells of the parathyroid with this, and inquired as to the condition of these cells in the present case.

Mr. **Walter Edmunds** referred to the imperfect state of our knowledge on the subject. The results of experimental work with the lower animals were very contradictory. If both thyroid and parathyroid were removed from dogs, the animals usually died, but 4 or 5 per cent. suffered no ill effects, and in the case of goats and guinea-pigs also no ill effects followed. In the cases that recovered no traces could be found of any gland that might have escaped removal. He thought that work on the secretory nerves might afford a prospect of yielding useful information. He inquired as to the cause of the thyroid fibrosis in the present case, and particularly as to the existence of any evidence of tuberculosis.

Dr. **Forsyth**, in reply, said that the oxyphile cells showed changes, and were scattered uniformly, not in clumps as in the normal gland. There was no evidence of any active tuberculosis in his case, but there was a calcified focus at the apex of one lung. He referred to experiments which showed that no effects followed the secretion of the secretory nerves on one or both sides.

THE ASSOCIATION OF TETANY WITH DILATATION OF THE LARGE INTESTINE IN CHILDREN.

Dr. **Frederick Langmead** read the notes of three cases of this nature.

Case I.—was that of a boy, æt. 6, who between November, 1903, and April, 1905, was admitted five times into the Hospital for Sick Children, Great Ormond Street, under the care of Dr. Garrod, suffering on each occasion from an attack of tetany.. Each attack was accompanied by the evacuation of yeasty pultaceous stools and distension of the abdomen. Abdominal examination revealed the presence of a large hollow viscus on the left side. All treatment was ineffectual until lavage of the large intestine by means of a rectal tube was resorted to, when on each occasion improvement leading to recovery was initiated. The last attack was complicated by fatal diphtheria. *Post mortem* the hollow viscus was seen to be the sigmoid flexure which was very dilated and occupied the greater part of the left half of the abdominal cavity. It held about 13 oz. of fluid.

Case II. was that of a boy, æt. 3 years and 2 months, who was admitted on May 10th, 1906, also under the care of Dr. Garrod, for his fourth attack of tetany. This proved to be accompanied, as in Case I., by the passage of pultaceous motions, and the presence of a large hollow viscus in the abdomen. Lavage was temporarily successful, but a month after admission, diarrhœa and rapid wasting began, and operative treatment was employed. Mr. Lane removed 10 ins. of dilated sigmoid flexure, and at first the child became better. Death, however, occurred twelve days after. *Post mortem* the remaining large intestine was found to be enormously dilated, the walls being thin and atrophic, and no obstruction being present.

Case III. was that of a girl, æt. 2½, who was admitted under the care of the late Dr. Sturges, in June, 1884, for repeated attacks, associated with abdominal distension, and offensive undigested motions. She was an emaciated child, and continued to waste, and died from a terminal broncho-pneumonia. *Post mortem* the only lesion found except broncho-pneuomnia was a dilated transverse colon.

He referred also to a case reported by Dr. Batty Shaw, and Mr. Mant, in *Clin. Soc. Trans.*, Vol. 39. It was that of a girl, who for four years had suffered ulcers of the bladder. On the right side there was tuberculosis of the testis, the prostate was healthy. The left kidney was extirpated, and the ureter taken special care of, by being implanted into the psoas muscle. The right testicle was then removed. As treatment of the tuberculous condition of the bladder a mixture containing calomel in suspension was injected into the bladder, after which iodine was given internally. After some months a cystoscopic examination showed that all the ulcers of the bladder had healed. In three months the patient had gained over 20 lbs. in weight. When he attempted to return to work, however, trouble began in the other kidney, and on examining this tubercle was observed over the papillæ. Installation of the calomel mixture was used as in the bladder, and the patient had now been free from trouble for a long time.

At the Freie Vereinigung der Chirurgen, Hr. Hildebrandt reported a case of

Rupture of the Hepatic Duct.

A child, æt. 4, had been run over by a carriage. Immediately afterwards the child vomited, but the next day it was apparently well. Then, however, the condition became worse, and the patient was brought into hospital. The abdomen was distended, and tender everywhere on pressure ; and in the lower part there was dulness that disappeared on change of position. Pulse 120, no fever. The stools normal in colour ; no vomiting. During the next few days rapid emaciation was observed. The abdomen also far more distended, the temperature rose to 38° and 38.5°, whilst the other symptoms remained unchanged. There was no jaundice, but bile colouring matter appeared in the urine. On the tenth day after the accident laparotomy was performed. In the abdominal cavity " gold clear " bile was found, and numerous fibrous deposits on the intestines. The region of the gall bladder was exposed. This was normal, but a longitudinal rent was found in the hepatic duct. The attempt to close it by suture did not succeed, and nothing remained but to drain. Rapid recovery took place, and in four weeks the child was well again.

The case was a typical one of rupture of the bile passages, and it showed that laparotomy in such cases should not be delayed too long, as in a few weeks so many adhesions take place in the abdomen that any operation that must be performed is attended with much more risk than if operated on early.

Hr. Bessel related a case in which there was not only rupture of the hepatic duct, but also a double rupture of the colon, a tear in the gastro-colic ligament, and rupture of the kidney. The patient, who was extremely collapsed, was only operated on on the second day. The rent in the colon was kept closed by prolapse of the mucous membrane, bile streamed continuously out of the rent in the bile passage. As this could not be closed by suture, a drain was inserted. Notwithstanding the severity of the injuries, the patient recovered.

Hr. Hildebrandt also related a case of

Rupture of the Ureter.

A man fell from a scaffolding at the height of the second storey of a house. He fell on his right side and at once felt pain. A tumour formed near the right kidney, which at first became smaller, but began to grow again in a few weeks ; there were also vomiting, pain and a feeling of fulness in the abdomen. After three months a tumour the size of a man's head could be felt of firm elastic consistence. The urine which at first contained blood became clear. The left ureter permitted a sound to pass easily, but in the right an obstruction was met with. The cyst was opened up by nephrotomy ; it was firmly adherent to the peritoneum, so that it was not possible to dissect it from it. The right ureter was torn transversely across, and there was an opening in the pelvis of the kidney. The kidney, which was very atrophic, was extirpated, the sac, which could only be extirpated in part, was drained, and the wound with the exception of the drain opening was closed. Recovery.

AUSTRIA.

Vienna, Jan. 13th. 1907.

Osteitis Syphilitica.

Lang brought a case of osteitis of the cranium before the members of the Gesellschaft, where a gumma had eaten through the bony structure in 1903. After two sittings under chloroform the necrosed portions of bone were removed and the wound subsequently healed. The brain substance is now covered over with a thick tense membrane, through which the pulsations of the brain can be felt. Soon after the operation he returned to work, the result of the operation causing no inconvenience.

Foreign Body in Bronchus.

Kahler presented a 4-year-old child from whom he had removed a bean from the right bronchus assisted by the bronchoscope. The bean was early observed to be firmly impacted in the right side immediately below the separation to the right and left, and covered with a thin flap of membrane lying over from the left side. With a pair of long forceps the bean was seized and extracted. Kahler has had 90 of these cases, and has successfully treated 50 per cent. by this means, but the others had to have tracheotomy performed.

Tetany and Adrenal Bodies.

Königstein reminded the members of a case he showed them half a year ago where the adrenals were found in a morbid condition, and which he then associated with the tetany present. He was now able to confirm this with another case which he would show them where the adrenal bodies only showed the morbid change present at the *post-mortem*.

The child was nine months old when received into hospital suffering from well-marked symptoms of tetany. The adrenal bodies when examined in the *post-mortem* room with the naked eye, or when tested with hæmatoxilin-eosin showed no changes in the organ, but when a small portion was examined under the microscope the same results were obtained as in the former cases. In the cells a large quantity of the substance dyed like glycogen. The cloudy condition in this case was not so intense as in the former one, but sufficiently distinct to confirm his earlier opinion on the subject that the cortex and not the glandular substance was the cause of tetany.

Myxo-Idiocy.

At the Gesellschaft for Innere Medicin, Lateiner presented two children, a boy æt. 3½ and a girl æt. 4½ years, the result of consanguinity. They measured 86 and 88 centimeters and weighed 13.80 and 14 kilogrammes each. The girl had all the symptoms usually associated with myxœdema, such as lipomatous growths on the shoulders and abdomen, while the boy had more marked mucous changes. Both children had a decided increase of the thyroid gland horizontally below the larynx. In the boy's case a round swelling like a plum having the consistence of a lipoma could be felt. These cases were pointed out as uncommon in the literature of myxœdema, and added a new feature to congenital myxo-idiocy. Rosenberg remarked that the same condition often arose when the gland was rudimentary, and might be designated the hypoplastic form, as they had all the myxœdemic symptoms in proportion to their smallness.

Infantile Giant.

Knoepfelmacher showed a child, æt. 6, 146 ctms. long, the upper extremities 57, and the lower extremities 67 ctms. in length. ; the hand was 15 and the foot 16 ctms. long. The whole skeleton was of great size and well proportioned. The muscles were strong and firm like an adult, and the genitals enormously developed, as at puberty, although the child was an imbecile. Zappert had recently one very similar, which he treated with ovarian tablets with astonishing results. The brain and functions of the body rapidly improved, and the giant growth was checked.

Indigo-Uria.

Hecht recorded the history of a case, where the urine was perfectly green when newly passed, and had an indigo reaction with chemicals. According to the *post-mortem* by Wang, the oxidation seemed to have taken place in the kidney, as he could find little colouring of blue in the sections of the diseased organ.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Annual Report of the Edinburgh Royal Infirmary.—During the year ending, 10,430 patients were admitted, the total number under treatment being 11,216, an increase of 200 as against last year. The average duration of treatment was 27.7 days, as compared with 28.3 in 1904-5. The percentage of deaths was 7.36, or, deducting those which took place within forty-eight hours of admission, 5.75, an increase of .04. During the year 37.235 out-patients attended the various departments of the infirmary. The total ordinary income was £33,695, and the ordinary expenditure £52,116, being £1,972 more than last year. The increased expenditure is accounted for by a rise in the number of occupied beds from 828 to 839, by the additional staff required to conduct the new surgical out-patient department, by the staff required for massage, and by the telephonic staff, and the growing use of the electrical department. Among the changes and additions during the year are the provision and equipment of a new electrical and a new bath department, the substitution of paid for unpaid nurses under the longer period of training, the reorganisation of the pathological, fire, and works departpartment. Among the economies effected have been a reduction in coal consumption, in maintenance and in medical expenditure, and cleaning. The legacies and donations for the year totalled £22,670, and the extraordinary expenditure reached £14,352—plumbing and new drainage, operating theatres, and surgical out-patient department being the main items. It is proposed to appoint an organising secretary for subscriptions whose time shall be devoted to stimulating interest in the Royal Infirmary. The reconstruction of the incidental delirium and medical out-patient departments have been under the consideration of the managers, but have been delayed for a year owing to more urgent matters demanding attention.

Rectorial Addresses in Edinburgh and Glasgow Universities.—The event of the week in the two sister Universities has been the delivery of the customary rectorial addresses. Of late years it has too often been the case that such occasions have afforded the rowdy elements of studentdom full scope for an exhibition of noisy horseplay, but this year a better order of things reigned, and the whole proceedings were unmarred by the slightest disturbance. It is to be hoped that the tradition having been reversed, the new order will establish itself, so that future Lord Rectors will deliver their addresses to audiences as courteous and appreciative as those of last week.

At Edinburgh, Mr. R. B. Haldane, K.C., M.P., secretary of State for War, delivered a masterly and humorous address on "the dedicated life," the theme being the duty which citizenship involves of directing the energies of the State towards great ethical ideals. He dwelt on the power of individuality, and on the function of the Universities in training thinkers who could plan and organise, who could carry out well-considered schemes for the advancement of humanity. As an illustration he took the case of Germany when she lay crushed after Jena, and showed how through the exertions of the galaxy of profound thinkers in Berlin, Jena and Weimar, the conception of the State was reconstructed, education, the key to all advance, was reorganised, and the military problem was solved. The labours of these men permeated the whole German people, and blossomed into full fruition after seventy years. After delivering his address, Mr. Haldane inspected the University Volunteers, and was subsequently entertained to luncheon in the University Union. The proceedings terminated in a torch-light procession.

Mr. Asquith was installed as Lord Rector of Glasgow University on January 11th, and addressed the students on "Ancient Universities and the Modern World." Of the origin of Universities, he spoke especially of their cosmopolitan and Catholic nature, and of their object in developing knowledge for its own sake, without, however, dividing it from practice; the steam engine and "The Wealth of Nations" were the most magnificent presents statesmen, financiers, and industrialists had ever received, and both came to them from within the walls of Glasgow College. The main topic of his address was the value of properly directed literary and historical studies; for instance, no more valuable lesson could be learned than from the study of the golden age of Rome. The best gift of the University to its students was the power, in after years, when they were immersed in the practical work of life, of keeping the windows of the mind and soul open to air and light.

After the address, Mr. Asquith attended a smoking concert given in his honour, and then drove to Queen Margaret College, where he addressed a few words to the women students.

BELFAST.

TUBERCULOSIS IN PIGS.

A case of considerable interest and importance was in the Custody Court of Belfast last week, when a firm of provision dealers sued the Corporation for £4 3s. compensation for the carcase of a pig seized by a Corporation official and destroyed by order of a magistrate, on account of the presence of tubercle. The interesting point is that the evidence of the disease was confined to the submaxillary glands, all the internal organs having been removed in the country, where the animal was killed, before bringing the carcase to Belfast for sale. The question at issue was whether a small spot of diseased tissue in a gland justified the destruction of the whole carcase, and of course in Belfast, where thousands of pigs are converted into ham and bacon every week, the question is of great importance. The obvious reply is that a more thorough inspection of the whole carcase should be made before the internal organs are removed. But unfortunately under present methods of working this would cost more than the value of the animal. The same difficulty does not arise with the carcases of cattle and sheep, for the whole animal is presented for sale, nothing being removed, and a complete inspection is easily made. The Bench dismissed the case on its merits, and were prepared to state a case.

LETTERS TO THE EDITOR.

FREE OR SOBER.

To the Editor of The Medical Press and Circular.

Sir,—May I venture to draw your attention to a serious and growing abuse? Many of your readers will remember how a famous Bishop of Peterborough once expressed the opinion that, for his part, he would rather the people should be free than sober, and it is, at any rate, becoming more and more evident that it is impossible by any practicable amount of coercive legislation to prevent a tolerably free people from getting drunk if determined so to do. This fact is being well brought out in a series of admirable articles in the *Times* on the licensing question. The crusade against drink and the public-house has led to an enormous increase in drinking clubs. A nominal subscription constitutes membership; the frequenters can stay and drink as long as they please, and can even be accommodated for the night if too drunk to leave. Then, again, in many towns the sale of spirits and bottled beer for consumption at home has increased enormously and women who dare not for shame frequent the public-house meet together to indulge in alcoholic drinks instead of tea. The chemists do a large trade in "nips," and in some places it is certain that these nips are often composed of vile substances such as methylated spirit. The *Times* does not speak of the enormous trade in "tonics" advertised under various fanciful names, and all alike containing a large percentage of alcohol. Although often described as made from fine wine, there can be no doubt that these preparations are too often merely concoctions of rude alcohol, sweetened, flavoured, and made pleasant to the taste. These appeal to women secret drinkers above the poorest classes. Such women can, without shame, obtain from the chemist supplies of their favourite "tonic," although they dare not send for or openly purchase a bottle of wine or spirit from a public-house or a dealer. Many women become habitual drunkards from being gradually led on to find solace in bogus tonics containing alcohol, and within the past few weeks there was notified the death of a lady, a prominent professed active teetotaler, in which the autopsy demonstrated alcoholic disease of the liver. It was elicited in inquiry that she had for a long time been in the habit of dosing herself with a certain "tonic," whilst ignorant of the fact that it contained a large proportion of alcohol. This illustration is sufficiently suggestive of the harm in so many different directions that the unrestricted trade in fraudulent quack medicines is inflicting upon the people.

I trust that the subject may give rise to a correspondence in which the views of your medical readers may be freely expressed. The time is ripe enough, in all conscience, for such a discussion.

I am, Sir, yours truly,

H. S.

SERUMS, VACCINE, AND HOMEOPATHY.

To the Editor of The Medical Press and Circular.

Sir,—If it is not too late to comment on some editorial remarks in your issue of December 26th, I shall be obliged if you will allow me a little space. The Christmas holidays put me in arrears with my journals, or I should have taken the opportunity earlier.

In your note on the annual meeting of the British Homeopathic Association, you say:—"It is entertaining to read that the present-day use of serums, vaccines, and emulsions brings the rest of the profession nearer to homeopathy." And you add:—"We remember some time ago a homeopath claiming diphtheric antitoxin for their own."

I think, sir, you will allow that if there are two men living who know more about diphtheria antitoxin in particular, and serums in general, than anyone else, these two men are Dr. Roux and Professor von Behring. It is on record that Dr. Roux has admitted that "there is truth in the Hahnemann method of curing likes with likes." And now Von Behring has published a statement which confirms this, and shows that it is the Seropaths themselves—if I may use the word—rather than the homeopaths who are proclaiming that the new practice is really homeopathy, with the infinitesimal dose thrown in. In his recent work (1906), entitled "Modern Phthisio-genetic and Phthisiotherapeutic Problems in Historical Illumination," Von Behring, speaking of the tuberculin treatment of phthisis, says the "scientific principle" of it is not established, but:—

"In spite of all our scientific explanations and experiments regarding small-pox vaccination, Jenner's discovery remained an erratic block in medicine till the biochemically thinking Pasteur, devoid of all medical class-room knowledge, traced the origin of this therapeutic block to a principle which cannot be better characterised than by Hahnemann's word, 'Homeopathic.'

"Indeed, what else causes the epidemiological immunity in sheep, vaccinated against anthrax, than the influence previously exerted by the virus, *similar* in character to that of the fatal anthrax virus? And by what technical term could we more appropriately speak of this influence, exerted by a *similar* virus, than by Hahnemann's word, 'homeopathy'?

"I am touching here upon a subject anathematised till very recently" (I fear, sir, the present might also be included)—"by medical pedantry; but if I am to present these problems in historical illumination, dogmatic imprecations must not deter me. They must no more deter me now than they did thirteen years ago, when I demonstrated before the Berlin Physiological Society the immunising action of my tetanus antitoxin in infinitesimal dilution. On this occasion I also spoke of the production of the serum by treating animals with a poison which *acted the better the more it was diluted*" (italics mine), "and a clinician, who is still living, remonstrated with me, saying that such a remark ought not to be made publicly, since it was grist for the mill for homeopathy. I remember vividly how Dubois-Reymond, who during the progress of the demonstrations and discussions had become drowsy, suddenly sat up all attention when I replied in almost these words:—'Gentlemen, if I have set myself the task of rendering an incurable disease curable by artificial means, and should find that the road of homeopathy led to my goal, I assure you, dogmatic considerations would never deter me from taking that road."

I think, sir, you will admit that homeopaths have plenty of outside justification for the claim they make, a claim which seems to have caused you some entertainment.

I am, Sir, yours truly,

John H. Clarke.

8, Bolton Street, W., January 13th, 1907.

NOTES AND COMMENTS.

To the Editor of The Medical Press and Circular.

Sir,—The readers of The Medical Press and Circular no doubt appreciate the attention that is given in your journal to those questions which deal with the various delusions and humbugs, more or less fraudulent, to which an imaginative and ignorant public is exposed at all times in matters medical. In this week's Medical Press and Circular four out of the eight articles deal with questions of medical humbug: "Quacks and Patent Medicine Vendors," "A Bonesetter's Challenge," "Hospital Abuse, &c.," and "Dr. Doyen's Cancer Serum," are each of them subjects which in your opinion require attention. Under the heading "Notes and Comments" the part played by "a well-known monthly medical journal" is the subject of comment, as the conduct of proper practitioners is fairly criticised by you. Your remark that "the patience of the general practitioner is nearly exhausted" in regard to hospital abuse may be extended in many directions, and special contributions might be made by your readers and others in this class of subject under the special heading of "Notes and Comments," and which would have far more effect than the work of any Royal Commission.

It was painful to read the report of that meeting at which the Hon. Sydney Holland charged Sir Henry Burdett with wilful mendacity. It is needless to make any remark upon this occurrence, except that it is probable it would not have occurred at a meeting of only qualified professional men. Their sense of mutual regard and respect is happily more cultured than among some men, when engaged in discussion.

I am, Sir, yours truly,

One of your Readers.

OBITUARY.

JAMES ROSS, M.D.

We regret to announce that Dr. James Ross, physician and surgeon in the Clitheroe district, died early on the 5th inst. at his residence, Meadow Bank, Chatburn, aged fifty-five years. The cause of death was pneumonia, and the end was somewhat sudden. He was a well-known medical gentleman throughout North-East Lancashire, having formerly practised in Burnley. He leaves a widow and five children. Deceased was medically educated at Queen's College, Belfast, whence he graduated M.D.R.U.I. in 1874.

SURGEON-GENERAL RICHARD CHAPMAN LOFTHOUSE.

THE death is announced of Surgeon-General Lofthouse, at the age of 74, on January 10th at Harrogate. Appointed an assistant surgeon in July, 1854, he served with the 10th Hussars in the Crimea from April, 1855, his service including the siege and fall of Sevastopol, the battle of Tchernaya, and the affair near Kertch. Joining the 14th Light Dragoons in India in 1857, he served through the long operations of Sir Hugh Rose and Sir R. Napier in the suppression of the Sepoy revolt in 1858 and 1859, including the sieges of Rahutghur and much other active service. He was mentioned in despatches and thanked by the Director-General Army Medical Department. He was promoted surgeon in 1867, surgeon-major in 1873, and deputy-surgeon-general in 1884, in which year he retired.

SPECIAL ARTICLE.

LUNACY IN IRELAND.

THE annual report of the Inspectors of Lunatics for Ireland (a) hardly attracts as much interest as usual, on account of the recent publication of a Supplementary Report dealing with the Increase of Insanity in Ireland. It is stated that there were on January 1st, 1906, 23,365 lunatics within the official knowledge of the Inspectors. This shows an increase of 369 during the year, as against 202 in the previous year. The decrease in the number of lunatics in workhouses has continued, so that the number in these institutions is now the lowest during the past twenty-five years. Only 14 per cent. of the total number of lunatics are now in workhouses, whereas the proportion in 1880 was 27 per cent.

Instructive tables are given, showing in series of numbers of lunatics under care, and the proportion per 100,000 of the population, for each year since 1880. The actual number of insane under care has increased from 12,982 to 23,365, and the proportion per 100,000 of the population from 250 to 532. If to the number of insane under care on December 31st last be added the number of lunatics and idiots at large according to the last census, the total (27,233) represents 620 per 100,000 of the population, or one person of unsound mind in every 161 of the population.

Although the number of insane persons has shown a steady increase, there has been since 1903 a slight falling off each year in the number of admissions to asylums. The respective figures for 1903, 1904, and 1905, are 3,950, 3,910, and 3,772.

The total number of patients discharged during the year was 1,876, viz., 1,022 males and 854 females. Of these 1,389 (722 males and 667 females) were discharged recovered; showing a decrease of 29 on the number for the previous year. The percentage of recoveries on the admissions was 36.8, being .5 per cent. higher than that for the previous year.

The number of deaths during the year was 1,450, of which 809 were males and 641 females. This shows an increase of only one on the numbers for the previous year, the males having increased by 57 and the females having decreased by 56. The death-rate per cent. of the daily average number resident was 7.7, viz., 7.9 amongst the males, and 7.4 amongst the females. The general rate was .1 lower than that for the previous year—the rate in the case of the males being .4 higher, and in the case of the females .8 lower. Six of the deaths were by suicide; four resulted from misadventure; and, in two cases (a male and a female), the patients were killed by fellow-patients.

The percentage of deaths on the daily average number resident in each district asylum during the years from 1896 to 1905 is given. From this table it will be seen that the highest death-rate during 1905 was 11.2 per cent. in Maryborough, and the lowest 5.0 per cent. in Mullingar Asylum. The highest rate was 1.5 per cent. less than the corresponding rate in the previous year, which was 12.7 in the Sligo Asylum, while the lowest rate was .1 lower than that for the previous year, viz., 5.1 in the Kilkenny Asylum.

In 238 cases the cause of death was verified by post-mortem examination. Of the deaths 407 were due to phthisis, 55 to general paralysis of the insane, 30 to dysentery or colitis and diarrhœa, and 18 to typhoid fever.

The Inspectors again draw attention to the neglect of pathological research in most Irish asylums, and point out that in this respect they are far behind the more important asylums in England, Scotland, France, Germany, Italy, America, and New South Wales. They suggest that some arrangement might be come to—at all events in the more remote districts—by which a number of asylums might combine in providing a common laboratory, and in appointing a pathologist who would give instruction to the junior members of the staff, and carry out the more important investigations. Such an arrangement for the furtherance of the study of mental disease was contemplated and authorised by the provisions of Section 5 of the Act 1 Edwd. VII., cap. 17.

The financial tables should be of great value to those interested in asylum management. They exhibit —as is to be expected—wide variations, both in the cost per head of the several classes of expenditure, and in the net cost per head for maintenance. Thus the cost per head for salaries and wages among the district asylums varies from £3 17s. 8d. in Ballinasloe to £7 4s. 2d. in Londonderry; for provisions and groceries, from £6 18s. 9d. in Downpatrick to £10 9s. 11d. in Cork; for wines, spirits, and beer, from less than ½d. in Armagh to 6s. 1d. in Clonmel; for tobacco and snuff, from 1s. 10d. in Maryborough to 7s. 9d. in Kilkenny; for medicines and appliances, from 7d. in Antrim to 6s. 7d. in Cork; for clothing, from 15s. 8d. in Carlow to £3 3s. 1d. in Mullingar; for fuel and light, from £1 10s. in Clonmel to £3 2s. 9d. in Mullingar. The net cost per head varies from £19 8s. 9d. in Castlebar to £26 16s. 5d. in Ennis.

Full particulars are given of the inspections of the various asylums and licensed houses.

(a) "Lunacy—Ireland." The Fifty-fifth report (with appendices) o the Inspectors of Lunatics (Ireland), for the year ending December 31st 1905. Dublin: H.M. Stationery Office, 1906. Price 1s. 1d.

REVIEWS OF BOOKS.

LINDSAY ON DISEASES OF THE LUNGS (a)

THE favourable reception of the first edition of his "Lectures on Diseases of the Chest" has given the author an opportunity of producing an enlarged second edition entirely devoted to pulmonary diseases, the lectures on heart disease which were previously incorporated being now omitted, and several new chapters on lung diseases being added. The work as it now stands is a fairly complete compendium of our clinical knowledge of lung disease, presented in an attractive and readable form, and made more interesting by the personal tone which the writer's experience enables him to add to its pages. The first four chapters are devoted to a description of the physical examination of the thorax, including a summary under each heading of the causes and conditions underlying the various abnormalities that may be revealed. Throughout these chapters the author keeps the practical examination of a patient clearly before his mind, and we are glad to notice that, while using every recognised means of examination and dogmatically stating the value of each sign where value in his opinion lies, he refuses to base definite opinions on any finical distinctions between nearly allied signs or equivocal phenomena. Thus in discussing râles and rhonchi he freely admits that our present classification is unsatisfactory, and that a "consonating râle and a crepitant râle are not usually differentiated," and further on quotes, apparently with some approval, Sahli's statement that ægophony, pectoriloquy and bronchophony cannot always be distinguished. Chapters on pulmonary symptoms, including those that are met with in other parts of the body in connection with lung disease, follow, and then a most useful chapter on the naked-eye and other characteristics of the sputum. This brings what we may call Part I. of the book to a termination, the remainder of the volume, about 450 pages, being occupied with a systematic account of the different diseases of the pleura and lung, the largest single section of this latter part being given, as might be expected, to an account of pulmonary tuberculosis in all its phases. In considering the treatment of this disease, the writer is at his best, and we recommend a careful perusal of his teaching in this respect to all practitioners. The comparative uselessness of the many treatments which are introduced yearly, such as intratracheal injections and intravenous injections, is at once stated, and thus the way is paved for a candid, thorough, and common-sense discussion of the problem. Under Pneumonia, also, a good critical account of the therapeutics of that disease is to be found, and a much-needed warning note is sounded on the question of over-feeding. In conclusion, we can cordially recommend the work, and we offer our congratulations to the author on its appearance.

(a) "Lectures on Diseases of the Lungs." By J. A. Lindsay, M.B., Professor of Medicine, Queen's College, Belfast. Second Edition, enlarged and re-written. Pp. 520. London: Bailliere, Tindall and Cox. 1906. Price 10s. 6d.

ASH ON HYPNOTISM. (*a*)

Hypnotism still remains to most medical men a subject on which judgment should be reserved. That hypnotism is an ordinary phenomenon of the mind is not now in doubt; no one believes in dual personalities except such as like picturesque explanations for things not fully understood. But that hypnotism is of so much value as to be worthy of a place alongside ordinary therapeutical methods is still questionable, and we do not think Dr. Ash's book will do much to convince those seeking assistance. The most we ever find about hypnotism is that it is a measure pregnant with possibilities, and that occasionally with a suitable subject a lucky hit is made. It is claimed that hypno-therapeutics are still in their infancy—a perfectly reasonable plea; but if hypnotism is so little understood, the responsibility of using it on the subjects of disease is not without a grave aspect. Dr. Ash deals with the technique of inducing hypnosis and gives certain practical hints; this part of the book will be useful to those who wish to launch out into experiments.

LITERARY NOTES.

We have received Herbert Fry's Royal Guide to the London Charities for 1907. As usual, it is full of well-sifted information on the subject with which it deals, and it remains as valuable as ever for the medical man who wishes to know how to deal with the various classes of poor patients which private charity cannot cope with. Fry's "Charities" is a synonym for accuracy.

⁂

The prize of £8,000 instituted by the King of the Belgians is likely to cause some difficulty in its bestowal. It was promised by His Majesty to the discoverer of a proved remedy for Sleeping Sickness, and as Dr. Vancampenhout, a Belgian scientist, is reported to have actually cured two men afflicted with the disease, he is a claimant. Dr. Koch's recent discoveries in Africa have rendered considerable service to the work of research, and the question arises, to whom shall the prize be awarded. Both seem entitled to it, and the authorities are at a loss to know to whom they shall offer it.

⁂

At the present time, when the terrible wastage of infant life is attracting so much attention, a volume which the Caxton Publishing Company announce for immediate issue will appear very opportunely. The work is by Professor Budin, the famous obstetrician of Paris University, whose lectures are well known to the readers of this journal. The work, which is translated by Dr. W. J. Maloney, with an introduction by Sir A. R. Simpson describes in elaborate detail, with numerous coloured graphs, a method of treatment which has already attained marvellous results in France in reducing infant mortality.

⁂

The "Lemco" Company are at present making an offer which will doubtless prove attractive to householders, especially such as use Lemco in their *menage*. The offer takes the form of a present of Mrs. Beeton's well-known book "Household Management," to such as send on or before March 31st next coupons representing five pounds weight of Lemco. Each jar contains a small coupon under the capsule, and it is these coupons that are to be sent. The Company have long gone on the principle that the more cooking was cultivated, the more Lemco would be in demand, and they have given away some millions of cookery books already. At present, one called "Lemco Dishes for All Seasons" can be obtained by writing name and address on a Lemco wrapper, and as it contains *inter alia* some twenty recipes for sick-room dishes it is likely to be specially useful to medical men. The address of the Company is 4, Lloyd's Avenue, London, E.C.

⁂

Among the diaries received for 1907 is the popular Wellcome's "Photographic Exposure Record and Diary," which has undergone its annual revision, no efforts having been spared to bring the information right up to date. A glance at the table of plate speeds will be sufficient to convince the reader that the compilers have lost no time in adding particulars of the latest reliable plates and films. An entirely new series of examples illustrates the article on exposure, and increases its value, and as a large number of medical men resort to photography for pleasure or for professional purposes, this will be greatly appreciated. The usual diary and memoranda pages are retained, as in previous issues, but increased space is provided for the record of negative exposures, there being now room for 336 entries. Two editions are issued as usual one for the Northern Hemisphere and one for the Tropics and Southern Hemisphere. The familiar art green canvas binding has been retained, and the price is still 1s.

A fourth edition of Hadden's "Pocket Vocabulary of Medical Terms" has just been published by Messrs. Hadden, Best, and Co., revised by Dr. Philip Cowen and Mr. Herbert Davey. The book is intended for the use of registrars, poor-law officials, and others who in the course of their business have to deal with medical terms. The volume has been brought thoroughly up to date, and is now the best book of its kind in the market.

⁂

A dainty booklet, entitled "A Few Hints on the Care of Children at Sea," reaches us from Messrs. Bale, Sons, and Danielsson. It is written by Dr. Samuel Synge, and gives, within the compass of thirty pages, many useful suggestions which mothers and nurses are sure to appreciate. The price of the booklet is one shilling net, and medical men who have patients going on a voyage will find this a useful guide, as it is full of valuable hints which only a writer with experience of such matters can give.

(*a*) "Hypnotism and Suggestion: A Practical Handbook." By Edwin Ash, M.B., B.S.Lond., M.R.C.S., sometime Demonstrator of Physiology in St. Mary's Hospital Medical School, &c. London: J. Jacobs. 1906. 4s. net.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL LITERATURE.

Use of Intercutaneous Stitch in Plastic Operations on the Perineum.—Anspach (*Amer. Jour. of Obst.*, December, 1906). The intercutaneous stitch had given such excellent results in cœliotomy wounds, the writer began to use it in posterior colporraphy operations. The usual Hegar or Emmet's operation is performed up to the insertion of the external sutures, and then these external sutures are introduced and brought out just within the skin borders of the denudation. After these sutures are tied, the intercutaneous (subcuticular) stitch is employed, running from above downward. The advantages claimed are as follows:—The crown sutures are buried, catgut may be used, and the pressure necrosis and the pitting of tissue commonly observed are entirely avoided. F.

Prolapsed Ovaries.—Gardner (*Amer. Jour. of Obst.*, December, 1906). A very large proportion of prolapsed ovaries occur in association with retrodisplacements of the uterus, and when we take into consideration the frequency of retrodisplacements, and the fact that about 25 per cent. of them are congenital, one of the most prolific causes of prolapsed ovaries is accounted for. The direct cause of the prolapse, both in cases associated with retrodisplacements, but more particularly in those in which the uterus maintains a normal position, is the elongation of the ovarian ligament. Another condition found is that nearly all prolapsed ovaries are enlarged, either as a cause or result. The symptoms complained of are pain in the pelvis in one or both ovarian regions, at times radiating down the legs, and invariably increased by the patient being on her feet; pain in sacral region, radiating upwards, and associated with paroxysmal occipital headache is very common. A very characteristic symptom is a severe paroxysmal intermenstrual pain in the pelvis. Dysmenorrhœa is usually severe, and usually begins before the flow, and lasts till a day or more after it has ceased. In nulliparæ it usually dates from the beginning of menstruation; in those who have borne children from some time subsequent to the last confinement. Nervous symptoms, painful coition and defœcation are also common. The writer next mentions the treatment by means of vaginal tampons and pessaries, by shortening the infundibulo-pelvic ligament, by stitching the ovary to the peritoneum at the pelvic brim, by bringing the ovary through an opening in the broad ligament, and fastening on the anterior surface, and, lastly, mentions shortening of the elongated ovarian ligament by a couple of fine silk stitches passed between the ligament near the ovary and the back of the uterus close to its junction with the other end of the ligament, as the treatment he has found most successful. If there is an associated retrodisplacement the operator can then proceed to do the operation of choice for its correction. F.

Contraction and Shortening of the Utero-Sacral Ligaments: A Suggestion as to Etiology and Treatment.—Craig (*Amer. Jour. of Obst.*, December, 1906). This paper embodies the results of personal observation in a certain number of cases of such a character as to lead the writer to consider the results worthy of confirmation or refutation by others. In a certain proportion of the cases in which the utero-sacral ligaments are found contracted, thickened and sensitive to the touch, they are so as the result of an active contraction of their muscle fibres, the object of which contraction is solely the defence of an inflamed cervix, aiming to draw it upward and there fix it, so lessening its irritation by the ordinary bodily and respiratory movements and minor traumatisms. This defensive contraction usually is found in connection with one particular form of cervical inflammation, namely, endotrachelitis. Why it does not occur in all cases of swollen, eroded, lacerated cervices the writer has been unable to determine, unless it be due to the fact that such conditions are not usually sensitive nor easily affected by traumatisms of a minor degree. If this contraction of these ligaments is merely the symptom of an endotrachelitis, when this condition is cured the contraction should subside, and here the writer quotes a case to bear out the statement. His treatment of the cervix consists of curettage in accordance with the technic and with the instruments described in a paper in the *New York Med. Jour.*, January, 1906. F.

Pubiotomy and its Relative Indications.—Moutgomery (*Amer. Jour. of Obst.*, December, 1906). The history of pubiotomy is directly connected with that of symphysiotomy, from which procedure it has been evolved, and over which it now seems to be a very distinct improvement. Gigli, in proposing the substitute in 1894, sought to present a linear osteotomy made through the pubic bone at a point where the soft parts would be less liable to damage, and permitting of the same pelvic enlargement as the older procedure. The lack of union and defective gait he has sought to replace, and bring the risk of wounding the bladder and clitoris to a minimum. The superior results obtained, as shown by statistics produced by the writer and Dr. Gigli, have won enthusiastic support for the procedure from Doderlein, Duehrsen and others in Germany, and the technic of the operation has been variously modified by them. In a few years it will be found that the Gigli wire saw and carrier will almost entirely replace the use of craniotomy instruments, the latter being reserved for use only on the dead child. An indication, other than contracted pelvis, for the performance of pubiotomy is the occurrence of an impacted mento-posterior face presentation in which a change of position cannot be effected by the Volland or other procedures. Pfannenstiel has advocated the use of this operation along with the production of premature labour at about eight to eight and a half months. With regard to the technic, the procedures divide themselves into three groups—the open method, the partly subcutaneous, and the wholly subcutaneous. The after treatment is exceedingly simple; a strip of adhesive plaster encircling the pelvis has proved sufficient for immobilisation in most cases. F.

The Employment of Scopolamine and Morphia During Labour is considered by Lehmann (*Zeitsch. für Geb. und Gyn.*, Bd., LVIII., Hft. 2), who used it in 70 chosen cases, the women all having normal labour. The first injection was given as soon as strong painful contractions set in, and was repeated when painful contractions again made themselves evident, but this had never to be done for at least an hour. Sometimes after another three hours a third injection was required. The dose each time consisted of scopolamine hydrobrom. 0.0003, with morph. mur. 0.01 dissolved in 1g. of distilled water. Forty-five women received two injections, thirteen three injections, and twelve, owing to the rapidity of their delivery, only one injection. The labours lasted from one to forty-three hours. As regards the influence over the pain, the labour in 61.6 per cent. of the cases was completely painless, in 37 per cent. the suffering was very much relieved, and in only 1.4 per cent. it had no effect. 13.3 per cent. of the children were born in a state of asphyxia, 10 per cent. had very shallow respiration, and the remaining 76.7 per cent. were perfectly normal. The proportionately large number of children born in asphyxia must be considered the result of poisoning of the ovum from transmission of the drugs through the placental circulation. As regards the effect upon the strength of the contractions, the results are exceedingly favourable, since weak pains were only observed in 16.3 per cent. of the cases. In 25 per cent. the labour was accelerated, and in 58.7 per cent. the power of the contractions was quite unaltered. The author comes to the conclusion that this method must be regarded as a most important addition to our means of relieving or removing the suffering during labour, but its great disadvantage lies in the increase of asphyxia of the infants. Its employment should therefore be restricted for the present. G.

The Lower Uterine Segment.—Aschoff (*Zeitsch. für Geb. und Gyn.*, LVIII., Hft. 2) says that all the many different opinions on the lower uterine segment are due most of all to the fact that the various authors wish to recognise the cervix as being different from it, and that the exact boundaries of the lower uterine segment have not yet been defined. In opposition to the macroscopical division of the uterus into two parts, the corpus and cervix with the frontier at the internal os, it must be considered, from the microscopical examination, as consisting of three parts: the body of the uterus, with its distinct corporeal mucous membrane, the upper third of the cervical canal, which is lined with mucous membrane resembling that of the body, and which the author calls the isthmus, and the lower two-thirds lined with typical cervical mucous membrane—the cavity of the cervix. The body of the uterus and the isthmus are divided from one another by the orific. int. anatomicum, the internal os of the uterus according to the old definition, and the isthmus and cavity of the cervix by the orific. int. histologicum—the internal os of the cervix. Among these three parts of the uterus the isthmus is the lower uterine segment. When pregnancy occurs the body of the uterus is completely taken possession of for the accommodation of the ovum and the isthmus also to a varying degree. The upper border of the lower uterine segment, the contraction ring, corresponds to the internal os of the uterus, and the lower border in the majority of cases lies just above the internal os of the cervix, that is the boundary between the cervical mucous membrane, and the mucous membrane resembling that of the body. G.

Vaginal Hysterectomy for Total Prolapse of the Uterus.—Kirchgessner (*Zeitsch. für Geb. und. Gyn.*, Bd. LVIII. Hft. 2) says that this operation, in combination with a plastic operation on the vagina, when such was required, has been performed on forty women in the Würzburger Frauenklinik from 1892 to April, 1905. Three women died in the hospital after the operation, but only one death could be looked upon as the direct result of the operation. As regards the permanency of the cure, it was possible to keep thirty-two cases under observation, twenty-six of them being examined from time to time in the hospital. In twenty-six cases, *i.e* 81.25 per cent., permanent cure resulted; in four cases, *i.e.* 12.3 per cent., there was a partial recurrence, and in two cases, *i.e.* 6.25 per cent., there was a large recurrence. Several months to eleven years had elapsed since the operation In the majority of the cases the ages of the patients were between 45 and 65. G.

A Classical Case of Chorio-epithelioma Malignum is recorded by Czyzewicz und Nowicki (*Monatssch. für Geb. und Gyn.*, Bd. 24, Hft. 4). The patient, æt. 27, had aborted four months before they saw her, and had been bleeding continually since. The uterus on examination was found to be about the size of a man's fist, soft like dough, and not painful. The internal os was closed. There was considerable bleeding; the right ovary somewhat enlarged. Shreds of soft tissue were removed by the curette, and microscopically thev increased the suspicion that it was a malignant growth. The bleeding continued. The patient was again curetted, and as the bleeding did not then stop, the removal of the uterus was decided upon. Before this was done the patient had a severe attack of internal hæmorrhage, which compelled an immediate laparotomy. The hæmorrhage was now found to be coming from a small perforation of the enlarged ovary. Owing to the serious condition of the patient, the ovary alone was removed. Microscopical examination of it revealed chorio-epithelioma malignum. The immediate extirpation of the uterus was, of course, now decided upon, and again before it could be done the patient developed a right-sided croupous pneumonia, which, however, ran a normal course. The uterus was then removed per vaginam. The patient recovered very well at the beginning, then she got an attack of hæmoptysis, and one month later she died from gradual loss of strength. The autopsy revealed a dissemination of the chorio-epithelioma throughout the whole body. From this case the authors come to the conclusion that the microscopical diagnosis of a chorio-epithelioma malignum may in some cases present practically unsurmountable difficulties, and that in such cases one should not always demand an exact microscopical diagnosis before hysterectomy is decided upon. The clinical symptoms are of much more value. The authors conclude as follows:—(1) Malignant chorio-epithelioma grows and extends itself so rapidly that it may cause severe internal hæmorrhage. Probably the metastases grow more quickly than the mother tumour. (2) An intrauterine tumour which is not broken down, and which has a smooth surface, may remain unnoticed during curetting. (3) The clinical symptoms are of the most importance in the diagnosis of malignant chorio-epithelioma. A doubtful or negative microscopical result is not significant. (4) The internal genital organs must be removed by laparotomy, not through the vagina, as early as possible. G.

Total Prolapse of the Uterus in the 16th Year.—Sutter (*Monatssch. für Geb. und Gyn.*, Bd. 24, Hft. 4) records the case of a nullipara 18 years of age, who three years before he saw her got prolapse of a small portion of her vagina while doing some heavy work. This gradually became larger, and in twelve months had developed into a complete prolapse. On examination he found the patient badly nourished and anæmic. There was total prolapse of the vagina, and in it could be felt the round ligaments, the ovaries, and the small retroflected uterus. He amputated the hypertrophied portio, did an anterior colporrhaphy, and an Alexander-Adams operation. In four weeks there was a recurrence consisting of prolapse of a small portion of the posterior vaginal wall. The vagina had again become very wide, the uterus somewhat descended, but had remained well anteflected. Posterior colporrhaphy was performed, and by pulling the tissues and muscles well together a firm perineum was produced. The patient was discharged quite cured. The case is particularly interesting since prolapse at this age is so very rare. The author believes it to have resulted from the severe straining, the weak constitution, and before all the infantile state of the genitals. The combined effect of these was to produce a weakening of the pelvic floor, and the vicious circle was then completely closed by the hypertrophy of the prolapsed uterus. The prognosis in such cases is very bad. As regards treatment, the author lays most stress on the importance of making a firm pelvic floor with a particularly solid and thick recto-vaginal septum. To this fixation of the uterus must be added when there is retroflexion or the uterus is very mobile. G.

Many Years in Hospital.

Miss Ellen Elizabeth Carr, who was admitted to the Royal Hospital for Incurables, Putney Heath, in the year 1868, died the other day. after being an inmate of that institution for thirty-nine years. Although suffering from an incurable disease, Miss Carr maintained to the last a cheerful and contented disposition. At the time of her admission to the hospital it was not anticipated that she would live more than a few years. Her age at the time of her death was seventy years.

Medical News in Brief.

Royal College of Surgeons of England.

A quarterly meeting of the Council of the Royal College of Surgeons was held at the College on Thursday last, Mr. Henry Morris, President, in the chair.

The President stated that the vacancies on the Court of Examiners occasioned by the expirations of the periods of office of Mr. Wm. Watson Cheyne, C.B., and Mr. Frederic Eve would be filled up at the ordinary meeting of the Council in February, and that Mr. Cheyne did not propose to offer himself for re-election.

In reference to a letter from the Liverpool School of Tropical Medicine asking the views of the College upon a scheme for revising the course of instruction at the school, the Council expressed the opinion that so far as it relates to the subjects of tropical medicine, tropical surgery, and tropical hygiene, the scheme deserves approval. The Council also noted with satisfaction that it is proposed to afford greater opportunities for clinical observation than exist at the present time.

The Council adopted a report from the Committee of Management submitting the proposed arrangements with the London School of Tropical Medicine for the attendance of assessors from the Royal Colleges of Physicians and Surgeons at its examinations, and a further report from the same committee, which included the following recommendations, was also adopted: That Berkhamsted School, which is already recognised for instruction in chemistry and physics, be also recognised for instruction in biology; that the course of laboratory instruction in public health given at Guy's Hospital Medical School be recognised as fulfilling the conditions of the regulations for the diploma in public health; and that the Borough of Hornsey Isolation Hospital be added to the list of fever hospitals recognised for instruction in infectious diseases for the final examination of the Examining Board in England and for the diploma in public health.

Sir John Tweedy, on behalf of Mr. Sidney Young, presented to the College a transcription, made by Mr. Young, of the Book of Ordinances, dated 1435, of the Craft of Surgery of the City of London, with an illuminated frontispiece by Mr. Austin Travers Young, representing in proper colours the Arms given to the Craft by King Henry VII., in the year 1482. A report from the library committee recommending the provision of additional acommodation for the storage of books was adopted.

Government Report on Tropical Diseases.

The report of the Advisory Committee for the Tropical Diseases Research Fund for 1906 was issued last week in Blue-book form, which states that the revenue for the year amounted to £3,000, made up as follows: — Colonial Governments' contributions, £1,800; Imperial Government's contributions, £500; Indian Government's contributions, £500; Rhodes Trustees, £200.

The expenditure of the year was made up of the following grants:—£1,000 to the London School of Tropical Medicine; £500 to the Liverpool School; £750 to the University of London; and £500 to the Royal Society.

The grant to the Liverpool school was employed by the school for the payment of the salaries of a lecturer in economic entomology and parasitology, and of a lecturer in tropical medicine. The London school grant was devoted to the payment of the salaries of a combined teacher and investigator of protozoology and a combined teacher and investigator of helminthology, and to the provision of suitable apparatus. By means of the grant to the University of London there has been established a Professorship of Protozoology. The contribution to the Royal Society was employed on the research into sleeping sickness. All medical officers appointed to posts in the Crown Colonies or Protectorates are in ordinary circumstances required, before proceeding to the Colony or Protectorate, to undergo a course of three months' training at one of the Schools of Tropical Medicine. A longer period has been recommended, but the committee suggest that, if any step is taken, it should be on the lines of enabling those medical officers who are considered by the Colonial Government under which they serve to show exceptional promise, to attend a more advanced course of instruction on the first occasion of their being on leave of absence in England.

Scottish Poor Law Medical Officers' Association.

The annual report of this Association has just been issued. In it the grievances of members are referred to as having been brought before several members of Parliament, with the result that they gained the sympathies of an increased number of M.P.'s. In regard to the Royal Commissionon on Poor Law, the report states that evidence relating to Scotland is expected to be heard in June or July next, and that the chairman and secretary, along with the Scottish Committee of the British Medical Association, have had formulated a series of questions: (1) relating to the outdoor medical treatment of the sick poor; (2) relating to the indoor medical treatment of the sick poor, and (3) as affecting the general public. Joint action of the inspectors of poor, poor-law medical officers, and governors of poorhouses in Scotland had been taken on other matters which would be brought before the Commission, and they were unanimously of opinion that every poor-law medical officer should become a statutory official, only dismissable by or with the consent of the Local Government Board, as recommended by the Departmental Committee of the Local Government Board; and that Scottish poor-law officials be granted superannuation on similar lines to the Poor-Law Superannuation Act in England.

New Scholarships.

The Drapers' Company, one of the most celebrated City Guilds of London, whose generous contributions to medical institutions are so well known and appreciated by the profession, have now arranged that the munificent bequest of Mr. Thomas Appreece Soley, a past Master of the Company, shall be applied to the foundation of scholarships, each of the value of £60 per annum for two years, for the study at some place of advanced education approved by the Company, of medicine, theoretical or applied science, art, or law, or for the degree examination of some University of the United Kingdom. Boys between 16 and 18 years of age are eligible for these scholarships, which are renewable for a third year in special cases. The scheme also provides that the Company shall have the right to nominate a son or grandson between 18 and 23 years of age of a member of the Company for an exhibition of £70 per annum, tenable for three years at King's College, Cambridge. To both scholarships and exhibition a condition is attached, requiring the parent of the holder to satisfy the Company that his net income is insufficient to afford his son the educational advantages which will accrue to holders of scholarships and exhibition.

Health of the Navy.

The report on the health of the Navy for 1905 states that the returns for the force may be considered as very satisfactory. As compared with the averages of the last eight years, there are decreases in the proportions of invalidings and deaths, and this year's death ratios are the lowest recorded since 1856. The ratio of sickness per 1,000 shows a reduction of 119.29, as compared with the last eight years' ratio. The invaliding ratio, viz., 23.89 per 1,000, shows a decrease of 4.98, in comparison with the average for the last eight years. As regards the death rate the ratio per 1,000 was 3.9, showing a decrease of 1.42 when compared with the last eight years' ratio. The average number of men sick daily was 3,365.53, giving a ratio of 30.31 per 1,000, and showing a decrease of 5.44 in comparison with the last eight years' average. The total days' sickness on board ship and in hospital was 1,228,419, which represents an average loss of service from disease and injury of 11.06 days for each person, which is a decrease of 1.99 in comparison with the average of the last eight years. The total number invalided was 2,653, which is in the ratio of 23.89 per 1,000, and shows a decrease of 4.98 in comparison with the average of the last eight years. Of the above total 1,719 persons were finally invalided from the service. The total number invalided out of the Service was 1,941. Deaths numbered 433, a ratio of 3.9 per 1,000, showing a decrease of 1.42 per 1,000 as compared with the ratio for the last eight years. In the total force the average number of entries on the sick list for disease and injury per man was .73, a decrease of .02 in comparison with 1904. The average ratio of sickness per 1,000 daily was 30.31, which is a decrease of 1.04 as compared with 1904. The Channel Fleet shows the lowest sick rate. The total number of persons invalided was 2,653, of whom 2,445 were invalided for disease and 208 for injury. The death rate due to disease alone was 2.74, and that due to injuries was 1.15 per 1,000.

Society for the Relief of Widows and Orphans of Medical Men.

At the quarterly meeting of the above society held on Wednesday last, Dr. Blandford, President, in the chair, the deaths of two members were reported, and the resignation of one accepted. Three new members were elected. The deaths of two widows were also reported, one whose husband had paid a life subscription fee of £26 5s., and had received in grants £1,217, and the other £857, her husband having paid £21 in subscriptions. £536 had been distributed as an Xmas present among the annuitants of the charity. The sum of £1,275 10s. was voted for the half-yearly grants to the 48 widows and 21 orphans at present in receipt of grants. During the past quarter six letters had been received from widows of medical men asking for relief, but this had to be refused, as their husbands had not been members of the society. An application for relief was granted the widow of a member at the rate of £40 per annum. Membership of the society is open to any registered practitioner residing within a radius of 20 miles from Charing Cross. Full particulars may be obtained from the Secretary at 11, Chandos Street, Cavendish Square, W.

British Medical Association.

The preliminary arrangements for the visit of the British Medical Association to Exeter are well in hand. The meetings have been fixed for Tuesday, July 30th to Friday, August 2nd. A list of the officers of the various sections is given below. The President-Elect is Dr. Henry Davy (Exeter). The address in Medicine will be delivered by Dr. W. H. White, the address in surgery by Mr. H. T. Butlin, and the Popular Lecture by Sir J. W. Moore. The following is a list of the local medical men appointed in the several sections :—

Pathology.—Vice-President: W. L. Pethybridge, M.D., B.Sc., Plymouth; Hon. Secretary, R. V. Solly, M.D., F.R.C.S., Exeter

Medicine.—President, W. Gordon, M.D., F.R.C.P. Exeter. Vice-Presidents: W. Powell, M.B., F.R.C.S., Torquay; E. L. Fox, M.D., M.R.C.P., Plymouth; Hon. Secretary: A. B. Soltau, M.D., F.R.C.S., Plymouth.

Diseases of Children.—Vice-Presidents: L. Mackenzie, F.R.C.S., Tiverton; F. Hichens, M.D., Redruth; R. H. Lucy, F.R.C.S., Plymouth; Hon. Secretary: J. H. Gough, M.D., Torquay.

Psychological Medicine.—Vice-President: R. L. Rutherford, M.D., Exeter.

Electrical Section.—Vice-Presidents: J. D. Harris, M.D., Exeter; W. Cheyne Wilson, M.D., Plymouth.

Tropical Diseases.—Vice-President: Lieut.-Col. R. Caldwell, F.R.C.S., Plymouth; Hon. Secretary. Lieut.-Col. G. M. J. Giles, M.B., F.R.C.S., I.M.S. (retired), Plymouth

Surgery.—Vice-Presidents: E. J. Domville, M.R.C.S., Exeter; C. E. Bell, M.R.C.S., Exeter; Hon. Secretary: B. Dyball, F.R.C.S., Exeter.

Opthalmology.—President: L. H. Tosswill, M.B., Exeter; Vice-Presidents: J. R. Rolston, M.R.C.S., Plymouth; A. C. Roper, F.R.C.S.E., Exeter; Hon. Secretary: R. Pickard, M.S., F.R.C.S., Exeter.

Laryngology, Otology, and Rhinology.—Vice-President: G. Jackson, F.R.C.S., Plymouth; Hon. Secretary: C. E. Bean, F.R.C.S.E., Plymouth.

Dental Surgery.—President. J. M. Ackland, M.R.C.S., L.D.S., Exeter; Vice-President: T. A. Goard, M.R.C.S., L.R.C.P., L.D.S., Exeter.

Obstetrics and Gynæcology.—Vice-Presidents: W. F. Thompson, M.D., Launceston; W. L. Woollcombe, F.R.C.S.E., Plymouth; Hon. Secretaries: G. H. Johnson, M.R.C.S., Teignmouth; E. J. Toye, M.D., Bideford.

State Medicine.—Vice-Presidents: E. A. Brash, M.R.C.S., Exeter; F. M. Williams, M.R.C.S., Plymouth; Hon. Secretary: S. Noy Scott, M.R.C.S., Plymstock.

Naval and Military.—Vice-Presidents: Col. G. D Bourke, R.A.M.C., Devonport; Brigade-Surgeon Lieut.-Col. J. Raglan Thomas, M.D., V.D., Exeter; Hon. Secretaries: Fleet-Surgeon H. S. R. Sparrow, L.R.C.P., R.N., Royal Naval Barracks, Plymouth; Surgeon-Capt. J. R. Harper, M.R.C.S., Barnstaple; Surgeon-Capt. J. S. Steele Perkins, M.B., V.M.S., Exeter.

Local Secretaries: Russell Coombe, M.D., F.R.C.S., Exeter; G. T. Clapp, M.B., Exeter; L. R. Tosswill, M.R.C.S., L.R.C.P., Exeter. Hon. Secretary of the Pathological Museum Committee: R. V. Solly, M.D., Exeter.

Ambulance Service for Smallpox Patients.

At last Saturday's meeting of the Metropolitan Asylums Board, a letter was read from the Greenwich Board of Guardians, strongly deprecating the proposal which they said they understood had been made to discontinue the river ambulance service for small-pox patients, and to convey them by road. The letter was referred to the Ambulance Committee.

Annual Dinner of the Royal College of Surgeons, Ireland.

This annual function will take place on January 26th next. His Excellency the Lord Lieutenant has graciously signified his intention of being present. A meeting of the College will be held before the dinner for the purpose of conferring the Honorary Fellowship of the College on Mr. Priestly Smith, Professor of Ophthalmology in the University of Birmingham.

Annual Dinner of the British Gynæcological Society.

The annual dinner of this Society will be held to-morrow (Thursday), January 17th, at the Café Monico, Shaftesbury Avenue, London, W. Mr. F. Bowreman Jessett, F.R.C.S., the President, will preside, and it is hoped that there will be a large attendance of Fellows.

Amongst those who are expected to be present are the Presidents of the Royal Colleges of Physicians and Surgeons, the Master of the Apothecaries' Society, the Presidents of the Obstetrical and the Royal Medico-Chir. Societies, the Director-General of the Medical Department of the Royal Navy, and Surgeon-General Sir Thomas Gallwey, K.C.M.G. Any Fellows who have not intimated their intention of being present are requested to communicate immediately with the Secretary, Dr. Beckett-Overy, 24, Alexander Square, S.W.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office: if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad Foreign subscriptions must be paid in advance. For India Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs.15.12.

ESTER.—The relationship between University College and University College Hospital has been a very close one in the past, the hospital having been governed by the Council of the College, though actually managed by a committee. Lately this relation has been changed entirely. The Hospital is now to be a separate corporation. The hospital funds and school funds are to be entirely distinct.

CANIS SUM.—The name of the energetic member of the "nine miles long" petition is Mr. Ellis Griffith. He is the Liberal Member of Anglesey. There was 400.000 signatures; we do not know why they could not have been condensed into a smaller space, but the advertisement of the cause would have been less.

A CURE FOR INSOMNIA.

THE Vicar of Burgess Hill Parish Church is currently reported to have told his parishioners that many cures for insomnia were advertised, but medical men never recommended the most certain cure—a sermon! If anyone troubled with insomnia would only go to his church and listen to his sermon, he could promise the patient the most cosy of naps.

INQUEST.—The diagnosis would seem to lie between ringworm of the nail and chancre of the finger. Microscopical examination would easily demonstrate the former, but the search for Schaduin's spirochœte would be a longer, more tedious, and less certain business.

A. S. R.—The patient might be fairly regarded as yours under the circumstances. The question is whether he is worth having in any case.

DR. ADOLF ERDOS.—The Medical Sickness and Accident Society insures its members against accident and sickness in Great Britain, but we have no information whether these privileges are extended to practitioners resident abroad. You will see a reference to this Society in our last issue, page 51.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 16th.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—8 p.m.: Exhibition of Mounted Specimens by Mr. Rousselet. Annual Address:—The President: The Flowering Plants of the Mesozoic Age in the Light of Recent Discoveries.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Berry: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. E. Cautley: Asthma in Infancy and Childhood.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m.: Demonstration:—Mr. C. Nourse: Larynx.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Dermatological (Dr. Meachen), Ophthalmological (Mr. Brooks), Medical (Mr. Whipham).

THURSDAY, JANUARY 17th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Mr. R. Jones (Liverpool): On the Treatment of some Paralytic Deformities.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Gynæcological Operations (Dr. Giles), Medical (Dr. Whiting), Surgical Out-patient (Mr. Carson). 4.30 p.m.: Lecture:—Mr. Edmunds: Diseases of the Thyroid Gland.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Syphilis: I., History and Primary Invasion (Constitutional and Local). Erythematous: I., Macular; and II., Maculo-Papular.

FRIDAY, JANUARY 18th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5 p.m.: Cases will be shown by Dr. F. J. Poynton, Mr. H. S. Clogg, Dr. E. Cautley, Mr. P. L. Mummery, Dr. C. O. Hawthorne, Dr. T. R. Whipham, Dr. G. Carpenter, and others.

EPIDEMIOLOGICAL SOCIETY (11 Chandos Street, Cavendish Square, W.).—8.30 p.m.: Microscopical Demonstration:—Dr. J. B. Murray. Paper:—Dr. E. F. Bashford: Real and Apparent Differences in the Incidence of Cancer.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. StClair Thomson, Clinique. (Throat.)

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.). 10 a.m.: Dr. Moullin; Gynæcological Operations. 2 p.m.: Medical and Surgical Clinics. Dr. Ball: Diseases of the Throat, Nose, and Ear. 2.30 p.m.: X-Rays. Operations. Dr. Abraham Diseases of the Skin. 5 p.m.: Clinical Lecture:—Mr. Armour.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical (Mr. H. Evans). 2.30 p.m.: Surgical Operation (Mr. Edmunds). Clinique. Medical Out-patient (Dr. Auld), Ophthalmological (Mr. Brooks). 3 p.m. Clinique. Medical In-patient (Dr. Leslie).

SATURDAY, JANUARY 19th.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. Out-patient Demonstrations. 10 a.m.: Surgical and Medical. 11 a.m.: Eye.

Vacancies.

Carmarthen, Cardigan, and Pembroke Joint Counties Lunatic Asylum. Carmarthen—Junior Assistant Medical Officer. Salary £150 per annum, with furnished rooms, board, washing, and attendance. Applications to W. Morgan Griffiths, Clerk to the Asylum Visitors, Carmarthen.

Edinburgh School Board.—Medical Officer. Salary £400 per annum. Applications to G. W. Alexander, Clerk, School Board Offices, Edinburgh.

Liverpool Dispensaries.—Head Surgeon. Salary £200 per annum, with board and apartments. Applications to K. Stretch, Auditor. 56 Vauxhall-road, Liverpool.

Liverpool Dispensaries.—Assistant Surgeon. Salary £100 per annum, with board and apartments. Applications to K. Stretch, Auditor, 56 Vauxhall Road, Liverpool.

Bath Royal United Hospital.—Resident Medical Officer. Salary £100 per annum, with board, lodging, and washing. Applications to J. M. Sheppard, F.C.I.S., Secretary

Royal Cornwall Infirmary, Truro.—House Surgeon. Salary £100 a year, with board and apartments. Applications to J. C. R. Crewes, 4 Parkvedras-terrace, Truro.

Rochdale Infirmary.—House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to Henry Booth, Secretary, Infirmary Offices, 38A, Yorkshire Street, Rochdale.

Newport Borough Asylum, Caerleon, Mon.—Assistant Medical Officer. Salary £125 per annum, with board, apartments, and attendance. Applications to the Medical Superintendent.

Cameron Hospital, West Hartlepool.—House Surgeon. Salary £100 per annum, with board, rooms, and washing. Applications to J. G. Taylor, Secretary.

Sir Patrick Dun's Hospital. Assistant Surgeon. Immediate application to Secretary, Medical Board. (See advt.).

Appointments.

COGHLAN, E. F., M.R.C.S., L.R.C.P.,Edin., Clinical Assistant to the Chelsea Hospital for Women.

GUBB, ALFRED, S., M.D., M.R.C.S., Honorary Physician to the British Consulate at Mustapha Supérieur, Algiers.

LAMBKIN, F. J., Brevet-Colonel, R.A.M.C., Lecturer in Syphilology at the Royal Army Medical College.

LATHAM, ARTHUR M.D., B.Ch.Cantab., F.R.C.P.Lond., Advisory Physician to the Hospital for Diseases of the Throat, Golden Square.

LAWRENCE, ARTHUR GARNONS, M.D.St.And., M.R.C.S., L.S.A., J.P., Medical Officer of Health for Chepstow.

MARTIN, JAMES PIRIE, L.R.C.P.Lond., M.R.C.S., Medical Officer for the Districts of Box and Colerne by the Chippenham (Wilts) Board of Guardians.

MIDDLETON, E. W, M.D.Balt., Clinical Assistant to the Chelsea Hospital for Women.

OSMOND, CHARLES HOLDWAY, L.F.P.S.Glas., L.S.A., District Medical Officer by the Bristol Board of Guardians.

PATRICK, J. KING, M.B., Ch.B.Glasg., Anæsthetist to the Glasgow Royal Infirmary.

PRINGLE, A. M. N., M.B., C.M.Edin., Certifying Surgeon under the Factory and Workshop Act for the Ipswich District of the county of Suffolk.

SHORNEY, H. F., M.D., B.S.Melb., Resident Medical Officer to the Hospital for Diseases of the Throat, Golden Square, W.

Birth.

HARTLEY.—On Jan. 7th, at 4, De Parys Avenue, Bedford, the wife of Arthur Conning Hartley, M.D., F.R.C.S.Edin., of a daughter.

Marriages.

GARLAND—AVELING.—On Jan. 9th, at St. Matthew's Church, Upper Clapton, Frank Hooper, fourth son of Thomas Garland, of "Trenance," Stamford Hill, to Dorothy Mary, youngest daughter of the late C. T. Aveling, M.D. of Stamford Hill, and Mrs. Aveling, of 88 The Common, Upper Clapton.

PRANCE—BULLOCK.—On Jan. 10th, at St. John's Church, Putney, George Frederick Charles, youngest son of the late Robert Rooke Prance, M.D., of Hampstead, and Mrs. Prance, 35 Netherhall Gardens, Hampstead, to Frances Beatrice, youngest daughter of the late Henry Bullock, F.R.C.S., of Spring Grove, Isleworth.

Deaths.

BLAKE.—On Jan. 9th, at Jubbulpur, India, William Twynam Blake, B.A.Cantab., Indian Civil Service, the eldest son of William H. Blake, M.B., B.S., of Harpenden.

GROTH.—On Jan. 6th, at 22 Panton Street, Haymarket, London, Ernest Groth, M.D., Physician to the German Hospital, and formerly Physician Deaconesses' Hospital, Tottenham, and Senior Physician Islington Dispensary, in his 67th year.

EVANS.—On Jan. 13th, at 89 Savernake Road, Parliament Hill, London, T. C. Evans, M.R.C.S.Eng., and L.S.A Lond., late Surgeon Superintendent, Indian Emigration Service, aged 51.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, JANUARY 23, 1907. No. 4

NOTES AND COMMENTS.

Zancigomania. THE question of the hour that is agitating those large sections of society where science is taboo and thought a bore, is whether the Danish music-hall performers calling themselves the Zancigs are or are not telepathists (whatever that may mean). The lady and gentleman in question, by a judicious method of advertisement and by a still more judicious invitation to appear before the King, have succeeded in focussing a prodigious amount of popular attention on their tricks. The lady Zancig, wearing spectacles, stands on the stage at the Alhambra, while her husband in the auditorium puts to her conundrums suggested by people around. The lady, with great facility, grasps what is intended, and gives the answer in a commendably brief period. Now were we not too old to be surprised at anything, we should wonder why this performance should be leading to domestic crises as acute as those of the Tichborne times; indeed, the display of the Zancigs seems to us considerably less astonishing than finding a pack of cards in the leg of a pair of dress-trousers or extracting a white rabbit (which is not there) out of a top-hat. The difference between scientific men and the laity is that whereas the former, in contemplating a phenomenon, *a priori* assume a natural explanation, the latter prefer for romantic reasons to assume an *a priori* metaphysical one. In other words, scientific men want to know the truth, and unscientific people prefer not to know it. As for the present Zancigomania, one can only congratulate the Danes—who must be the reverse of melancholy—on their astuteness, and the British public on their incurable stupidity.

Magic Boots. THE American criminal lawyer is a species all his own, for nimble-witted as are many of our own advocates, it must in fairness be conceded that they cannot hold a candle to their Transatlantic brethren for unscrupulous ingenuity. A remarkable person has just been tried in the Supreme Court in New York for an offence we have not yet encountered in this prosaic land, to wit, selling magic boots. This latter-day Jack-the-Giant-Killer was a cobbler by trade, and finding soleing and heeling but a slow path to affluence, he conceived the idea of endowing his creations with magical powers. Electricity was the instrument selected for this purpose, and he put forward magnetised boots warranted to cure a number of diseases of which rheumatism and locomotor ataxy were two of the least conspicuous. The boots sold like hot cakes, £20 being by no means an out-of-the-way sum for a pair. Eventually the American law took their creator into its meshes on a charge of violating the Medical Act. The defence made by his lawyer was worthy of a better cause. The magic was dropped, and counsel set forth that Hilgert, his client, was an experienced and scientific boot-maker. Now poor health is due to an unbalanced state of the human system, and by scientific boot-making the balance could be restored. Hilgert's "scientifically-made boots not only assist locomotion, but also assist the circulation of the blood, which is life." But in spite of his advocate, the defendant apparently could not resist the temptation of claiming magic for his goods, for in the box he explained that by wearing these boots his clients, one of whom was Dr. Potter, Bishop of New York, found it unnecessary to wear braces! The only explanation of this remarkable phenomenon which occurs to us is that braces are clearly unnecessary in the presence of straight-jackets

£50 a Pig. THE consideration of this point leads us to wonder whether now that mechanical restraint is all-but removed from our asylums, it might not be possible to put a little more moral restraint on some of their administrators. Mr. Davey, Chief Inspector of the Local Government Board, is not likely to speak except by the card, and in his evidence before the Royal Commission on the Care of the Feeble-Minded last week he mentioned some facts about lunatic asylums which would really seem to be more appropriately connected with the inmates than with their governors. Let us not be understood to wish for anything but the most considerate and humane treatment for the insane, and we certainly do not agree with Mr. Davey when he said that he could not understand why entertainments and tennis-courts should be provided in asylums. Such measures are necessary parts of curative treatment. But it is hardly credible that an asylum architect should be so modest as to wish to provide separate mortuaries for male and female patients! "Corruption," said Mr. Davey very truly, "hangs round the skirts of extravagance," and he instanced as an example of the latter a proposal in Sussex to build pig-styes which worked out at £50 a pig! Without commending the average stye, we cannot help supposing there is some happy sanitary mean between it and the luxurious cottage which that sum would connote.

An "O" Too Much.

ON Dr. Doyen, his micrococcus, his serum, and his biograph, we have had frequent occasion to comment in these columns. We have also touched lightly upon the question of his fees, but have not enjoyed full opportunity of forming a judgment. From news that comes from Paris, his charges seem to be modelled on the same Napoleonic lines as the other attributes of that extraordinary person. In the present case, Mr. Crocker, a wealthy American whose wife was suffering from malignant disease, heard, doubtless through the agency of his native press, of Dr. Doyen's wonderful new cancer serum, and the poor patient was hurried over to France to be cured by it. The extent of Dr. Doyen's ministration, according to Mr. Crocker, consisted in paying six visits, administering eleven injections, and writing eight prescriptions. Mrs. Crocker grew obviously worse, and was taken home just in time to die. On the subject of fees, Dr. Doyen's modesty at the beginning of the treatment—he referred Mr. Crocker to his "business manager," as he himself could not discuss such mundane affairs—was only equalled by the business manager's effrontery when Mrs. Crocker was well under treatment, for he sent to her husband to inform him that the fees were £4,000, and payment in advance was expected. One cannot be surprised at Mr. Crocker writing to ask if there were not an "o" too much. Indeed, as fees rule in this benighted country and in America, even specialists are expected to do a precious deal for £400. However, the secretary politely replied that there was no error, and the money was subsequently paid. Were £650 a visit at all a common rate of remuneration, we can imagine that even peers might find medicine a more pleasing calling than promoting and directing bogus companies in the City.

Undertaking—A Conscientious Objection.

THE now famous Mrs. Green explained to her neighbour that there were "'usbands and 'usbands"; "ours," she added pathetically, "are the and 'usbands." There would seem on that analogy to be conscientious objectors and conscientious objectors, and an amusing variety of the latter class was recently furnished at the Southend Police Court, where an applicant who was asked his reason for claiming exemption said that he was an undertaker! The Bench apparently did not see that this cheerful calling coincided with the loop-hole provided by the Act, and the plea was held not to be valid. True, the undertaker has since written to the press to explain that in the pursuit of his calling he has been employed by mothers who had attributed their children's death to vaccination, but in such cases the "funeral furnisher" would do better to consult the death certificates in the possession of the registrar than take unconfirmed the expert opinion of uneducated mothers. One would have thought surely the last man to object to a rise in the death rate would be the undertaker.

LEADING ARTICLE.

PROPOSED CHARTER OF THE KING EDWARD VII. HOSPITAL FUND.

THE relationship of the various hospital funds to the community at large is obviously a matter of considerable public interest. These funds distribute vast sums of money for the benefit of the medical charities in various parts of the United Kingdom. In addition to the functions of collection and distribution, the funds have latterly exercised a sort of disciplinary control over the management and the policy of the hospitals to which they make grants of money. Properly exercised, this power is doubtless capable of much salutary effect upon hospital executives, but it must be borne in mind that the decision of the funds is absolute and irresponsible. No matter how harsh and arbitrary their action may appear, they are not called upon to state their reasons for adopting any given course. As a case in point their action regarding the Royal Orthopædic Hospital may be quoted. This institution stood upon an enormously valuable freehold site in Oxford Street. It was proposed to sell the ground, and in spite of the resolute opposition of a minority of governors, that course was ultimately adopted, under the chairmanship of Mr. Harry Marks, M.P. The Hospital Sunday and King Edward's Funds pressed on the transaction by urging amalgamation and withholding grants. To-day the site is covered with most valuable buildings; the birthright of the Royal Orthopædic is gone, and its financial resources merged inextricably in those of the amalgamated institution. The Funds were kept informed of what was going on by the *Lancet* and by THE MEDICAL PRESS AND CIRCULAR. Especially were they apprized of the fact that the opposition had forced up the sale price of the hospital by no less than £12,000. At the time we challenged the Funds to institute a public enquiry into the affair. We now ask whether they dare bring out their records of information and minutes of investigation before they undertook the serious responsibility of urging the sale of the hospital site. We have treated this matter at some length because it so forcibly illustrates the powers of the Funds, as well as the absolutely irresponsible way in which they may be exercised. At the present moment the reminiscence has no little point. The youngest, but not the least wealthy, of the Metropolitan funds is that founded by King Edward. It has leapt into popularity almost at a bound, and its coffers are replenished in a way that emphasises not only the wealth, but also the divine gift of charity that is possessed by our fellow-countrymen. Nevertheless, we believe that the King Edward's Fund is constituted on a basis that is unsound, and that must be rectified if the Fund is to survive as a permanent institution. The inherent flaw is its non-representative character—the absence of representation of the medical charities, which are true beneficiaries of the funds, and of the medical profession, by whose gratuitous services those charities are conducted. In fact, the management of the King Edward's Fund is as autocratic and irresponsible as any secret Russian bureau. It is no answer to say that the *personnel* and the motives of the Fund are above suspicion. We have given one instance in which we believe the Fund's judgment was defective, its action arbitrary, its information possibly or probably imperfect, and its guidance unduly biassed. We are prepared to furnish further instances of *prima facie* injustice in the dispensation of grants. Apart from particular instances, the general viciousness of autocratic control in a great public institution, supported by public money and devoted to public benefit, is to our mind sufficiently apparent to condemn the whole thing. Holding these views, it was with nothing less than a shock of pained amazement that we read the Bill to incorporate the King Edward's Fund. This short Bill was recently published by the *British Medical Journal*, and we reproduce it in another part of our present issue for the benefit of our own readers. Briefly put, the Bill provides for the autocratic government of the Fund by placing full and supreme powers in the hands of the President. The principle thus adopted is reactionary and absolutely out of touch with the spirit of the age. The present President is the Prince of Wales, who has on various occasions shown himself possessed of a strong will and a sound judgment. In this instance he will do well to think twice before giving his sanction to a method of control that has always been repugnant to Englishmen. At this very moment the medical profession is in revolt against the hospital system, and as they provide the honorary staffs of the medical charities, and their professional interests are seriously affected by hospital competition, surely they are entitled to representation on the Council of the King Edward's Fund. Every hospital, large and small, within the Metropolitan area has a clear right to representation. As things go some of the professional philanthropists and *ex officio* members of the Fund Council are committed to a policy of exterminating the small hospitals and of exacting payment from hospital patients. Why should not the general practitioner, the small hospitals, and the poor patients themselves all have a vote in the management of King Edward's Fund? The voice of the people must sooner or later assert itself in this as in all other public questions with which they are intimately concerned. It is impossible to think that our great King, who has always shown himself in sympathy with the wise independence of his subjects, will allow the Fund he has created to become a potential instrument of injustice and abuse by reason of the absence of popular representative control. Nor can we imagine the Prince of Wales for a single moment giving his approval to any scheme of the kind—that is to say, when the consequences have been duly set forth. In conclusion, we may add that this protest has been entered as a simple act of duty, and it in no sense detracts from our grateful admiration of the kindness, the graciousness, and the sustained sympathy with which this particular institution has been founded, fostered, and brought to maturity by His Majesty King Edward.

CURRENT TOPICS.

The Edalji Case.

THE efforts of Sir A. Conan Doyle have not so far prevailed upon the Home Office to grant a "free pardon" for the offence which it now seems to be generally as well as officially admitted was never committed by Mr. Edalji. However, the time is still young, and the *Daily Telegraph* may yet vindicate the right of the people of this country to review the administration of criminal law. Clearly, an immense volume of public feeling is concentrated upon the case. A flood of correspondence, containing a host of suggestions and criticisms, has been poured into the columns of the *Telegraph*. But it has remained for a correspondent of our own to advance the theory that the crime was purely artificial, that is to say, manufactured deliberately for the sake of obtaining incriminating evidence. Such a possibility is, of course, too far-fetched to be considered seriously. On the other hand, imagination fails to grasp the set of circumstances under which it was possible for any human being to steal into a field at night and commit a crime of so gross and violent a nature when the field itself, not to mention its approaches, was closely guarded by a vigilant body of police constables. Some human hand must have committed the outrage. The police assert that Mr. Edalji was the criminal, and at the trial they supported the case by a mass of untrustworthy circumstantial evidence. That being dismissed as untrue, are the county police now absolutely at fault as to the alternative culprit? So far as Sir Conan Doyle's theory of Edalji's inability to find his way about at night by reason of defective sight, we express no definite opinion, but regard the burden of proof as still resting upon its author. A week ago that distinguished writer appealed to the three leading journals for an answer to the particular point. In return we furnished the view of a medical authority in questions of vision. It is a matter of some personal congratulation to ourselves that the MEDICAL PRESS AND CIRCULAR alone among the medical journals spoke out decisively against the justice of Edalji's conviction so long ago as the year 1903. The case demonstrates the necessity of a Court of Criminal Appeal, if we would avoid similar miscarriages of justice in the future.

The Fallacy of Big Muscles.

It is high time the medical profession spoke out upon the modern craze for physical development. The confusion that has not unnaturally arisen in the mind of the populace is to mistake big muscles for a strong constitution. As a matter of medical observation it is often exactly the other way about. The great athlete with the build of a prizefighter and the muscular strength of a gladiator throws up the sponge and dies forthwith when attacked with influenza or some other malady that would be readily surmounted with ordinary precautions by the plain man of average stamina. More than that, the heart is often damaged in the strain of developing big muscles, and it seems pretty certain that the body resistance of the muscular giant to disease is less than that of the man in the street who is content to have at command a moderate amount of strength sufficient to meet the everyday exigencies of life. The sooner the "strong man" error is scotched publicly the better, and Staff-Surgeon A. Gaskell, who recently discussed the subject, in an official report, may be congratulated on the bold way in which he has attacked what a journalist has picturesquely called the "cult of the bulging biceps." Most medical men of experience know the pale, attenuated, ailing patient who pulls through all kinds of untoward symptoms, but who nevertheless outlives scores of friends and relatives of boisterous health and strength.

The Fasting Man in "Fun City."

The ghastly exhibition of Sacco, the fasting man, in the so-called "Fun City" in the London Olympia, offers one of those sharp contrasts not unfamiliar in modern life. On the one hand we see crowds of pleasure-seekers, while on the other we have a poor wretch trying to beat his previous record of endurance against starvation. One newspaper account states in so many words that Sacco is already a dying man. He has undertaken a fast of fifty days, allowing himself only cigarettes and mineral waters, and on the twenty-seventh day he has lost no less than thirty-four pounds weight. The reporter described him as terribly wasted and scarcely able to stand up. We have often in the columns of THE MEDICAL PRESS AND CIRCULAR protested against the gross folly and inhumanity of such exhibitions. The limit of human endurance has long since been ascertained for all practical purposes, and the death of Sacco is not needed to fix a fatal point, which after all can only be absolutely true for his individual case. We are strongly of opinion that all public performances or shows involving probable danger to human beings should be rendered illegal by the legislature. If Sacco dies at Olympia, an event that seems to be well within the bounds of probability, the police would do well to enquire if there be not some legal method of prosecuting the authorities of "Fun City" for their share in the matter.

The Unqualified Practitioner of Medicine.

EARLY in the present month the Liverpool coroner was called upon to investigate a case in which a child died after being seen and prescribed for by an unqualified American, named M'Kay. It appears that the same man has been previously warned as to his conduct by the City Coroner. On this occasion the mother of the child said that the name of "Dr. Ross" was on a lamp outside the surgery, and she went there expecting to see some one of that name. The man M'Kay appears to have assumed a tone of effrontery, if not of defiance. He asserted that the name of Dr. Ross was painted over, and that half-a-dozen tenants had been there since Dr. Ross. In seeing the child he asserted he was doing nothing wrong, and that it was not nice "to be dragged to that Court for the sake of a sixpenny bottle of medicine." His own name was on the door in big letters. Surely on the facts as reported, M'Kay could be prosecuted by the police, not only for an offence under the Apothecaries Act, but for personation and obtaining money under false pretences. If the local medical men have no machinery capable of setting the law in action, one of the medical defence unions would probably take up the case. The duty should clearly fall to the General Medical Council, were it representative of the medical profession, instead of being an autocratic and irresponsible administrative body.

The Insurance of Servants.

MEDICAL men, like the rest of the community, will have to bestir themselves in the face of the fresh Workmen's Compensation Act, which comes into operation in July next. The new feature that is likely to affect medical men as employers is the inclusion of domestic servants within the range of compensation for accident or sickness contracted in the course of their employment. Should a servant slip down and break her fibula, or develop housemaid's knee from kneeling, or be laid up from a great variety of other causes, the employer will, after next June, be called upon to compensate him or her upon a fixed scale. In the existing depressed state of medical incomes, at any rate among the rank and file of the profession, it would be impossible to incur such a potential addition to possible expenses. A run of trivial domestic accidents and sickness might readily prove the last straw upon the camel's back, when the margin is already cut down to its narrowest possible proportions. All medical men will therefore have to insure their employees, and we shall hope before long to have in our advertising columns particulars of some solid and substantial company prepared to undertake this class of business.

Health of London and Dublin Compared.

THE Public Health Committee of the London County Council have reason to be proud of the fact that since 1891, the date of the Public Health

(London) Act, the death-rate has fallen by some 30 per cent., from 21 per thousand to 15.1 per thousand. It is also gratifying that the rate for 1905 is the lowest on record. No better illustration of the value of wise sanitary administration could be offered. What has been done in a huge and dense population such as that of London ought surely to be attainable in lesser cities. Nevertheless, the death-rate in many cities with a population under half-a-million is still alarmingly high. In Dublin, during the past few months, the annual death-rate, as calculated from weekly records, has, on more than one occasion, been above 30—twice the average rate in London. It has constantly fluctuated about 25. Dublin is a city with many advantages from the point of view of sanitary administration. It has an excellent water-supply, many open spaces, and from its position is easily drained. Nevertheless, it contests with Moscow and Trieste for the highest death-rate in Europe. People are wonderfully tolerant of anything to which long use has accustomed them, but it is surely time that some attempt were made to explain the extraordinary mortality to which Dublin is subject, and to deal with the health problem in a radical fashion.

Railway Carriages and Disease.

WE have often drawn attention to the part played by insanitary railway carriages in the dissemination of disease, and it is certainly true that during the past few years there has been evident some slight endeavour on the part of the companies to suit themselves to modern requirements in regard to cleanliness. There is still, however, much to be done in that direction. It is true that notices appear here and there prohibiting promiscuous spitting, but on many lines they are still absent, and on others they are regarded both by passengers and officials as a dead letter. We have, indeed, heard a distinguished lawyer, now holding a judicial position, maintain that "no law could prevent a man spitting where he chose." The law can do it, however, but it is not often put into operation. Moreover, on many lines there is little attempt to keep the floors of the carriages in a cleanly condition, and ventilation is usually deficient, as the ordinary passenger has a dread of open windows. As far as Ireland is concerned, there appears to be at present an excellent opportunity of urging sanitary reform on the carrying companies, since there is sitting a Vice-Regal Commission to inquire into the management of the Irish railways. It is to be hoped that some representative body interested in the health of the country may bestir itself to offer evidence on the subject.

PERSONAL.

THE DUCHESS OF ALBANY has consented to become patron of the Infants' Hospital which is being built in Westminster.

DR. DAVIDSON is one of the candidates who will contest Hammersmith in the Labour interest.

DR. EDWARD CARNELL, of Harrogate, has been made a member of the Livery of the Apothecaries' Society.

MAJOR R. W. H. JACKSON, R.A.M.C., has been appointed Specialist Sanitary Officer for the Belfast District.

DR. MAYNIER and DR. ROBERTSON and his wife are reported to be among those killed in the earthquake at Kingston.

DR. SAVAGE, of Birmingham, with his nephew and niece, who were in Jamaica, are missing.

MAJORS HUTTON and MARGIN, R.A.M.C., and Lieut. SIDGWICK, R.A.M.C., were injured in the same catastrophe; the last-named gentleman sustained a compound fracture of the leg, but is reported to be progressing favourably.

MR. E. M. WRENCH, F.R.C.S., of Bakewell, Derbyshire, has been decorated with the fourth class of the Royal Victorian Order.

SIR WILLIAM CHURCH, K.C.B., took the chair at the annual dinner of the University College Colston Society at Bristol.

BARON KOMURA, the Japanese Ambassador, has promised to be present at the dinner of the new University of Leeds on January 31.

LIEUT.-COLONEL GUY CARLETON JONES has been gazetted Director-General of the Army Medical Services of Canada, *vice* Colonel Fiset, D.S.O.

DR. SINCLAIR BLACK, of the Robben Island Leper Hospital, will read a paper on Leprosy in South Africa at the Polyclinic on Friday next.

A COMPLIMENTARY dinner was given to Dr. Bruce, of Dingwall, on his retirement from the General Medical Council. Sir William Turner, K.C.B., was in the chair.

DRS. DAVIES (Hoxton), Baxter Forman (South Kensington), W. R. Smith (St. George's-in-the-East), and Vosper (West St. Pancras) are standing as Moderate candidates.

SIR JAMES BARR will take the chair at the dinner of the hospitals amalgamated with University of Liverpool to-night. Lord Derby and Sir John Moore are to be present.

MAJOR-GENERAL LORD CHEYLESMORE will give away the prizes to the London Companies of the R.A.M.C. Volunteers at their headquarters, Calthorpe Street, W.C., on February 9th.

THE names of Drs. Salter (Bermondsey), Searson (West Marylebone), and Dr. Beaton (North St. Pancras, are announced as Progressive candidates for the forthcoming election of the London County Council.

MISS ANNIE W. HYATT, M.B., has been elected deputy to her father, Dr. J. T. Hyatt, Medical Officer of Health for Shepton Mallett U.D.C. Confirmation of the appointment will be needed from the Local Government Board.

SIR CHARLES CAMERON, M.D., F.R.C.S.I., C.B., has been appointed a member of the Advisory Board for the Army Medical Service as representing Irish Sanitation.

MR. W. DUNNETT SPANTON, F.R.C.S., J.P., consulting surgeon to the North Staffordshire Infirmary, has been elected President of the British Gynæcological Society for the current year.

A CLINICAL LECTURE ON THE MENTAL RISKS OF ADOLESCENCE.

By T. S. CLOUSTON, M.D., F.R.C.P.,

Physician Superintendent, Royal Asylum, Edinburgh; Lecturer on Mental Diseases, University of Edinburgh.

The meaning of the word "adolescence" is not always definitely understood. It is often used synonymously with the word "puberty," but this is undoubtedly a mistake. Puberty denotes the onset of the reproductive function. Adolescence means its slow and gradual development, co-ordinately with development of the whole organism, until full manhood or womanhood is attained. We shall be near the mark if we count adolescence as on the average covering the years from fifteen to five-and-twenty. It is the period of life which, until lately, had not attracted the attention it deserved either from the biologist, the physiologist, or the pathologist. Professor Stanley Hall has lately written two exhaustive volumes on every aspect of adolescence which, if they err in any way, do so by over-fulness of treatment. To-day we have to look at adolescence from the clinical point of view, and we shall confine ourselves chiefly to the mental aspect of the clinical disturbances. It would be unscientific, however, to exclude the consideration of the motor, sensory and nutritional risks of adolescence. As a matter of fact, that cannot be done. Few of the mental disturbances to which adolescence is liable but are accompanied by either motor, sensory or nutritional disturbances. The physiological and the psychological issues of adolescence are the most momentous of any period of life. Intelligence, emotion, volition, character, inhibition, and every feeling relating to sex are involved in it. It is the period when there is a continuous adaptation going on in a hundred ways between the most delicate organic structure in Nature and its functions and the environment of a highly complicated and specialised life—that of modern society. This process of adaptation depends for its success on a healthy machinery in the mental cortex of the brain. The health of that marvellous organic structure means that it has the power of continuous development on certain normal lines, that its resistiveness to outward and inward causes of functional disturbance shall be great, and that its reactiveness to its environment, mental and bodily, shall go on without explosiveness or mental failure. I shall only say here that the adolescent period is subject to almost every form of neurosis as well as the mental, and that they all, when occurring at this period, are tinctured by the developmental or adolescent character.

I shall divide the clinical examples of adolescent mental risks into three sections. The first will represent the risks which I was going to call minor, but by that term I do not mean that they are of small importance. I include in it the examples of mental unfitness for work, of mental "breakdown," of unfitness for school life, and of a certain mild paralysis of mental action, all of which are by no means uncommon. I also include in it the cases of simple diminution of volitional power, so that irresolution, fickleness, want of power to follow any kind of continuous work, morbid laziness, and lack of mental energy are the chief characteristics. I also include cases illustrating a paralysis or perversion of the social instincts, so that affection for father, mother, brothers and sisters is no longer exhibited. This is very frequently so accentuated that there is a positive aversion to those nearest to the patient. I include cases where the temper becomes so bad that almost all inhibition over it is lost; cases of such a mild emotional depression that the patients cannot enjoy life in a normal way are also placed in this section. Along with those I put the cases where common sense is lost, and there is exhibited a visionary optimism which passes all reasonable bounds, where, in fact, there is a mild cortical excitement. I shall also include the cases where there is a frothy religionism exhibited that has no relation to duty. I also include the case that breaks out into spasms of immorality of every kind, especially sexual immorality. All those cases exhibit mental risks that mostly cannot be called insanity in the technical sense, although they are first cousins to that condition. None of them can be properly understood except by taking physiological and medical views of the symptoms. The ordinary ethical and educational views of such cases, without regard to the faults of brain working, are necessarily incomplete, and are mostly wrong. They are not only wrong in their diagnosis, but they are wrong also in their modes of treatment of those conditions.

The first case illustrating my thesis is that of a delicate-looking girl of 16, with all the appearances of a neurotic constitution. She had been a nervous child, but it was only after she went to school that anything very marked was noticed in her mental constitution. Before puberty she learned her lessons fairly well, but with occasional difficulties in applying her mind to them. Lately, she has exhibited the following very striking condition:—When spoken to she talks rationally on any subject. In conduct and appearance there is little difference between her and other girls of her age. Her memory is good, her intelligence is in many ways above the average, but she is extraordinarily super-sensitive in regard to her school work. She is intensely desirous to do it well, but has become utterly and absolutely unfit within the past few months to do any kind of lessons, to do any reading even, or systematically to apply her mind in any direction whatever, even to simple knitting or ladies' work. There is a slight tinge of depression in her emotional nature, she has not the elasticity and spirits of the average girl of her age. She has got somewhat thinner lately, and her sleep is not altogether satisfactory. She is perfectly conscious of those mental deficiencies, and it worries her. Herditarily she came of a very nervous stock on her father's side. She had at least two paternal uncles insane. She was gentle, and seemed to have no bad habits whatever. There could be no doubt that this whole condition was the result of disease and not of moral obliquity or an unwillingness to do her school work. I, of course, stopped all lessons or any reference to lessons, and literally "turned her out to grass," to live in the fresh air, to have plenty of milk and fattening diet, to have some Maltine and Parrish's syrup, and I told her mother that for two years school or lessons were not to be mentioned to her—that her employments were to be entirely hand and not head occupations. During those two years she lost all these peculiarities, and after some months got much stouter. She still remains somewhat nervous, but I think has a reasonable chance of getting through life without any attack of acute insanity or passing into dementia, of which I think she ran great risk had her school education been persisted in. Such a girl should certainly never marry if the good of future generations is considered.

The second example of those minor risks was that of a girl who, up to 15, had been somewhat like ordinary children, but from that time on to 20, when I saw her, she had developed the most extraordinary series of moral and social perversions that it was possible to conceive. She was not stupid, and she was not immoral in the sexual sense, but she took a violent dislike to every near relation she had, especially to her mother—a gentle and too indulgent parent—and her conduct generally at home became simply abominable. She was disobedient, rude, untruthful, with no sense of right and wrong, and with nothing that could rightly be called a concience. Her whole social nature was perverted. She took up with persons in a lower station of life, and would attempt to bring them into her father's house. She scandalised her religious acquaintance by using profane and improper language. If she had any sympathies, they appeared to be with the low and the bad. Respectability in any form she seemed to resent. To strangers, "when she liked," she could appear attractive and amusing. She made an onset on a stout farm labourer, secured his affection, married him, and was never heard of again in her own "set." But hard farm work, the bearing of children, and the responsibilities of life seemed in a way to mitigate some of her social and moral eccentricities. This young woman had a brother who was an epileptic, and several other near relations who suffered from marked neurosis.

I have known hundreds of cases of which the following is a typical example. A young man of 20, of neurotic parentage, of a gay, pleasant disposition, and who was especially noted for avoiding any disagreeable tasks or unpleasant duties, of an artistic temperament and very social disposition, began at 20 to indulge in taking too much alcohol. At first he did so in a social way with his companions, but within two years he had acquired such a craving for it that he had no control over his impulses, and got it in any circumstances and at any price. Bouts of drinking came on him at periodic times, with intervals when he was almost free from the tendency. His whole moral life was changed and deteriorated. His work could not be depended upon, his sense of duty was reduced almost to nil, and he was unfit to continue the profession which he had entered. By 23 he was a typical dipsomaniac, a drunken, useless, and a most harmful social unit, a curse to society, and a disgrace to his connections and friends, his will power gradually getting weaker until he became somewhat silly before he drank himself to death at three-and-thirty. Such cases, which I have called "developmental dipsomania," form by far the most frequent type of this disease, and abound in society, especially in the families of the neurotic, the hypersensitive, the artistic by temperament, and also in families of a certain religious type. A few of them —a very few—recover after full development has taken place, from 28 to 35, but by that time, in most of them, the brain has sustained irreparable alcoholic damage in its highest centres. What might have been if the law allowed us to send them early enough to islands where whisky is unknown, to hard work in the fresh air, to a good moral atmosphere, where strict discipline of life could be enforced, we cannot tell, for such counsels of perfection are at present impossible. The law allows every British subject to drink himself to death if he can pay for his liquor, and we doctors are laughed to scorn if we mention the word disease in connection with such cases.

There is another adolescent risk somewhat similar to the drink craving, which is often seen among the lower classes of society. It is that of what I have called "adolescent criminality." It is a fact that by far and away the greatest number of first convictions of crime—I think they amount to 85 per cent.—take place before the age of five-and-twenty. When the hereditary and the physchological peculiarities of such criminals are carefully studied we find that they come from the criminal, the neurotic, or the degenerate classes. Their great peculiarity is the arrested development of the quality of mental inhibition, hence their fall into the temptations of vice and criminality. I knew a lad once who came of a poor and physically degenerate stock. He received a good education for his class, was subjected to religious instruction, but at 17 fell into the ways of a thief, was detected, and sentenced to imprisonment. From that time he was a habitual and acute thief all his life. He had a high arched palate, a squint, badly formed and placed ears, a somewhat silly expression of face, and his muscular movements were ungainly and improperly co-ordinated. He was, in fact, a moral and physical degenerate, whose chief mental weaknesses had developed in adolescence. He represents thousands of criminals who become so from the same cause.

The patients who suffer from those various mental deficiencies which place them in this section do not necessarily exhibit any outward bodily peculiarities or any stigmata of degeneration. Some of them are well grown, symmetrical in form, and with a good expression of face and eye, though others, no doubt, are asymmetrical in head and face, with high vaulted palates and unpleasant expressions.

It may seem far fetched, but I am quite convinced that many of the precocious youths of both sexes who give great promise up to 15 or 16, and then fall into stupid, lazy ways, and are no good at any real work of life afterwards, being really below the average of their age and class in real intelligence—that most of this class, too, may be reckoned as examples of adolescent mental risks.

Looking to the cases in this section of minor adolescent risks, it is very difficult to speak as to a prognosis of their future. Some of them are curable, recover, and do their work in life fairly well, a few even becoming brilliant examples of men and women; but most of those who recover are, on the whole, below the average of their class in regard to their success in life, and are unreliable. A large number, again, are incurable, and become the eccentric, the cranks, the shiftless, the drunkards, and the criminals of society.

The next section of adolescent mental risks of which I would speak are those who remain mentally normal until they have passed 20 years of age, and then for a few years become subject to attacks of depression of mind. Some of them, where such attacks are mild, where the self-control is not decidedly impaired, and where there are no suicidal tendencies, are not ranked among the technically insane. Some again, where the attacks become more acute, where they cannot control or look after themselves, where suicidal impulses arise, pass beyond the line of sanity, and are treated as suffering from mental disease. A good example of this form of mental risk is the following:—A young lady of three-and-twenty, whose father and mother were both able but markedly neurotic, but where no actual technical insanity was proved to exist among ancestors or collaterals, had worked hard at school and college. She was a keen, sensitive girl, with high ideals, and a large capacity for unselfish deeds. By the way, there had been a fair amount of consumption among her ancestry, and she had a brother who fell into that disease. She took an attack of influenza, and from that time her nervous energy was evidently sapped. She never regained her sleep, her appetite became poor, she lost flesh, and in a few months was in a state of distinct melancholia, suffering mental pain in an intense form, very sleepless, very restless, and incapable of looking after herself. She was introspective to a morbid degree, and accused herself of all sorts of evil deeds of which she certaintly had not been guilty. She tortured herself by exaggerating her real and imaginary failures of duty. She was sent to the country with a sensible relation and a good nurse, was made to live in the fresh air all the time, was fed on milk and fattening diet, was encouraged and almost compelled to occupy herself in various ways, and in about four months seemed to have recovered. But within the next three years she had several lesser relapses into the same condition of melancholia, thus exhibiting the periodicity which almost all the adolescent neuroses are more or less characterised by. Before she was 26 she made her final recovery, regaining flesh and spirits, looking much more womanly than before she took the attack in appearance and manner. She was not sent back to study, and for many years, and so long as I could trace her, she was well, and led a normal family life. Her case is very typical of this section of mental risks during adolescence. Apparently, she almost escaped mental neurosis, but the influenza acted as its exciting cause. Had she been a girl without means she certainly would have had to be certified, and sent to a mental hospital. She was undoubtedly insane in the medical sense part of the time of her first attack. The prognosis in such cases is good, and the treatment is what I have indicated. This section represents mental disease as technically understood in its first stage, and when it appears for the first time in a family the nervous temperament which had existed in ancestry had, through the marriage of two persons of the same diathesis, become accentuated into melancholia, and the age of adolescence and development was the most defenceless time of life on the part of the mental cortex.

The third section of adolescent mental risks represents a still stronger tendency to actual insanity. It is the one which is characterised by maniacal attacks usually of an acute character, periodic improvements and relapses, but, above all, by the tendency of many of the cases who suffer from it to pass gradually, after a number of maniacal attacks, into that most terrible of all mental conditions, Secondary Dementia, which represents a premature mental death with the ordinary bodily functions remaining to a large extent intact, and with the capacity for more or less continuous life for many years. In the year 1873 I studied this condition, described it, and called it "Adolescent Insanity," a term which has come into general use since then. Of late, Kraepelin and many other German and American psychiatric authors have described a considerable number of the cases of it under the term "Dementia Præcox." I find no fault with Kraepelin's descriptions, which are for the most part true to nature; but I would object to the number of varieties of Dementia Præcox which he has set up, because I believe they do not represent permanent facts in disease. He has divided Dementia Præcox into "hebephrenic," "paranoic," and "katatonic" varieties, and has otherwise elaborated his descriptions, so that a large number of the cases of adolescent insanity would be excluded. I strenuously object to the term "Dementia" being used to denote any curable variety of insanity, and Kraepelin admits that some of his cases of Dementia Præcox recover. I also say, without fear of contradiction by any experienced psychiatrist, that in the early stages of many of the cases it is quite impossible to say whether they are going to recover or to become demented. I also aver that Kraepelin's varieties often pass into each other as different phases of the brain disease in the same case. I agree with Dr. Lewis Bruce that many of the cases are of toxic and bacterial origin as the immediate and exciting cause of the mental symptoms; but I am quite sure that behind, and of more importance than the toxic and the bacterial causes, is the innate hereditary weakness in all those cases which exhibits itself during the momentous period of adolescent brain development. In a very few of such cases, the disease begins at puberty, in a large number between puberty and eighteen, and in by far the largest number between eighteen and five-and-twenty. The mental changes that take place between eighteen and five-and-twenty in the human brain are incomparably more important than those which occur between puberty and eighteen. Take the following as a typical instance of this section with which I am dealing:—A student of 23, who had worked hard, whose mother had had puerperal mania after almost every child she had had, and had been latterly epileptic, his father nervous, two sisters and one brother having attacks of mania subsequently to his own. In addition to his hard study and a sedentary life, he had been given to evil sexual habits. He suddenly became morbidly exalted, sleepless, talkative, restless, and was soon violent and unmanageable—was, in fact, suffering from an attack of acute, almost delirious, mania. His temperature was over 100 degrees, he was sent to Morningside, and lost, through his excitement, 28 lbs. in the first six weeks. All kinds of sedatives were tried, temporarily in vain. After about two months the intensity of his mania abated, but his expression of face became enfeebled-looking, his habits degraded, and it seemed as though he were to pass into dementia; but by means of careful and brain-stimulating treatment, he slowly recovered, more than regained the weight he had lost, and became, to all intents and purposes, a sane man. But after going back to city life, he had various domestic trials, and became insane again in eighteen months. He passed through another attack of mania, and recovered. He then had a third attack, and as the excitement abated he passed into that bourne of mental death from which no patient ever returns, and he remained during the rest of his life a mindless dement. Let us now look at a case with somewhat the same symptoms, but the termination of which was more fortunate, a lad aged 21, an intelligent and hardy fisherman, a ruddy son of the sea. At first he behaved as though something were preying on his mind, in which he suffered from a sort of mild prelude of sane depression. This soon passed into an elevated and maniacal condition of brain, and lasted for a week, and he then appeared to get well. In a few weeks he again became maniacal, and in ten days became rational and quiet. After a few months he appeared to get quite well, left the hospital, and he looked a full bearded young man, apparently several years older than he was on admission. This process of completed bodily development connected with improvement of mental symptoms, I attach great importance to. It means, I think, that Nature has completed her work in building up the man and woman, body and brain. When it is connected with recovery it is a good sign; when it is connected with threatening dementia, it is a bad sign. This young man's heredity was extremely neurotic. He came of a family where among ancestry and collaterals there had been insanity, epilepsy, idiocy, and phthisis in a large number of cases. He resumed his work, earned his livelihood, and has had, in the 20 years that have elapsed since I first knew him, one maniacal attack from which he soon recovered. He has married a wife, begotten children, and no doubt has thus handed on his nervous adolescent risks in an abundant degree to future generations.

The treatment of all such cases should be in principle supporting and non-stimulating, with plenty of occupation and fresh air. I would not say but what there are a few who need rest in bed in the early and very acute stages. Dr. Lewis Bruce has given us in his "Clinical Studies in Psychiatry" very careful and most instructive observations and studies in regard to the blood condition of such cases. He shows that in some there is a persistent hyperleucocytosis, and in others a fall in the number of leucocytes to below 8,000 cmm. of blood. Where the leucocytes tend to fall unduly, and do not rise in number even during a tendency to brain excitement, he says the prognosis is bad. He also shows that in many of the cases who recover, they have a persistent hyperleucocytosis, which shows that against the bacterial invasion to which they are subject, there is going on all the time the formation of antibodies to counteract their evil effects.

As a statistical fact, the mental risks of adolescence are so great that 75 per cent. of the chronic insanity now existing in the country result from them. Almost all the typical secondary dementia, and most of the delusional insanity arise out of, or have as a preliminary stage, attacks of adolescent insanity.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Macleod Yearsley, F.R.C.S.Eng., Senior Surgeon to the Royal Ear Hospital, London, the subject being "Chronic Non-Suppurative Diseases of the Middle Ear." A post graduate lecture.*

The annual dinner of the Incorporated Society of Medical Officers of Health was held on January 11th in the Holborn Restaurant. Dr. D. S. Davies, medical officer of health for Bristol, presided, and the company numbered about fifty.

ORIGINAL PAPERS.

THE HISTORY OF OVARIOTOMY. (a)

By F. BOWREMAN JESSETT, F.R.C.S.ENG.,
President of the British Gynæcological Society; Surgeon, Cancer Hospital, Brompton, &c., &c.

THIS, in all probability, will be the last valedictory address which will be issued from this chair to the Fellows of this Society, as Fellows of the British Gynæcological Society. I think the Society can congratulate itself upon the work it has accomplished since its formation. Before the seventies and early eighties of the last century, little was understood respecting the diseases peculiar to women, and their surgical treatment. In 1884 a small band of earnest workers met with the object of forming a society for the promotion of the study of gynæcology, among them Drs. Robert Barnes, Lawson Tait, Meadows, Aveling, Routh, Granville Bantock, Heywood Smith, Edis, Lloyd Roberts, Travers, and Mansell Moullin. Of these our hon. president, Dr. Robert Barnes, Dr. Routh, Heywood Smith, and Mansell Moullin are the only survivors. The idea was to make the new society as cosmopolitan as possible, and it was decided that it should be named the British Gynæcological Society.

The Society was registered under the Companies Acts of 1862 and 1883 as an "Association for the promotion of the study and science of diseases of women by means of meetings, lectures, records of practice, and a journal of transactions, and by other lawful means." The Memorandum of Association was deposited on February 14th, 1885, and the Association duly registered on March 4th, 1885, so that you see the Society has completed its majority.

The British Gynæcological Society, when the final ceremonies of marriage with her cousin, the Obstetrical Society have been duly gone through, and the Register signed, will sink her present name, and in future will appear as "The Obstetrical and the British Gynæcological Society." I have said she will sink her name, but not her identity, for I am sure there are many Fellows who will, by the work they bring before the new Society, uphold the traditions of those Fellows who have done so much during the past twenty-two years, by earnest research and hard work, the results of which have been presented in the shape of papers read at the meetings, the exhibition of specimens, and by the Journal in which will be found all papers reproduced and discussions. Besides this, a most valuable collaboration of all available reports of gynæcological work throughout the world is contained in the Journal, which reflects the highest credit upon the industry and energy of the various editors and their staffs.

In this address I propose limiting my remarks to the history and progress of Ovariotomy and the Treatment of Tumours of the Uterus.

OVARIOTOMY.

The question of dealing with ovarian cysts appears to have been discussed as long ago as the eighteenth century, but does not appear to have got any further than discussion. In the year 1762, Dr. William Hunter published a paper on "Cellular Tissue," in which he says: "It has been proposed by modern surgeons of first repute to attempt a radical cure of ovarian cyst by incision or suppuration or by excision of the cyst." Having pointed out the difficulties and dangers following this, he concludes with these words, which foreshadow some of the recent modifications in the operation:—"If it be proposed (he says) to make such a wound in the belly as will admit two fingers or so, and then tap the bag and draw it out so as to bring its root or pedicle so close to the wound in the belly that the surgeon may cut it without introducing his hand, surely in a case otherwise so desperate it might be advisable to do it, could we know beforehand that the circumstances would admit such treatment."

Later, John Hunter, in a lecture delivered in 1785, says:—"I cannot see any reason why, when the disease (ovarian dropsy) can be ascertained in an early stage, we should not make an opening into the abdomen and extract the cyst itself. Why should not a woman suffer spaying without danger as well as other animals do?"

It was not, however, until the year 1809 that McDowell, a Virginian, who had attended a course of lectures delivered by John Bell, of Edinburgh, performed the first ovariotomy in Kentucky. So successful was he that he is reported to have lost only one case—the last—in five women on whom he operated.

In the year 1823 Dr. James Blundell, having made a number of experiments on the rabbit with the object of improving the surgery of the abdomen, and observing the toleration of the abdomen in man when wounded by accident or design, came to the conclusion that a moderate opening into the human peritoneum would not necessarily, nor even generally, prove fatal from inflammation or otherwise, and, further, that certain viscera, or parts of viscera not essential to the welfare of the structure may be removed from the belly without necessarily or even generally causing death. He therefore proposed that the following operations might be performed:—

Division of both Fallopian tubes.

The extirpation of healthy ovaries in dysmenorrhœa and menorrhagia.

The extirpation of ovarian cyst in scirrhus. This operation, he says, he is persuaded will come into general use.

The removal of a large circular piece of the cyst in ovarian dropsy when the sac cannot be extirpated.

The removal of the cancerous womb.

Extirpation of the puerperal uterus when Cæsarian section is performed.

In rupture of the bladder, lay open abdomen, tie bladder, discharge urine and wash out the peritoneum thoroughly by injection of warm water.

Lizars, of Edinburgh, appears to be the first to attempt ovariotomy in this country. In 1827 he performed two operations, the first successfully, the second died in a few hours, while Dr. Granville is recorded to have operated in 1836 in London on two cases. The first case was abandoned on account of adhesions; the second, a fibrous tumour was found and removed, the patient dying on the third day. The results were so disastrous that the operation seems to have fallen into abeyance until 1842, when Dr. Protheroe Smith and Dr. Clay, of Manchester, operated on several cases successfully. But it was not until 1846 that the operation was performed successfully in a London hospital by Cæsar Hawkins. Mr. Hawkins did not repeat the operation, and only one or two surgeons in London, Dr. F. Bird, Mr. Lane, and Dr. Protheroe Smith, who had successful cases, attempted it.

In 1850 Dr. Duffin inaugurated a new era in ovariotomy by raising the question of the danger of leaving the tied end of the pedicle in the peritoneal cavity, by insisting on the importance of keeping the ligatured stump outside. In only one case is he reported to have adopted this procedure, and in this he found he could only stitch the cut extremity to the wound; it answered admirably. There can be no doubt, as Sir Spencer Wells has said, that this argument of Duffin's led to great changes and results, to the use of the clamp and to all modifications, and ultimately to researches as to the physiological and pathological phenomena of ligatured stumps within the peritoneal cavity and to the study of the subject of drainage.

In 1853 Spencer Wells first commenced work in London, and in the following year joined the Samaritan Hospital. Baker-Brown at the same time was operating, but with poor success, and for the following four and a half years he did none, saying that peritonitis was sure to beat one.

It was not until 1856 that Spencer Wells, having returned from the Crimea, where he had been engaged in war surgery, began seriously to pay his attention to ovariotomy. Baker-Brown had given up the operation, very few were attempting it, and most men were lapsing into the old state of indifference, if they were not loudly protesting against it. I will not trouble you with the different methods of dealing with the pedicle adopted in these days. Some adopted ecraseur, cautery, or whipcord ligatures, the ends hanging out of the wound, but the clamping was the most usual way. The death-rate still kept very high—as much as from 20 to 25 per cent. It is undoubtedly due to Spencer Wells that ovariotomy became recognised as an established operation. Until the year 1877 he had performed 408 operations with a mortality of 99 cases, about 25 per cent., but during the last two or three years the mortality was only 10 per cent. Lawson Tait was at this time also busily at work.

(a) Abstract of Valedictory Address to the British Gynæcological Society, January 10th, 1907.

In the year 1877 Lister came to London and introduced his system of antiseptic surgery with the carbolic spray. Wells hesitated, but Knowsley Thornton introduced the new practice into his wards, and Bantock for a time followed his example, abandoning it later for absolute cleanliness. It may not be uninteresting here to give Wells' table of his series of cases during the first twenty years of his practice, showing how experience and more care in technique reduced his mortality from 30 per cent. to a little over 9 per cent.

	CASES.	DEATHS.	RECOVERIES	
First five years, 1858 to 1862	30	9	70 %	successes
Second five years, 1863 to 1867 ..	83	21	74 %	,,
Third five years, 1868 to 1872 ..	133	36	73 %	,,
Fourth five years, 1873 to 1877 ..	162	33	80 %	,,
Last two years, 1876 to 1877	71	7	90 %	,,

Billroth, who had been operating in Germany from 1865 until 1884, had performed 327 operations, 101 of which had died, a mortality of 31.5 per cent. In his remarks upon his cases he says :—

" *Granted that the operation is well done, and that the patient does not die within about twenty-four hours from loss of blood or shock (which has occurred to me only four times in 222 cases), the result depends upon whether the sponges, fingers, instruments, secretions, and, above all, the ligature threads are clean.*"

Sir Spencer Wells claims long before Lister had tried any of his methods—indeed, from the very beginning of his practice—to have insisted upon all possible care in protecting patients before, during, and after operation from all known causes of excessive mortality. Yet his mortality was terribly high in comparison with that of gynæcologists of the present day, as, although he adopted strict antiseptic methods, as prescribed by Lister in those days, viz., carbolic spray during the performance of the operation, antispetic dressing to the wound after, and all instruments, sponges, ligatures, etc., being placed in carbolic acid solution, he lost from 1878 until 1884 out of 247 cases, 27 patients, making a mortality of 10.9.

That this high rate of mortality was due to a very great extent to faulty after-treatment, and not to any errors in technique in the mode of operation, I think must be generally admitted, and it is due, I think, very much to the suggestion of Lawson Tait, who startled the profession by advocating large doses of magnesium sulphate for the treatment of peritonitis, that operators began to have better results after all abdominal operations. Previous to this, after ovariotomies, myomectomies, &c., patients were given opiates by the rectum or mouth if there were not much retching, the object being to keep the bowels quiet, and it was a dictum that they need not act for ten days or more ; Spencer Wells states a case in which they did not act for nineteen days, and then acted naturally. Now, although Lawson Tait recommended the aperient treatment for peritonitis in cases after abdominal operation, it was a misnomer, as the cases undoubtedly were not those of peritonitis, but of distension of the intestines due to paresis of the bowel, and many of those patients who died lost their lives not from peritonitis, as supposed, but from exhaustion due to vomiting, pain, and possibly septic absorption due to this over-extension of the bowel.

It has now long been recognised that the bowels should be relieved by aperients and enemata within forty-eight hours of the operation being performed.

The results, then, of the operation for removing ovarian tumour, were even up to the early eighties not such as to encourage one very much. However, we know now that the mortality after this operation by improved technique and after-treatment is reduced to from 2 per cent. to 1 per cent.

TREATMENT OF UTERINE TUMOUR.

In 1887 Lawson Tait brought before the Society the importance of washing out the peritoneum after certain operations, with a view of cleansing, in the place of doing so by sponging, as he had a dread of sponges, looking upon them as a most efficient means of carrying infection with which he was acquainted. This and drainage, like many other forms of treatment, had practically dropped into disuse, excepting in cases where there has been some escape of pus, or in which many adhesions had been torn through, and there had been considerable oozing, it is thought necessary to either flush the peritoneum or drain. In any case, the glass drainage tube, like the " serre nœud," is now a thing of history.

How different are the results at the present time, when in skilled hands the operation of hysterectomy is performed with a mortality of less than 5 per cent. This happy result is due no doubt to several causes. The operation being acknowledged as a most successful one, patients suffering from uterine tumours are advised to have them removed early, before their strength has been reduced by constant hæmorrhage or life made unendurable owing to the pressure of these large tumours. The insistance of having the patient properly prepared, the abdomen thoroughly cleansed with antiseptic solution, all instruments boiled and sterilised. The use of properly sterilised swabs during the operation, as well as all dressings to be applied after the operation ; dressings are not disturbed for a week or ten days after the operation. The care taken by the operators to thoroughly cleanse their hands, and the administering of an aperient to the patient twenty-four hours after the operation. The adopting the position as suggested by Trendelenburg, of placing the patient in an inverted position by means of elevating the pelvis during the operation, so as to allow the intestines to gravitate out of the field of operation. The use of Doyen's retractor, by which a much better view of the floor of the pelvis can be obtained. The attention to smallest detail, arresting all bleeding, and the careful stitching of the peritoneum over the floor of the pelvis, care being taken to bury all stumps to which ligatures have been applied. The care which is now taken in closing the parietal wound in layers is a most important innovation of late years, whereby the risk of hernia of the wound is reduced to a minimum.

The question of removal of the uterus for malignant disease has always been a source of anxiety to surgeons. So far back as 1828 Blundell proposed excision of malignant uterus per vaginam. He carried out this operation in four cases, three of which proved fatal, two within six hours of the operation, one after thirty-nine hours, and one lived a year. To Dr. Purcell is due the honour of having performed vaginal hysterectomy for cancer of the uterus first in this country at the Cancer Hospital in 1883. The operation had been performed on the Continent by Freund, Olhausen, and others, but with very meagre success. Out of ninety-four cases commented on by Oldhausen, only twenty-four survived. I performed the operation in 1886 on three cases, two of which died from peritonitis, and the third made a very tardy recovery. Since that time I have performed the operation in over 200 cases, and the mortality is so low, and the patients convalesce so well, that I am still an advocate for the operation in preference to the abdominal operation in certain cases. As time advances and science and practice improve, so do old operations become superseded by new, and I know the Americans and Germans and many British surgeons now almost invariably remove the uterus for cancer through the abdomen, whether with more favourable results, I think is still open to question.

Although the Hunters suggested the feasibility of opening the abdomen for the removal of ovarian cysts, little did they dream of the far-reaching results which were to follow the perfecting of that operation—the removal of suppurating tubes, the study and treatment of ectopic gestation, Cæsarian section, all connected with gynæcology, and then the extension to intestinal surgery, the surgery of the liver and kidney—verily, what a monument is perpetuated by the surgery of the abdomen alone, which has attained such brilliant success, to the discovery and research of those two great and distinguished men, Sir James Simpson and Lord Lister.

TETANIA PARA-THYRO-PRIVA.

By Prof. JAKOB ERDHEIM, M.D.,

University of Vienna.

THE history of tetania after the removal of the thyroid gland begins with the name of Nathan Weiss in 1880, who was a member of Billroth's Clinic at the time, and who had commenced the entire extirpation of the thyroid for the radical cure of goitre. Three years later Reverdin and Kocher, for the first time, noted the sequence of cachexia strumapriva. These observations arrested the attention of physiologists, and gave the first proof of a long-hidden conjecture that these ductless glands had some connection with the due elaboration of the blood. Tetania strumapriva connected the function in some way with the nerve system, and led Schiff, Wagner, and Eiselsberg in the following year to make experiments with animals to prove the veracity of the statements whose labours confirm the truth of a pathogenic tetania. Further progress in the knowledge of tetania remained in abeyance till 1890, when Gley again gave a new impetus to the investigation by declaring that Sandstroem had discovered the active principle or functional agent in the gland, which he named glandulæ para-thyroidæ, epithelial bodies, or vesicles found in the yellow fluid that exudes from the gland when cut. Gley further affirmed that this gland was in sympathy with the hypophysis cerebri or some portion of the brain near the sella turcica. This conclusion was drawn from the inference that thyroectomy was better borne by animals that had large hypophysis cerebri than in those that had small organs. Hofmeister affirmed that the enlargement of the thyroid was only a vicarious expression of the hypophysis, and that the origin of the disease was central. The function of the gland was then attacked. Was it athyrea, hypothyrea, or dysthyrea that influenced the gland in the second place? Idiopathic athyrea, or loss of secretion, caused the gland to atrophy; but the symptoms were different in such cases in being slow and degenerative, and without tetany, which was usually present in hyperthyrea if the gland were removed. Rehn held to a dysthyrea or alteration in the quality of the secretion as the true cause. Closer investigation and comparison soon arranged Basedowi, cretinism, and chrondro-dystrophy as allied diseases, though symptomatically expressed in different shapes.

Vassale and Generali next commenced a series of experiments on dogs, founded on the assumption of Reverdin that a para-thyroid body existed in man, as well as in fishes and other mammalia. The entire gland was removed in one portion, and partially in another. When the whole gland was removed tetany invariably followed; when partially removed this was not so constant on the cachexia. This lead to closer investigation of the anatomy of the organ by Kohn, who discovered the large epithelial bodies in the gland which have now received the classic distinction of glandulæ para-thyroidæ. On closer inspection they found that these para-glandular bodies were the active agent in the prevention of the tetany when not injured, but when destroyed the tetany appeared. These experiments were confirmed by Walbaum, Pineles, and others, who removed the glandulæ para-thyroidæ alone and obtained the tetany, but when they extirpated the entire gland no tetany was observed, but the cachexia was pronounced.

At this point of the history Erdheim commenced his own experiments on rats by destroying the epithelial bodies with the galvano-cautery. Fifty animals were operated on in different ways, some partially, others complete para-thyroidectomy; some partial thyroidectomy and others complete thyroidectomy. The result proved that complete para-thyroidectomy—*i.e.*, where all the epithelial bodies were destroyed, but the gland substance retained, produced tetany; but in cases where some of these epithelial bodies were preserved in the gland, tetany was absent. In the latter cases of partial para-thyroidectomy, the nerve disturbance was in proportion to the number of epithelial bodies left; if few, the tetany was more severe than in the cases where a greater number were destroyed. In the cases of total para-thyroidectomy, the animals usually died within two to five and a half months from severe cachexia, as a result of inanition. The real cause of the inanition seemed to be the inability to take food, due to some trophic disturbance of the teeth. This trouble usually appeared about the sixth or seventh week after the operation, when the teeth began to break and fall out. The histological examination showed that the changes were mostly in the dentine, which became dry, brittle, and chalky about the tenth day after the operation without any real local cause.

This trophic disturbance has not hitherto been observed, or described, in experimental tetany, as far as laboratory work is concerned, and it may be of interest to follow in the trophic changes in man where no such changes have yet been recorded. The falling-off of the hair and the nails was apparently associated with the decay of the teeth, and resembled in many respects the exhaustion or decay witnessed in old age. Erdheim also observed cloudiness of the lens in the tetanic rats not before recorded from the laboratory, although cataract has been observed to succeed tetany.

Like other laboratory experiments, our reasoning has to be modified in the dog. According to Gley, only two of these epithelial bodies can be met with in the dog, although Kohn affirms there are four. Be this as it may, Erdheim obtained very different results in the dog than in rats. In the latter he always obtained tetany; in the former never once. In rats he found many of these epithelial cells in the neighbourhood of the thymus, and, struck with the rarity of them in the thyroid, his curiosity led him to investigate this region more carefully. Laying the neck bare, he found ten of these epithelial bodies around the margin of the thymus accessories in one, and 32 in another dog. These were strewn throughout the thymus as well, in all sizes, so that their function must not be neglected in determining the results. These facts may account for the absence of tetany in dogs, but they do not invalidate the hypothesis that the cause of tetany rests in the epithelial bodies. It is safe to presume that the operations on the human subject bear this interpretation, that some surgeons have removed different numbers of these epithelial bodies and obtained different results. Although the assumption of some special agent has been accepted, no surgeon hitherto has been able to demonstrate this active part in the gland, which may be termed para-thyro-priva, and is the principal cause of the tetany. With this proof in view, Erdheim performed three operations on the human subject of partial strumectomy on both sides of the gland, which produced the typical tetany. The first died four months after the operation from tetany of an epileptiform character. The second case died after five months; the third in seven months in a similar manner to the first.

The post-mortems gave very little information, as the morbid changes were few beyond lobar pneumonia, with cloudy swelling and œdema in the lung tissue. All the other organs were healthy. The examination of all the epithelial bodies in the gland could hardly be undertaken from their number, as they would exceed thousands of incisions, but in all the three there were a large number of healthy corpuscles not necrosed, although one of them had the principal ones destroyed, as well as that in the thymus and small accessories. In the second only one epithelial corpuscle was destroyed, and in the third neither the principal nor the accessories were present. The experiments were in accordance with the theory after extirpation of tetany being produced by the necrosis of the epithelial corpuscles, although a large number were preserved in a healthy condition. These conclusively prove that extirpation of the gland produces para-thyro-priva. When it is assumed that tetany is a rare occurrence in total extirpation of the gland in the human subject, we must modify the assumption to a part of the gland being removed, and that the principal epithelial corpuscles have been preserved. It is generally admitted that tetany is not so frequent since the operations have been confined to partial removal of the gland, as more of the epithelial corpuscles must have been preserved. Unilateral operations have been quite as successful in many cases as the partial removal of the gland where a compensatory hypertrophy of the epithelial corpuscles has taken place in the residuum.

The most important question for practical solution is how to preserve the epithelial bodies in operating. This is difficult in human subjects, as their position is variable and topography uncertain. None of the operations hitherto have been free from tetanic attacks, though not so frequent as stated above. At this point Erdheim showed several preparations where the recurrent nerve on both sides with the epithelial bodies had been carefully observed, as these latter are often found near or over the recurrent nerves. The best operations seem to be those practised by Mikalicz, which is a wedge resection, and Kocher, who practises enucleation resection. Both of these operations leave the recurrent nerves and their coverings intact. It is true that Billroth early acknowledged the preservation of the recurrent nerves, and carefully dissected them from the gland before its removal, but his efforts met with no better success owing to the removal of the epithelial bodies.

In supporting this theory we have other conditions in the gravid state to reconcile with these epithelial bodies. If an animal in the gravid state have these bodies disturbed, severe tetanic convulsions occur; but where there is no pregnancy the tetanic phenomena are absent. Again, after removing both of the principal epithelial bodies, severe tetanic cachexia set in, but no pregnancy ever took place. To obtain an exact relationship between the gravid uterus and the insufficiency of the epithelial bodies, it was necessary to destroy one of these, leaving the rest intact, while other experiments were conducted with partial lesions. From four animals treated according to the first method, three of them became gravid, two dying from tetany in pregnancy. Twenty other animals were treated by removing half of the epithelial bodies; 14 of them became gravid, of which ten were only once, two were twice, one three times, and one four times; but in all of the cases they ended with tetany, commencing in the last third of pregnancy, and continuing to parturition.

There is another symptom that should be noticed in conjunction with the tetany—viz., the falling out of the hair. It is a premonitory symptom, and is to be observed in the human subject as well as animals. This theory of Erdheim is at variance with Pincle's explanation, who maintained that the tetany was always synchronous with a recurrence of the increase in the residue of the gland, which he presumed was due to pressure on the remaining epithelial bodies. This hypothesis presumes that the epithelial bodies become hypertrophied. In connection with this might be quoted one of Billroth's cases in 1886, where a woman, æt. 36, had the thyroid entirely extirpated on account of adenoid tumours. All went well in the clinic after the operation, but after her return home she developed tetanic symptoms resembling the contractions in pregnancy. Later this phenomenon gave way to a chronic cachexia. In 1887 she became pregnant, with the typical symptoms renewed. In 1888 she again became pregnant, with a hard tumour appearing behind the manubrium sterni. During the latter period the cachexia had disappeared, and always about the period of the menses this tumour increased. In 1891 the tumour became very active, and increased enormously, giving great pain, so that in September, 1892, she returned to Billroth's clinic, where it was diagnosed as a sarcoma, probably malignant. In the neck there was no trace of the thyroid gland. It was resolved to resect the tumour, and when examined, was found to contain carcinomatous cylindrical cells or malignant adenoma. In the cell trabecula colloid matter was found, which confirmed the opinion that the neoplasm was a cancerous struma metastasis. On the ninth day after the operation, tetanic symptoms again set in, but soon improved. After some time cachectic symptoms appeared. About this time a knobby tumour commenced to grow below the scapula, which was diagnosed as a metastatic growth. During this time the patient was otherwise quite well. In November, 1893, she bore a healthy child, and shortly afterwards died from cachectic symptoms. In this case the tumour behind the sternum must be acknowledged as an accessory epithelial body, which vicariously became hypertrophied and performed the necessary hæmopoetic or hæmatosis in the sanguinary system.

From Billroth's other cases to the year 1890, he relates twelve of tetany after total extirpation. Five of these were "Foudranter tetany," two chronic that died, two which lingered long, and one that recurred.

During the last five years 356 cases have been operated on, with 16 giving symptoms of tetany; 11 slight in the face, two continued some time, while the others were easily cured with thyroid gland. It may be assumed that better results have been obtained in the extirpation of this gland where care has been taken to preserve the recurrent nerves and tie the inferior thyroid arteries, which points to the preservation of a greater number of the epithelial bodies which usually lie round these parts.

The methods that have given the best results in this respect are:—Socin's enucleation, Kocher's enucleation resection, and Billroth's half to four-fifths extirpation.

In connection with this compensating theory, Paltauf found in goats, which he had operated on to produce struma-priva for the treatment of Basedowi patients, that the isolated epithelial cells were greatly hypertrophied and of a dark red colour when examined in the post-mortem room.

There are difficulties in our theory common to all assumptions founded on clinical experience. If the "insufficiency" of the epithelial body is the cause of tetany, Kassowitz has pointed out that the tetany of the rachitic child will be due to the same cause, although it may be of an idiopathic nature, and not operative These attacks are more frequent than in the adult, commencing in the winter months sporadically, but very frequent in the months of March and April, disappearing altogether in the summer and autumn. In all these cases testimony of rachitis will be present in the bones of the head, but the child seems to recover with the season, probably from obtaining more fresh air. If an adult, the same clinical history is experienced. The question is: Can this be a lighter form of the new-born theory? In all the forms we must admit the convulsions arise from a toxine on the centre, which cannot come from the same source. In the experimental or operative, the toxic action would be endogenous from the epithelial bodies being destroyed, which neutralise the poison that acts on the trophic nerve and induces the convulsions. On the other hand, the poison seems to be from without, which we may term a respiratory noxa passing from the periphery along the nerve trunk to the centre. This may explain the prompt action of phosphoric medication, which allays the rachitic, but has no effect on the purely neurotic. In the former it seems to modify the cranial rachitis and reduce the collateral hyperæmia in the cortical centres. The exogenous noxa is neutralised by open air, generous diet, and careful hygienic attention.

THE HÆMO-RENAL SALT INDEX

AS A

TEST OF THE FUNCTIONAL EFFICIENCY OF THE KIDNEY (a).

By DAWSON TURNER, B.A., M.D., F.R.C.P.Ed., M.R.C.P.Lond.

Lecturer on Physics, Surgeon's Hall, Edinburgh.

The author first briefly described the methods employed for determining the electrical resistance of the fluids, and demonstrated an apparatus he had devised for use with only 5 cubic millimetres of blood, instead of the 5 or 6 cubic centimetres generally required. He had compared systematically the electrical resistance of the blood and of the urine in a large number of medical and surgical cases, and had originated a term expressing the ratio between the two, to which, after consultation with Dr. George Gilson, he had given the name "Hæmo-Renal Salt Index." In health this index is equal to 3, 4, or 5, whole numbers, thus :—

$$\frac{\text{Electrical resistance of blood}}{\text{Electrical resistance of urine}} = \frac{900}{225} = 4$$

The higher the hæmo-renal index is, the healthier, other things being equal, is the patient. If the index increases it indicates that the blood contains fewer salts, or is richer in corpuscles (which, as Professor Stewart and Mr. M. Wilson have shown, obstruct the passage of an electric current), and that the functional activity of the kidney is increasing. If the hæmo-renal index diminishes then the kidney is becoming sluggish and less efficient. Experiments on artificial urines, made of solutions of urea and sodium chloride in distilled water, had shown that the salt was the main factor in influencing the electrical resistance of the urine. Reference was next made to a number of cases, and particularly to some medical cases, whose hæmo-renal indices had been examined from time to time over periods of more than two months ; he pointed out that the hæmo-renal index well reflected the general condition of the patient, rising with improvement, and falling again with relapses. In diabetes and in pernicious anæmia the electrical resistance of the urine was sometimes very high, giving a low hæmo-renal index. In surgical cases this method of investigating the renal efficiency seemed to be of considerable value, and its indications so far agreed totally with those of cryoscopy. Some surgical conditions in which a successful operation had afterwards been performed were referred to in detail :—(1) Female, æt. 37, under the care of Mr. F. M. Caird. Disease of right kidney. The resistance of the blood was 1060, which is normal. The resistance of the urine segregated from the right (diseased) kidney (4 specimens) was 330 ohms ; urea 5 grs. to ounce, pus cells present. The resistance of the urine segregated from the left (healthy) kidney was 235 ohms ; urea 7.5 grs. to ounce. Hæmo-renal index of right kidney $\frac{1060}{330} = 3.2$; of the left kidney, $\frac{1060}{235} = 4.5$. These indices were very satisfactory, showing that the left kidney was very efficient—nearly one and a half times as much so as the right, and that operation was therefore not contra-indicated. Operation showed that the right kidney, though containing a good deal of kidney substance, was the seat of so many small calculi (practically a mass of sand) that removal of the entire organ was necessary. The result was in all respects satisfactory. (2) Male, æt. 24, under the charge of Mr. Cotterill ; probable disease of left kidney. The resistance of the urine segregated from the right (healthy) kidney (4 specimens, two with indigo carmine) was 371 ohms. ; the resistance of the urine segregated from the left kidney was 675 ohms. The resistance of the blood was 960. The hæmo-renal index of the healthy kidney $\frac{960}{371} = 2.5$—below normal, indicating that kidney was not very efficient. The hæmo-renal index of the left (diseased) kidney was $\frac{960}{675} = 1.4$—far below normal, showing that the kidney was very inefficient. Operation showed that the left kidney was simply a bag of pus ; the patient died about twenty-four hours later. The speaker concluded by remarking that the method was another example of the application of precise scientific measurement to clinical medicine and surgery, and that it was of extreme importance to the medical student to have a proper training in medical and experimental physics.

(a) Abstract of Paper read before the Edinburgh Medico-Chirurgical Society on Jan. 16th, 1907.

THE OUT-PATIENTS' ROOM.

CHILDREN'S HOSPITAL, PADDINGTON GREEN.

Nævus of the Forearm.

By Arthur Edmunds, M.S., F.R.C.S.

Amongst the out-patients was a child (male), æt. 9 months, who was brought with a large nævus just above the wrist-joint. The nævus was situated over the flexor tendons, and extended nearly halfway round the limb. It was irregular in outline, and measured about one inch in the long axis of the limb. It consisted of two portions, one of which was deep to the skin, showing the usual bluish colour, while the other portion invading the skin itself was bright red. The question of treatment, Mr. Edmunds said, presented itself, and one had to consider the best method to adopt. The need for treatment for these cases was, he thought, well shown in another case which was attending his out-patient department, in which a child had been born with a nævus on the right shoulder about as large as the palm of the hand. There had been difficulty in establishing respiration, and in consequence the chest had been rubbed briskly with brandy. This had produced vesication over the nævus, and subsequently suppuration and sloughing. A linseed-meal poultice had been applied by the parents, with the result that an enormous sloughing cavity was produced, at the bottom of which about two square inches of the trapezius were exposed, the child suffering correspondingly from septic absorption. This case, he said, illustrated the need for active interference with these tumours. A similar amount of suppuration and sloughing among the tendons surrounding the wrist-joint could hardly fail to permanently incapacitate the hand. With the nævus in the patient at present under consideration, excision was first considered, this being the ideal treatment wherever possible. There was, however, one great drawback to this: so extensive an area of skin would have to be removed that it would be impossible to suture the incision—at any rate, without very great tension. A tense contracting scar upon the abdomen would, he pointed out, cause but little inconvenience, but upon the wrist, where there was only a limited amount of tissue, it would have acted as a constricting band producing permanent œdema of the hand. Electrolysis was a method which was admirable in many ways but it was extremely slow in its action, and, in some cases was practically ineffectual. He had decided, therefore, to employ the electro-cautery. This had been done several times, and the effect on the tumour was very satisfactory. The cautery employed was a fine platinum point heated to a moderately bright red heat; this was thrust into the tissue at intervals of about a quarter of an inch all round the margin of the nævus, and then the surface of the tumour was punctured all over, the punctures being about the same distance apart. A very distinct sensation could be felt by the operator when the dermis itself was perforated, the needle going on with a jerk, and so indicating that he had gone far enough. No hæmorrhage resulted as a rule, but occasionally, especially if the needle became over-heated, a slight amount of blood escaped. This was checked by a further application of the cautery, till the whole surface was dry. A dressing was then applied, consisting of a thin layer of wool painted over with Friar's balsam. By employing the cautery in this way, Mr. Edmunds said, only a very limited amount of the surface epithelium was destroyed, and when the dressing fell off after each application, the punctures were found soundly healed. The operation was repeated, the punctures now being made between the original ones, whose site was indicated by bluish white scars. In this way, by repeated applications of the electro-cautery, the nævus was being cured without any septic complications and without any excessive cicatrisation. The epithelium which had been destroyed at one operation was regenerated on the adjacent epithelium, and served in its turn as a source for fresh epithelium to replace that destroyed by the second operation. In this way, although the whole of the epithelium over the tumour was at one time or another destroyed, there was no great deficiency at any one time, and in consequence there resulted no ulceration or contraction. The scars produced by this method were, he remarked extremely good, being little inferior to those produced by electrolysis. In fact, the operation of electrolysis very frequently, he considered, was nothing more or less than a puncture with a fine cautery, the negative needle having an action which was practically that of a hot fire. The operation he had just employed has to be performed repeatedly until the whole nævus was cured, but the time and trouble spent were, he thought, amply compensated by the result obtained.

OPERATING THEATRES.

ST. PETER'S HOSPITAL.

CASE OF URETERO-LITHOTOMY.—Mr. SWINFORD EDWARDS operated on a man, æt. 28, who had been admitted for hæmaturia. The patient had never suffered any pain on micturition, nor was there any increased frequency in passing water. The patient stated that the discoloration of the urine was greater towards the end of the act of micturition. Taking this together with the absence of pain, Mr. Edwards thought that on cystoscopy he would find a vesical papilloma. Cystoscopy was carried out under an anæsthetic, when the right ureteric orifice was found to be protruding and everted, with œdematous folds of mucous membrane. The left ureteric orifice was normal. There was no other lesion in the bladder. The appearance of the right ureteral orifice, Mr. Edwards said, clearly pointed to a stone, probably impacted in the ureter, and which this canal was making every effort to get rid of. Operative interference had been postponed, not only to get the patient's consent, but also, if possible, to verify the diagnosis by radiography. The man was again brought up the following week, an X-ray photograph having in the meantime been taken, which showed a well-marked shadow deep in the pelvis on the right side, apparently at about the level of the upper part of the great sacro-sciatic notch. The operator made a six-inch incision on the right side in the abdominal parietes, as if he were about to ligature the common iliac. The peritoneum having been reached, this was carefully peeled off the posterior abdominal wall; a considerably dilated ureter was found to the under-surface of the serous membrane; this was isolated and followed down towards the bladder over the iliac vessels. The stone was carefully palpated for, first intra-abdominally, and secondly bimanually, one finger being in the rectum; but these means failed to locate it. Accordingly the dilated ureter was opened just above the level of the pelvic brim, and a probe passed downwards towards the bladder; a stone was struck about two inches from the aperture in the ureter. An endeavour was now made to express the calculus through the opening in the ureter, but it could not be manipulated higher up than one inch below the incision already made; a second incision was therefore made on to the stone, the left hand of the operator steadying it for this purpose. The calculus was extracted and was found to be black in colour, somewhat polished on one surface, and of the size of a long plum-stone. Both incisions into the ureter were now closed by Lembert's sutures, and after careful swabbing of the part of all bloodclot, a long rubber drain was inserted, one end being placed over the ureteric lesion and the other brought out through a separate opening made in the flank just above the iliac crest. The various layers of the abdominal wall were brought together by sutures. Mr. Edwards said that this case only instanced the fact that one could never be quite certain of a correct diagnosis by symptoms only, for here the symptoms had decidedly pointed to the presence of a vesical papilloma and the symptoms of stone were remarkable by their absence. From what was brought to light at the operation, one might have expected, he remarked, to have found not only hæmaturia, which certainly was present, but also attacks of renal colic and ureteral pain; combined with this one might have expected to have discovered a large and tender kidney, possibly also some increased frequency in micturition, and a deposition of crystals and some little pus in the urine; all the more might one have expected to have found some loin pain, as the effects of back pressure were markedly displayed in the dilated and thickened ureter. The absence of pain in this case he thought might be accounted for by the fact that the stone was roundish and smooth, instead of being of the spiculate variety. The obstruction of the passage of the calculus into the bladder was, he thought, probably caused by the narrowing of the ureter, where it passes obliquely through the bladder-wall. Mr. Edwards believed that this was quite the best method of approaching a stone when it is impacted in this position, or in any part of the ureter between the bladder and the iliac crest; for stones in the pelvis and in the upper part of the ureter, the ordinary lumbar incision was, of course, the one to employ. He remarked on the failure at first to locate the calculus by bimanual palpation, and he wondered for a moment if the shadow cast in the X-ray photograph might not have been caused by an enlarged lymphatic gland, which was found lying under the external iliac vein just below the brim of the pelvis. The fact of striking the stone with the probe gave him, he said, the certainty that it was there, and thereby assured the success of the second endeavour.

It is interesting to note that the patient made a very rapid recovery. The drainage-tube was taken out on the third day. No urine has escaped, and now, a week after the operation, the patient is practically convalescent.

TRANSACTIONS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held January 16th, 1907.

Dr. J. O. Affleck, President, in the Chair.

Dr. **Byrom Bramwell** showed a case of loss of the stereognostic sense. The patient was a man who had fallen and sustained a fracture of the base of the skull. This was followed by weakness of the right arm and right side of the face. Two months later he was admitted to hospital complaining of stammering and loss of power on the right side, the dynamometer reading being 30 in the right hand and 120 in the left. Tactile sensation was impaired all over the right half of the body. The condition was regarded as in part functional, and under treatment by isolation and suggestion, there was considerable improvement. The patient, however, returned to hospital after a few months with the same speech defect as before. There was also hemianæsthesia on the right side, deafness in the right ear, and loss of the sense of smell. The visual fields were not contracted. He was again healed by rest, isolation, and suggestion. He now showed weakness in the right side and partial anæsthesia. There was in addition complete loss of the stereognostic sense. The patient could feel touch and temperature, but could not distinguish the forms of common objects—a tumbler, a knife, keys, coins, &c.—placed in his right hand. On shaving the head a depression was found in the skull just behind the motor areas, and it was proposed to have the bone elevated with the object of seeing whether that would relieve the symptoms.

Dr. **Allan Jamieson** showed two improved appliances for dermatological therapeutics. One was called epicolloid; it had been prepared at his desire by dissolving pyroxylus in acetic ether. It presented certain practical advantages over flexile collodion, and could either be used as a protective, or as a basis for applying zinc oxide, salicylic acid, &c. The other was a specially thin and translucent form of adhesive plaster for covering cracks and abrasions.

Drs. **Bruce** and **Harvey Pirie** showed specimens of syphilitic meningo-myelitis, with photographs and microscopic demonstration.

Dr. **Chalmers Watson** gave a microscopic demonstration of the favourable effect of oatmeal on the thyroid gland of growing animals.

Mr. **Cotterill** showed an enormous tumour of the parotid.

Dr. **Dawson Turner** read a paper on the

HÆMO-RENAL SALT INDEX AS A TEST OF THE FUNCTIONAL EFFICIENCY OF THE KIDNEY,

a full abstract of which will be found on page 93.

Dr. **Burn Murdoch** read notes of some

CASES TREATED BY BIER'S METHOD.

Case 1 was that of a schoolboy who received an injury to the shin on January 18th; on the 20th, there was an acutely painful swelling of the bone with constitutional symptoms. The temperature was 102°, and the pulse 120. The symptoms pointed to acute osteitis, and an operation suggested itself; but Bier's treatment was adopted, with the result that the pain at once disappeared, and the temperature fell to normal by January 23rd. Case 2 was of a similar nature. Shortly after the receipt of the injury the tibia became acutely painful, and the temperature rose to 100°; next day it rose to 103°, and the congesting band was applied. The temperature fell to normal in a week, and all symptoms subsided. Case 3 was one of extremely obstinate ulceration of the leg, resembling what is known as Bazin's disease. The patient had been under treatment in private and in hospital for more than a year without being cured; under Bier's treatment the ulcers healed in ten days. As to the nature of the first and second cases, the speaker said that they clinically exactly resembled cases which, in the past, had been diagnosed and operated on as acute osteomyelitis by the surgeons called in in consultation. He warmly advocated Bier's method from the point of view of the general practitioner. The paper was discussed by Drs. Dickson and Flett, both of whom mentioned very successful cases healed in this way, and by Mr. Wallace, who said that, on the whole, he had been less fortunate. He doubted whether passive congestion could be of great use in osteomyelitis; probably, too, it was less successful in cases in which a suppurating focus had been incised than in cases in which this had not been done.

Dr. **James** read a note on the

NOTIFICATION OF INFECTIOUS DISEASES.

The infectivity of phthisis was relatively slight; notification was therefore undesirable on two grounds—(1) because it handicapped the patients in earning their livelihood, and (2) because it diverted the attention of the public and the profession from the true cause of the disease. He proposed to consider the notification of phthisis in relation to the notification of other diseases. The argument of those who favoured notification was that the organism was present in a great number—perhaps 40 or 60 per cent.—of healthy persons; as soon as the nutrition became lowered it started phthisis. By compulsory notification the foci of infection would be stamped out, and the disease exterminated. Dr. James, however, argued that the soil was as important a factor as the seed, and asked, Can you exterminate the soil? We had had compulsory notification of infectious disease for twenty years; let us see what it had done. He showed charts of the mortality from phthisis, typhoid, diphtheria, scarlet fever, and measles during a period of forty years, twenty years before, and twenty years since the enforcement of notification, and in these it was demonstrated that except in the case of scarlet fever the fall in mortality was no greater than in the case of phthisis, which had not been notifiable. The general improvement in all cases was ascribable to improved sanitation and not to notification, except in the one case, scarlet fever. Notification, therefore, had not met with the success expected. At present all the public were crying out for notification as a panacea, just as sixteen years ago they had run after the tuberculin treatment. He thought the profession ought to think the position out carefully and not give advice which would afterwards turn out to be wrong. What possibly could be expected from the results of notification, when we were as yet in the dark as to how infection arose, whether through milk, air, &c. The conditions under which people lived were far more important than the virulence of the organism; a person might take phthisis when not in contact with infection if his vitality was lowered.

Dr. James's paper was strongly criticised by Dr. Byrom Bramwell, and Dr. Carnhill, and supported by Dr. McVie, Dr. Hunter, and Dr. Webster.

The prize of £50 given annually by Sir John Craggs, M.V.O., to the London School of Tropical Medicine for presentation to the author of the most valuable contribution to tropical medicine during the year has just been awarded to Fleet-Surgeon Bassett-Smith.

THE LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD JANUARY 4TH, 1907.

The President, Dr. J. B. BALL, in the Chair.

THE following communications were made :—

Dr. WATSON WILLIAMS showed stereoscopic skiagrams of the nasal accessory sinuses.

Dr. ST. CLAIR THOMSON and Dr. HERBERT TILLEY exhibited specimens of cartilage and bone removed by means of Killian's sub-mucous resection operation for the correction of deviations of the septum.

A discussion followed on the relative merits of local and general anæsthesia for this operation. On this point opinions appeared to be divided.

Dr. JOBSON HORNE exhibited macroscopic preparations illustrating cystic disease of the larynx and a condition simulating cystoma.

Dr. W. H. KELSON showed a woman æt. 65, with a circumscribed tumour of the palate of about eight weeks' duration. There was a difference of opinion as to its nature, the diagnosis being a fibro-adenoma or an endothelioma. It was generally agreed that it should be removed.

Dr. KELSON also showed a patient with ulceration of the epiglottis and of the base of the tongue which was regarded as malignant disease and inoperable.

Mr. P. DE SANTI showed a case of tertiary syphilitic laryngitis for opinion as regards treatment.

Dr. A. LIEVEN recommended tracheotomy to keep the parts at rest ; if it were not done now it would have to be done later to overcome the contraction of the glottis. He advised injections of calomel, using 1 part of calomel in 10 of vasanol, a new preparation of paraffin which was the least irritating vehicle he knew. A very small dose should be given at first, as the patient might be intolerant of mercury.

The PRESIDENT showed a case of laryngeal disease presenting difficulties of diagnosis. Opinions were in favour of it being due to syphilis.

Mr. C. A. B. HORSFORD showed a patient with considerable enlargement of the cervical glands following removal of a tonsil. The diagnosis rested between primary chancre of the tonsil, malignant disease, and deep suppuration in the neck. It was advised that anti-syphilitic treatment should be used before incising the neck.

Dr. HORSFORD was asked to report to the Society the subsequent history of the case.

On behalf of Dr. G. C. Cathcart, Dr. JOBSON HORNE showed the specimen from a case of fibroma of the larynx present at the last meeting of the Society. When the patient was exhibited there was a general consensus of opinion that the tumour, which occupied the left arytenoid region, was a cystoma. It was subsequently found to be a solid tumour which had to be removed through an external incision.

GLASGOW EASTERN MEDICAL SOCIETY.

MEETING HELD WEDNESDAY, JANUARY 16TH, 1907.

The Vice-President, DR. JOHN PATRICK, in the Chair.

DR. GEORGE MCINTYRE read an interesting and instructive paper, on the

TREATMENT OF ECZEMA,

with special reference to the mode of external applications for the relief and cure of that distressing skin disease. It is a well-known fact that eczema is an inflammatory condition of the skin, with the usual exudations, which is responsible for the papules and vesicles that occur ; that when it assumes a pustular form that is due to the invasion of the pus-producing organisms. Then the exudation is apt to cake and form crusts, which are a barrier to successful treatment. Now Dr. McIntyre insists that the skin must be kept clear of those crusts. For this purpose they may be softened by vaseline freely applied and covered with gutta-percha tissue. Or oil may be used. If the eczema be in the acute stage, starch poultices may be applied, but there must be a layer of muslin between the poultice and the skin. The starch poultice may consist of boracic acid, 2 ounces, 1 to 4 drachms of starch, mixed with cold water, and then one pint of boiling water added. The whole should be included in a jacket of muslin half an inch thick. For oozing eczemas, clear lotions (that leave no deposit) may be used in the first instance, such as lotions of boracic acid, or black wash, sopped on for ten minutes at a time. Lotions with sediments may be employed in dry erythematous forms, and should be brased on for ten minutes at a time. A protective layer of powder is thus obtained, and the parts further protected by lint and a bandage.

Calamine lotion is very suitable for general use to which may be added a little carbolic acid, if there be much itching. In any case the skin has to be, cleansed daily by oil or other agent.

Ointments are useful after the acute stage. They should be spread thickly on the smooth side of lint, to prevent sticking.

To remove grease in cleansing, hot water may be used for several minutes (two). Lassar paste—starch 1, oxide of zinc 2, vaseline 2—is very suitable for leeting surfaces, and is more porous than ointments.

Dr. DAVID COOPER, who has had a very extensive experience of skin diseases, laid emphasis on the importance of rest in bed in obstinate cases, and stated that by that measure alone he had seen refractory skin diseases take a turn for the better. He praised starch poultices, and some of the older methods of treatment, such as zinc-gelatine paste. He summed up that the whole treatment might be put under three heads—(1) cleansing ; (2) soothing ; (3) stimulating, with a good general knowledge of internal medicine.

Dr. PETER BUCHANAN spoke of the value of giving alkalies and aperients internally, which Dr. MACLACHLAN also emphasised.

Dr. SERVICE extolled the value of cleansing the skin by gruel or oil.

Dr. ALEXANDER MUNRO spoke of the value of simply applying boiled bread and milk, which the illiterate understood how to prepare, and he referred to the value of a poultice of a boiled potato beaten up with buttermilk, which practically was an easily prepared starch poutice.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT MANCHESTER, JANUARY 18TH, 1907

Mr. R. FAVELL (Sheffield) in the Chair.

Dr. E. O. Croft (Leeds) was elected President, Dr J. H. Willett (Liverpool) Secretary, and Dr. W. K. Walls (Manchester) Treasurer for 1907.

Mr. FAVELL showed a large hypernephroma of the left kidney which occupied the pelvis and lower portion of the abdomen, and was successfully removed by the abdominal route.

Dr. J. B. HELLIER (Leeds) showed a fibroid polypus of the cervical canal which was of such a size that it completely filled the vagina, and was so irregular in form that it closely simulated a "cauliflower excrescence of the cervix."

Dr. A. J. WALLACE (Liverpool) showed a uterus removed for cancer of the cervix by the abdominal route, with extensive dissection of the pelvic glands and connective tissue. The obturator gland was shown to be much enlarged by secondary deposits, as were also glands dissected off the iliac vessels. Dr. Wallace regarded vaginal hysterectomy as merely palliative. He had done the extensive abdominal operation in nearly 20 cases, with a mortality of under 30 per cent. In fat subjects the operation was dangerous and prolonged, but in thin patients it did not appear to be attended by undue risk.

Dr. LLOYD ROBERTS (Manchester) showed a fibroid 13 inches in diameter and weighing over 32 lbs. It was removed from a multiparous widow 44 years of age who had been aware of its presence for 14 years. It finally produced pressure symptoms, menorrhagia, and metrorrhagia. The capsule was incised, and the growth enucleated as a preliminary to the removal of the uterus at the level of the internal os. Recovery was uneventful.

Dr. E. S. BISHOP (Manchester) showed a specimen illustrating the advantage of anterior vaginal hysterotomy for the removal of certain sub-mucous fibroids, also an example of ectopic gestation, in which the symptoms and history suggested gonorrhœal pyosalpinx rather than tubal pregnanacy.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Jan. 20th, 1907.

SLOW PULSE.

THE slow pulse, or malady of Stokes Adams, is an affection characterised by a decrease in the number of radial pulsations, and by accessory nervous troubles.

The slowness of the pulse in this affection differs from that observed in cerebral diseases (meningitis, cerebral hæmorrhage), after strong emotions or intense suffering, during the convalescence of diphtheria, typhoid fever, and other grave maladies, or in poisoning by digitalis or lead.

The disturbance of the cardiac system in the disease of Stokes Adams is very special, as the sphygmograph tracings taken simultaneously on the radial pulse and the jugular veins go to prove. The jugular pulsations are synchronous with the contraction of the auricles, while those of the radial artery are the consequence of the contractions of the ventricles. In permanent slow pulse two or three pulsations of the jugular veins go to one of the radial artery. The defect in the propagation of a certain number of contractions of the auricles to the ventricles is the cause of the slow pulse in this affection.

In the normal state, says Professor Josué, the propagation of the wave of contraction goes from muscular cell to muscular cell. The contraction of the ventricle follows that of the auricle, because the stimulation is transmitted by a small muscular band uniting the auricles to the ventricles. This band, described by His, extends from the posterior wall of the right auricle to the inter-ventricular septum. His and Graupner demonstrated that if this band was cut in the dog, the auricles and the ventricles contracted independently. It is precisely this phenomenon that is observed in permanent slow pulse. It may be mentioned that Schmoll found recently, in making an autopsy of two subjects who had suffered from permanent slow pulse, that these bands of His had been destroyed.

The nervous troubles never fail in the course of the disease of Stokes Adams. They consist in simple vertigo or attacks of violent cephalalgia. Sometimes fainting or epileptiform seizures are observed.

The duration of the malady is variable, and in general difficult to limit. The individual sometimes succumbs suddenly during an attack; at other times death is the consequence of asystole, which develops generally very insidiously.

The disease is more frequent in man, and at an advanced age. Arterial atheroma, traumatic or spontaneous lesions of the bulb or of the pneumogastric nerve, have been incriminated as causes of the affection.

The treatment should be both moral and therapeutic. The patient should avoid fatigue, emotions, or efforts. He should lead a life of absolute tranquillity, and avoid any cardiac or nervous excitement.

The regimen will consist essentially of milk and milk foods; very little meat should be allowed.

If the patient is suffering from sclerosis of the arteries, small doses of iodide of potassium will be prescribed (10 to 20 grains a day). Trinitrine is also very useful.

Solution of trinitrine	mm. xxx.
Water (1-100)	oz. x.

3 tablespoonfuls a day

Sometimes signs of renal insufficiency, with a decrease in the quantity of the urine, are observed. In such cases an absolutely milk diet should be prescribed to ward off the danger if possible.

Where the patient is threatened with a paroxysm, nitrite of amyl might be inhaled. Chauffard recommended for the same reasons the administration of atropine, which has the property of paralysing the intra-cardiac terminations of the pneumo-gastric nerve.

When the heart weakens, and asystole sets in, sulphate of spartein may be given, or injections of caffein or camphorated oil. Digitalis, says Professor Josué, is an absolute poison in cases of slow pulse, and consequently should never be given.

TREATMENT OF BOILS.

Boils, or furunculosis, are considered difficult to cure. The existence of a special diathesis was mentioned to explain the failure of therapeutic treatment. Be that as it may, one thing is certain—that furunculosis can be cured by purely local treatment. M. Gallois is accustomed for several years to treat such cases as follows, and always successfully:—

Metallic iodine	dr j.
Acetone	dr. iiss.
Absorbent cotton-wool.	
Glycerine	oz. vj.
Boric acid	dr. v.
Ordinary cotton	
Three bandages of muslin.	

He proceeds as follows:—

In case of furunculosis there exists a large boil under development and a lot of small ones forming satellites. He takes a match and surrounds its free extremity with a piece of cotton, and dips it into the iodacetone and touches each of the little boils, giving them the appearance of so many "beaufy spots." For the large boil, if it has not burst, he paints on the same solution; if it is open, he does not touch it with the bistoury. He never incises boils, and rarely an anthrax.

He then takes a piece of absorbent cotton, large enough to cover the whole region, and steeps it in a solution of boric acid or simply in boiled water, and wrings it out as much as possible He pours on it the solution of boric acid in glycerine until it is thoroughly wet with it, and applies it to the boils and covers it with ordinary cotton, and the whole is fixed with a bandage.

The dressing is renewed once a day, or twice if suppuration were abundant. After the first dressing the boil is observed to be less turgescent, while the surrounding skin is in a perfect condition, all the redness and the little pustulæ have disappeared.

To succeed in this treatment, M. Gallois insists that care and antiseptic precaution should be observed; that for this reason the medical attendant should apply the dressings himself, and not entrust them to the patient or his friends. A boil well dressed according to the above indications is never followed by others.

ALBUMINURIA.

Lactate of strontium	grs. iv.
Theobromin	grs. iv.
Tannin	grs. iv.
Phosphate of soda	grs. iv.
Oxalate of cerium	gr. j.

For one wafer. To be taken in the morning in an infusion of broom tops.

HAY FEVER.

Solution of adrenalin	mm. xx.
Cocaine	gr. ½.
Water	dr. iiss.

Steep a plug of cotton fixed on the end of a probe, and apply the solution to the mucous membrane of the nostrils.

GERMANY.

Berlin, Jan 20th. 1907.

At the Medizinische Gesellschaft Hr. Toby Cohn showed a young girl suffering from

Loss of Speech.

A week before she suddenly lost her speech, then regained it for a few hours, and afterwards lost it again. A physical examination showed only a specific exanthema.

She understood perfectly what was said. She carried out orders, recognised objects, knew how to use them, but could not name them. She could read, recognised pictures, and could name them. She could count, could name the days and weeks, but could not use them with any sense. She could not write spontaneously, but could copy correctly, though her writing from dictation was altogether wrong, and the same with repeating what had been said.

Neither the motor nor the speech centre could here be affected. By a process of exclusion it might be assumed that the seat of the disease must be the point of union between the acoustic and the motor centres, which would about correspond to the Island of Reil.

Specific treatment would probably restore the speech.

Hr. Letten showed two preparations of extreme

Syphilis of the Liver,

the one taken from an elderly woman, the other from a child. Both patients died of hæmaturia (melæna ?), the woman from a single attack, the child from a fifth. There were numerous gummata, which were also present in the spleen, which was enlarged. There were also in the liver large contracted portions.

The bleeding in cirrhosis of the liver, as the speaker had already pointed out, did not proceed from the stomach, but from the lowest segment of the œsophagus, the venous blood from which emptied into the portal vein. The varices, as the patients bled to death, were naturally found empty at the autopsies, but in both the erosion of large veins was distinctly visible.

Hr. Heubner spoke on

Orthsotatic Albuminuria.

He opened up the much discussed question whether the disease in which patients excreted albumen when in the upright position only, whilst during lying every trace of it vanished, was a particular form of nephritis, or whether it was a disease *sui generis*.

The first attempts to answer the question were first made by systematic measuring of blood pressure, and were made by Edel, who was followed by many others. It was shown that in orthostatic patients certain things would cause increase or diminution of blood pressure which in the healthy would produce the exactly opposite effect. Examination of the pulse, and also of the excretion of NaCl had also been made without bringing the question nearer to a solution.

The speaker had recently had the opportunity of making a *post-mortem* examination of a person the subject of typical ortholic albuminuria. The case was that of a child who had been scrofulous, and who for a year had passed much albumen in his urine, whilst up and about; but absolutely none whilst lying in bed. The child died of cerebral tumour after it had lain eight days in agony.

Microscopically, the kidneys evidenced no visible change; they were examined very carefully microscopically, but showed nothing distinctly abnormal. A slight fatty degeneration in places he attributed to the prolonged agony; a slight erosion of tissue in a single spot about 1 ccm. in circumference, and such as was often met with in older people with perfectly healthy kidneys, did not in his opinion affect the question at all.

Hr. Kraus would attribute a certain *role* to a poor constitution, but that alone could not give rise to the condition. At the last Insurance Congress—and albuminuria played a considerable part in life insurance—the question was ventilated whether a benign excretion of albumen could be distinguished from a malignant one. It was then considered that if when 1 grm. of lactate of lime was given in 24 hours to a man going about, he lost his albuminuria, then it was a benign and not a progressive form of the affection. The idea was that the blood in these people coagulated with difficulty, and that it was rendered more coagulable by the lactate of lime. He made this statement for what it was worth, he would not hold himself responsible for either the fact or the explanation. The subject must be gone into more closely; pathological anatomy alone could not elucidate it.

Hr. Senator did not think the kidneys shown to be normal, and saw in the slight changes they showed a basis for the belief.

When in the erect posture the blood pressure in the veins was greater, in the arteries less, than when lying down; stasis therefore occurred when the individual was standing up. If the stasis was increased experimentally by compression of the renal veins, the condition was brought about in the urine as regarded quantity, concentration, &c., as in orthostatic albuminuria, except that there was no albumen. There must be a factor therefore in the kidney itself. If the case was gone into more thoroughly it would be found that the individual suffering from orthostatic albuminuria had passed through some infectious illness, ground enough for the origination of a nephritis, the last faint echo of which was, in his opinion, the albuminuria in question. (Discussion adjourned).

A correspondent in a professional journal writes that the title of Professor was first allowed to Privatdocenten in Prussia in 1882, and that for the last ten years it has been rather freely distributed amongst physicians and surgeons. In the extra-Prussian States the conferring of the title on medical men who are not members of a medical faculty is still rare, especially in Saxony. Here, however, there has recently been opened up a path by which the coveted distinction may be gained, that is by qualifying at the Veterinary High Schools!

At the Freie Vereinigung der Chirurgen, Hr. Bosse related a case of

Peptic Ulcer of the Abdominal Wall.

A man, æt. 40 who had long suffered severely from gastric trouble was admitted into the Charité. There was dilatation of the stomach and a flat resistance at the pylorus. Gastro-enterostomy was performed, after which the stomach contracted and the acid secretion diminished. But the patient did not recover so as to be able to return to his work. After some months he returned with fresh stomach troubles, a rise of temperature, and infiltration of the abdominal parietes. An exploratory incision went into the abdominal cavity; the adhesions were but few. A piece of the infiltrated portion of abdominal wall was examined microscopically, and was found to consist of inflammatory tissue. During the next few days the tumour increased and the patient got lower. A fresh laparotomy was done, during which a large cavity was reached at the bottom of which was a gastric fistula. Excision was impracticable, and the patient became collapsed and died He had since found experimentally that injection of pancreatic juice into the tissues set up violent inflammation.

AUSTRIA.

Vienna, Jan. 20th. 1907.

Neoplasm of Cranium

Schrotter presented two cases at the meeting for "Innere Medicin" where the cranium was greatly enlarged, although the cerebrum did not appear to be increased. A prominent ridge in the bony structure could be observed to cease at the brow and parietal bones. Both ossa zigomatica and the bones of the nose were equally enlarged and broadened. The symptoms were pain in the head, most severe at night. No disturbance could be detected in the ocular apparatus, but the hearing was very defective in the perception of sound. He considered the morbid changes to be of a neoplastic character, which might either be sarcomatous or carcinomatous. What the primary cause was he would not offer an opinion, as no pressure on the cerebral nerves was present, nor any other symptom that would lead to such a conclusion.

Alexander thought that the defective hearing was due to atrophy of the acoustic nerves, and probably that of the Corti fibres.

Sternberg said there were six morbid conditions that might produce an enlargement of the cranium—viz., hydrocephalus, acromegaly, ostitis, deformans of Paget, hyperostosis of the cranium or the leontiasis ossea of Virchow, multiple neoplasms, and the tumour forming ostitis deformans of Recklinghausen, which often causes an enormous increase of the cranium. Sternberg was inclined to diagnose the primary cause of Schrötter's as being due to metastasis from some hidden neoplasm, or multiple in combination with hyperostosis and Recklinghausen's changes.

Schrötter thought that when no symptom of a hidden neoplasm could be distinguished, it was dangerous to diagnose a tumour. For acromegaly we would look for changes in the epiphyses of long bones, which were quite absent in this case. He could not see how it could be anything else but a neoplasm, either sarcomatous or carcinomatous.

Congenital Cardiac Anomaly.

Grossmann exhibited a young man, æt. 18, who was born with additional toes and fingers, retinitis pigmentosa, and a persistence of the ductus Botalli. The growth of the brain was inhibited after birth, the cranium not measuring more than 51 centimetres in circumference. On account of absence of cyanosis, a loud second sound, and a distal murmur beyond the aorta, stenosis of the pulmonary artery was diagnosed. Beyond the patent ductus Botalli and stenosis nothing more during life could be asserted.

Schmidt thought he could distinguish a systolic murmur over the pulmonary artery. From this he assumed there was a congenital malformation of the organ and a conus stenosis of the pulmonary artery.

Grossmann said the open ductus Botalli was in favour of an open pulmonary artery; and the radioscope rather tended to confirm this opinion.

Cardiac Defect.

Schwoner showed a case of congenital heart disease in a child 10 years of age, measuring 120 cm. in length, very slim and pale. The patient was cyanosed, and had drumstick fingers. The apex beat was found in the fifth intercostal space and in the mammary line, to which the cardiac dulness extended towards the left, while it reached the middle of the sternum to the right. Auscultation revealed a systolic murmur at the apex, and a diastolic sound over the manubrium sterni and left margin up to the second intercostal space, where rough systolic and diastolic murmurs were clearly distinguished, and, when felt with the finger, had a rough vibration. The second pulmonary sound was not accentuated. With the Röntgen rays the vessels on the left were seen to be enlarged, as well as the pulmonary artery corresponding to the ductus arteriosus Botalli. The pulse had nothing peculiar about it. The diagnosis arrived at was that this was an aneurysmal widening of the ductus Botalli in conjunction with pulmonary artery. The most peculiar feature in this case was the ease and comfort with which the child could run about and ascend stairs and hills without the slightest discomfort, not even complaining of palpitation or any other cardiac symptom.

CONTINENTAL HEALTH RESORTS.

WINTER ON THE RIVIERA.

[From Our Continental Correspondent.]

To gratify "stay-at-home" partisans, some journals have recently expatiated on the apparently higher average temperatures in London than at Nice. The latest December days exhibited a different array of figures, and from present health reports it is to be regretted that in consequence a smaller number than in previous winters came southwards prior to Christmas. After all is said and done, for the aged, the delicate, the convalescent, for "all requiring a mild tonic treatment, with a combination of mountain and sea-air, the proximity of pine woods, a temperate climate, and a non-irritating atmosphere," no more convenient to our British shores, and no more enjoyable localities can be found that those lying along the "Azure Coast" between Cannes and San Remo.

Nowadays, the far advanced invalids do not, as a rule, seek these resorts. Years ago it was different, and these Riviera districts were full of invalids. It is to-day amusing to read (as in "Harper's Hand-Book of 1868"):—"Since its annexation to France Nice has rapidly improved, not only in population, which now (1867) amounts to 55,000, but in everything which tends to promote comfort and pleasure. The principal hotels are Grand Hotel Chauvin, Hotel d'Angleterre, and Grand Hotel Brizzi, and the proprietors and servants speak English. The Chauvin is an immense establishment admirably conducted by its proprietor, Mr. Chauvin. The Angleterre has long maintained its position as one of the best houses in Europe. The Brizzi is finely managed by Mr. Brizzi, former proprietor of the Grande Bretagne. . . . The climate and waters of Nice are noted for the cure of the following complaints—Indigestion, Scrofula, Nervous Affections, Paralysis, Neuralgia, all Lymphatic Maladies, and diseases peculiar to females."

Of the hotels famous in 1867, the Chauvin and Brizzi are past and known no more; the Angleterre is yet prominent, but, like its neighbour, Hotel des Anglais, nowadays more German than English, and the Grande Bretagne enjoys chiefly an American patronage.

To-day Nice abounds with many and excellent hotels offering to their guests the most recent comforts and luxuries. As, on the celebrated Promenade des Anglais, the truly "Royal Hotel" of Mr. Ruhl, and on the now fashionable heights of Cimiez, Mr. Agid's most modern "Winter Palace," a genuine "thing of beauty," amidst artistic gardens, and with the highest degree of hygienic perfection.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

EDINBURGH.

UNIVERSITY OF EDINBURGH.—ANNUAL REPORT.

During 1906 the total number of matriculated students (including 463 women) has been 3,199, the highest attained for 13 years. The numbers are distributed through the various faculties as follows:—Arts, 1,012; Science, 292; Divinity, 56; Law, 311; Music, 28; and Medicine, 1,500, including 35 women. Of the medical students, 45 per cent. were Scottish, 20 per cent. English, 9 per cent. Irish, 5.5 per cent. Indian, 18 per cent. colonial, and about 2 per cent. from foreign countries. The number of women attending extra-academical lectures with a view to graduating in medicine was 71. The degrees in medicine granted during the year were:—M.B.C.M., 1; M.B.Ch.B., 186 including 17 women; M.D., 90, including 2 women; Ch.M., 1. The diploma in tropical medicine was conferred on 5, and the special certificate on 60 candidates. The report goes on to refer to the new buildings for engineering and natural philosophy, which were opened formally on October 16th; the former had already been in use for some months, and the latter will be ready for occupation next year. In transforming the old surgical hospital into the new premises it has been found possible to preserve the historic outer fabric almost without change. Although the Carnegie foundation has not manifestly increased the number of students, it is still noticeable that Carnegie students take out a larger number of classes than they would probably otherwise have done. Of those appointed to Carnegie post-graduate Fellowships and Scholarships, a considerable proportion are Edinburgh graduates. A lectureship in systematic and clinical gynæcology was instituted early in 1906, and Dr. A. H. Freeland Benbow was appointed lecturer. A lectureship on general and experimental psychology has also been founded. The following important personal changes fall to be recorded: Early in the year Dr. Henry Harvey Littlejohn was appointed Professor of Medical Jurisprudence in succession to Sir Henry D. Littlejohn. Dr. Norman Walker was appointed Lecturer on Diseases of the Skin, in room of Dr. Allan Jamieson, resigned; Dr. Logan Turner, Lecturer on Diseases of the Ear and Throat, in place of Dr. McKenzie Johnstone, resigned; and Dr. Melville Dunlop, Lecturer on Diseases of Children, in room of Dr. Burn Murdoch, resigned. The re-cataloguing of the library having been completed early in 1906, the remaining months of the year have been occupied by the cataloguing staff in the alphabetical arrangement of the entries and the insertion of cross references, work which will be completed in the course of 1907. The number of books dealt with in the general library is about 210,000; besides this, departmental libraries have been catalogued.

THE LATE DR. ALEXANDER PEDDIE.—There has just passed away from our midst, at the advanced age of 97, Dr. Alexander Peddie, who died in Edinburgh on January 19th. He was the father of the profession in Scotland, and probably in Great Britain.

GLASGOW.

DEATH OF THE PRINCIPAL OF GLASGOW UNIVERSITY.—By the recent death of Principal Story, the University of Glasgow has lost one of the most energetic and masterful Principals it has ever been its good fortune to possess. Principal Story was born at Roseneath, on the Firth of Clyde, where his father was minister for the long period of forty years. He succeeded his father, and his sterling gifts soon gained for him a distinguished position. He was called to be Professor of Ecclesiastical History some twenty years ago. On the death of Principal Caird, he was selected as his successor. During the eight years he has occupied this high office, he has infused new life into almost every department of the University. In Medicine, particularly, the new research laboratories in Physiology, in Pharmacology, and Public Health would be a sufficient monument to perpetuate his memory. But the whole field of Medicine has been brought up to date, and it is not difficult to predict that within a few years Glasgow University will attract students from all parts of the world, and be second to none. The very reverend gentleman occupied a foremost place in the General Assembly of the Established Church. He was cast in a heroic mould, fearless in speech, honest in conviction, and a steadfast man to the end.

BELFAST.

DOCTOR'S ACTION AGAINST GUARDIANS.—At the Clogher, Co. Tyrone, Quarter Sessions held last week, Dr. Warnock, of Clogher, sued the Guardians for twelve guineas for acting as *locum tenens* for Dr. Ross, medical officer of Clogher Workhouse. It appeared that Dr. Ross had been unwell, and had presented a medical certificate and asked for four weeks' leave, which the Guardians had granted, stipulating, however, that he should pay his own *locum tenens*. Dr. Ross got Dr. Warnock to act for him, and sent the bill to the guardians, who passed it for payment, and then rescinded it at their next meeting. Meantime the Local Government Board had sanctioned the payment, and informed the Guardians that they were bound to pay a substitute for their medical officer when he was absent on sick leave. The County Court Judge said that the Local Government Board letter was clear, and gave a decree for the full amount with costs, and a guinea for expenses.

DEATH OF A STUDENT FROM CEREBRO-SPINAL MENINGITIS.—Much regret is felt in medical circles at the sad death of a medical student in Belfast from cerebro-spinal meningitis. He was apparently in his usual health last week, and attended church on the morning of Sunday the 14th, but later in the day felt poorly and went to bed. He was seen in the afternoon by one of his teachers, who found him with a temperature of 106°, a slow pulse, and signs of cerebral irritation. He was taken to hospital, and died on Monday. Cerebro-spinal fluid, removed by lumbar puncture, on being examined, gave a pure culture of the typical diplococcus of cerebro-spinal meningitis. It is not known how the young man became infected, but he lodged in a part of the city from which several cases of the disease have been removed to the Purdysburn Fever Hospital.

TYRONE COUNTY HOSPITAL.—At a meeting held in Omagh last week, it was decided that the memorial to the late Major Burleigh Stuart should take the form of furnishing the County Hospital with electric light. The greater part of the money needed has already been subscribed.

TYPHOID AND MILK.—It is only a few months since we had a severe outbreak of typhoid in a suburb of Belfast, the source of which outbreak was clearly traced to the milk supply, a woman convalescent from typhoid having been employed as a milker in a dairy. Now comes the news that an outbreak at the other side of the city, happily so far confined to eight cases, has been traced to a contaminated source of supply near Larne. This will be an additional argument for the reformers on the City Council who wish to introduce proper methods of dairy inspection.

LETTERS TO THE EDITOR.

SPIROGRAPHS OR NASAL "BREATH PICTURES."

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The practice of testing nasal patency by breathing upon a prepared surface is by no means new, but its usefulness has been somewhat restricted by the want of a satisfactory material.

Slates, glass, and polished metals all have their shortcomings, but experiments have shown that vulcanite with a medium polish gives a very reliable and faithful image. By placing the plate horizontally on the upper lip, half an inch from the nostrils, and giving one short and steady expiration, a well-defined steam impression results which on evaporating affords reliable evidence of the actual and relative patency of the nostrils.

The image may be temporarily fixed, or rendered more conspicuous for demonstration purposes by lightly powdering it with calcined magnesia, or fine starch. Small sheets of vulcanite with a suitable surface and of a convenient size for the purpose are supplied by the Medical Supply Association, 228, Gray's Inn Road, London.—I am, Sir, yours truly,

WYATT WINGRAVE, M.D.

Central London Throat and Ear Hospital.

THE CASE OF EDALJI.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The efforts to prove the innocence of Edalji by seeking to establish that the crime for which he was convicted was an impossibility, owing to his error of refraction, reminds me of what happened when a notorious murderer was tried, convicted, and hanged at Newgate some years ago. Then it was that an optician wrote to the *Times* stating that at one time the murderer in question had "consulted" him for a defect of vision, and that he had found a high degree of hypermetrophic astigmatism. That being the case, the optician inferred, and the public, through the columns of the *Times*, were actually and solemnly informed that the moral obliquity which had led to the murder of two poor girls by means of strychnine was probably dependent upon the ocular defect. To argue that Edalji could not have maimed cattle or horses at night because of his myopic astigmatism, is just as wise, or—more plainly—just as absurd. The evil that is in a man is not controlled by his eyesight, nor could any defect of vision be, conversely, responsible for a criminal instinct. To raise, therefore, this question of the defect of vision in Edalji's case seems to me to be likely to weaken, rather than advance, the attempts made to establish his innocence. It is curious that

Edalji should never have made any complaint about his vision until some time after his conviction and imprisonment. This clearly goes to prove that the subject of his eyesight had not claimed the attention of his family. Moreover, it shows that, previously to being convicted, his vision was sufficiently satisfactory to Edalji himself. The argument, therefore, that he could not have seen to perpetrate that which he was convicted of doing must fall to the ground. Myopes who have never worn any correction for their defect have a wonderful way of adapting their vision to circumstances, and, of course, as is generally known, of improving it by the instinctive action of partially closing the lids. Again, it is curious that Sir A. Conan Doyle was the first to tell Edalji that he (Edalji) could not have committed the crime owing to the defect of his vision. Apparently nobody at the trial had ever thought of such a thing—not even Edalji himself.

Yours truly,
An Ophthalmic Surgeon.

London, W., January 18th, 1907.

To the Editor of The Medical Press and Circular.

Sir,—Will you allow me, a plain man and a medical practitioner, to make a suggestion in the case of Edalji, who has all along had the benefit of your able championship? From the Conan Doyle correspondence in the *Daily Telegraph*, I gather that Inspector Campbell was out with twenty men in the neighbourhood of the occurrence. It seems, further, that these men watched all the approaches to the field in which the pony was maimed on the night of August 17th, 1903. Then, perhaps most significant fact of all, Sergeant Robinson admitted that a certain number of men were specially watching Wyrley Vicarage. Under these circumstances, the police assert that Edalji evaded their patrols and committed an insane felony, as it were, under their noses. His father swears he did not leave the locked bedroom until seven next morning. The police have in the long run been utterly discredited. It is clearly proved that young Edalji had long been with them an object of distrust and suspicion, so much so that when the outrages took place, they were keeping a systematic watch round his house. Now, it has seemed to me from the first that if so gross a crime could be permitted in spite of their surrounding the field where it was committed, they stand convicted as incompetent blunderers. Under these circumstances few would have wondered had the defence put forward a theory of police connivance. But the lame defence of Edalji is one of the not least curious features of this strange drama.

I am, Sir, yours truly,
A Mere Country Practitioner.

OBITUARY.

EBENEZER TOLLER, M.R.C.S.

The late Mr. Ebenezer Toller, M.R.C.S., whose death took place at Scarborough on December 20th, 1906, was descended from a remarkable Bedfordshire family, his grandfather and three great uncles being between seven and eight feet in height each, and his four great aunts are described on an old engraving held in the family as the "Four Beauties of Bedfordshire." Mr. Toller elected to enter the medical profession, and entered at King's College Hospital, London. Mr. Toller was recognised as a hard-working student, and his name was several times mentioned in the honours lists. On leaving King's College he at once entered the lunacy branch of the profession, and became resident surgeon to the St. Andrew's Castle Private Asylum, Bury St. Edmunds; thence he went to the Middlesex County Asylum at Colney Hatch; and later was a successful candidate for the post of Medical Superintendent of St. Luke's Lunatic Hospital, London, and the ability shown by him in his management there enabled him successfully to apply for the similar post at the Gloucester County Asylum, which he held from 1863 to 1882. Mr. Toller was the pioneer in providing in lunatic asylums those entertainments which are now looked upon as a matter of course in every asylum. His musical ability prompted him, when a medical officer at Colney Hatch Asylum, to get up concerts for the patients. These and other forms of entertainment which he organised attracted great attention at the time, and were commented on in the *Times* and other papers, as well as receiving the recognition of the Commissioners in Lunacy as far back as March, 1862. At St. Luke's Hospital he was able to draw upon his many musical friends, and his concerts in that institution became an important musical "function." Mr. Toller was also a strong advocate of treating the insane in surroundings as homelike as possible, and deprecated strongly their being kept in large numbers in great buildings. These views he brought before the Association of Medical Officers of Asylums at the Royal College of Physicians in 1864, in a paper which was afterwards published with plans of cottage asylums.

JOHN FALCONER, M.R.C.S.

We regret to announce the death of Dr. John Falconer on the 6th inst. at Lasswade. Dr. Falconer was a son of the late Dr. John Falconer, who during a long period was a medical practitioner in Loanhead, and who was a fine type of the old country doctor. Dr. John Falconer studied at Edinburgh University, but took his M.R.C.S. degree in London. At the outbreak of the Crimean War he went to Smyrna as medical officer attached to the Turkish forces who garrisoned that city. He afterwards proceeded to China, and settled in Hangkow, where he resided for seventeen years. Thirty years ago he returned to this country, and settled at Lasswade, and latterly he had also a house in Edinburgh. He was a keen Freemason, was Past Master of the Celtic Lodge, and was a member of the Supreme Council of Grand Lodge. For a year past he has been in failing health, and the death three weeks ago of his only son doubtless accelerated the end.

SPECIAL ARTICLE.

BILL FOR THE INCORPORATION OF KING EDWARD'S HOSPITAL FUND FOR LONDON.

7 Edward VII.—Session 1907.

ARRANGEMENT OF SECTIONS

	Section.
Preamble	
Short title	1
Incorporation	2
Objects	3
President	4
Management	5
General Council and its duties	6
Transfer of existing property, and as to property generally, and trustees	7
Investments	8
Gifts subject to conditions	9
Indemnity	10
Costs of Act	11

A BILL

To Incorporate the President and Council of King Edward's Hospital Fund for London; to provide for the Management of the Fund; and for other purposes.

Preamble.—WHEREAS His Majesty then Prince of Wales did in the year 1897 invite public subscriptions (annual and otherwise) to a Fund now known as "King Edward's Hospital Fund for London" (hereinafter referred to as "the Fund") with the object of securing more efficient aid and support for Hospitals of London and of thus commemorating the sixtieth anniversary of the reign of Her late Majesty Queen Victoria.

AND WHEREAS the Fund was established and the same has been generously supported by public subscriptions donations and by legacies and otherwise.

AND WHEREAS His Royal Highness George Prince of Wales is now President of the Fund.

AND WHEREAS His Royal Highness has from time to time appointed certain persons to act as an Advisory Council and as Committees and in various other capacities and has with the advice and assistance of such Council and Committees administered the Fund.

AND WHEREAS it is expedient that for the proper establishment and administration of the Fund upon a permanent basis the President and Advisory Council should be incorporated and that provision should be made for the regulation and management of the Fund and with respect to present and future investments.

AND WHEREAS the purposes of this Act cannot be attained without the Authority of Parliament.

MAY IT THEREFORE PLEASE YOUR MAJESTY that it may be enacted and be it enacted by the King's Most Excellent Majesty by and with the advice and consent of the Lords Spiritual and Temporal and Commons in this present Parliament assembled and by the authority of the same as follows:—

1. *Short Title.*—THIS Act may be cited as King Edward's Hospital Fund for London Act 1907.

2. *Incorporation.*—FROM and after the passing of this Act His Royal Highness George Prince of Wales now President of the Fund and the present members of the said Advisory Council and the persons who hereafter shall be the President and the General Council respectively under this Act are hereby incorporated by the name of "King Edward's Hospital Fund for London" (in this Act referred to as "the Corporation") and by that name shall be a body corporate with perpetual succession and a common seal and with power without any further licence in mortmain to take purchase and hold lands and hereditaments and to sue and be sued, and with all other rights powers and privileges of a body corporate.

3. *Objects.*—THE objects of the Corporation are to secure from public beneficence by means of annual or other subscriptions of donations and bequests or otherwise funds and property which and all real and personal property now belonging to or held by any person or persons in trust for the Fund shall constitute a general fund of which either the capital and income thereof or any part of such capital or income as the President of the Corporation in his uncontrolled discretion may from time to time think fit shall be applied (*a*) in or towards the support or benefit of all or such one or more to the exclusion of the others of the Hospitals of London as the said President in his like discretion shall think fit and whether such application shall be for the general or any special purposes of any particular one or more of such Hospitals of London (*b*) in giving aid or assistance generally to all or any one or more of such Hospitals of London as the said President in his like discretion shall think fit and (*c*) generally in doing all such other things as are incidental or may be thought conducive to the attainment of the best interests of the Hospitals of London or any one or more of them or of the persons or any of them for whose benefit such Hospitals exist which the said President in his like discretion shall determine.

IN this Act the expression "the Sovereign" means His Majesty his heirs and successors Kings and Queens of the United Kingdom of Great Britain and Ireland and the expression "Hospitals of London" means and includes the following Institutions namely any present or future Hospital Convalescent Home Nursing Home or Nursing Institution Lying-in Institution Dispensary Medical Mission Society for the provision of Surgical or Medical Aid or Appliances and any Institution for the Rest Relief or Cure of Sick Persons as shall be situate within the County of the City of London or the Metropolitan Police District as existing at the passing of this Act or as the same may be hereafter extended or any Institution which being situate beyond such County or District shall afford Medical or Surgical treatment or Rest Relief or Cure to Patients all or some of whom are persons usually resident or carrying on their vocation in life within such County or District.

4. *President.*—HIS Royal Highness George Prince of Wales shall during the pleasure of the Sovereign be the President of the Corporation and every succeeding President shall be appointed by and hold office during the pleasure of the Sovereign.

5. *Management.*—THE direction control and management of the affairs and property of the Corporation and the application of all moneys property and income of the Corporation shall be vested in the President whose powers shall include the following that is to say (*a*) power to appoint and at pleasure remove the members of the General Council and of any other Councils and Committees hereinafter mentioned and Trustees Treasurers Secretaries Auditors and other officers and to award them or any of them salaries or remuneration (*b*) power to appoint and dissolve Councils and Committees other than the General Council and from time to time to delegate to any Council or Committee all or any of his powers of direction control or management as he may think fit (*c*) power to make vary and rescind bye-laws rules and regulations for the management and administration of the affairs and property of the Corporation and the procedure relating thereto, including the use of the corporate seal and the keeping of regular books and accounts (*d*) power to direct the mode of collection of moneys for the Corporation and the distribution and allocation of such moneys and of all property and income of the Corporation to or for the benefit of all or such one or more to the exclusion of the others of the Hospitals of London as he in his uncontrolled discretion shall think fit and generally to determine the manner in which such moneys property and income shall be dealt with and applied for the purposes of this Act and in furtherance of the objects of the Corporation (*e*) power to determine whether any institution proposed to be benefited is or is not within the limits of the objects of the Corporation as defined by this Act and (*f*) power generally to do or direct to be done all acts and things which in his discretion he may deem conducive to promoting and effecting the objects of the Corporation.

6. *General Council and its duties.*—THE General Council shall consist of such and so many persons as the President shall from time to time appoint. The duties of the General Council shall be to render to the President at his request such advice and assistance with respect to the affairs and property of the Corporation and the exercise of his powers in relation thereto as he shall from time to time require.

7. *Transfer of existing Property and as to Property generally and Trustees.*—ALL real and personal property now belonging to or held by any person or persons in trust for the Fund shall forthwith after the passing of this Act be assured transferred delivered and paid by such person or persons to or otherwise vested in or placed under the control of the Corporation or (if the President shall think fit) of the Trustees or Trustee to be appointed under this Act for the purposes of this Act but as to property given to the Fund upon any special trust or condition now affecting the same subject to such trust or condition.

ALL gifts by will or otherwise which if this Act had not been passed would have taken effect in favour of the Fund shall enure for the benefit of the Corporation.

ALL property of the Corporation for the time being not applied for the purposes thereof shall be and remain vested in the Corporation provided that any part or parts thereof may if the President shall think fit be from time to time vested in trustees to be appointed and removable by him and the Governor of the Bank of England may be appointed Sole Trustee for the purposes of this Act during the President's pleasure.

SUCH Trustees or Trustee shall dispose and deal with the property vested in them or him as the Corporation shall direct.

8. *Investments.*—ALL moneys and funds the property of the Corporation may (but as to gifts heretofore accepted on behalf of the Fund or which may hereafter be accepted by the Corporation with any special restriction as to investment subject to such restriction) be invested in the purchase or on the security of land of any tenure or in or upon such investments (whether authorised by law for the investment of trust funds or not) as the President may think fit and any investments may in like manner be varied from time to time or realised and the proceeds applied for the purposes of this Act. Land belonging to the Corporation may subject only to the consent of the President be sold leased or otherwise dealt with by the Corporation with the powers of an absolute owner. Any investments forming part of the Fund at the passing of this Act may be continued and the same and any investments heretofore made shall be deemed to have been made under the authority of this Act.

THE provisions of section 5 of the Mortmain Act 1891 as to the sale of land assured by Will to or for the benefit of a charitable use shall not apply to gifts by Will to the Corporation.

9. *Gifts subject to conditions.*—THE Corporation may accept gifts and endowments of real and personal estate either for special purposes of the Corporation or in aid of the general purposes thereof and upon such terms and conditions (not inconsistent with the objects of the Corporation) as may be agreed upon between the Corporation and the person bestowing such gifts and endowments.

10. *Indemnity.*—ALL persons hitherto acting in the management and application of the Fund shall be indemnified by virtue of this Act in respect of all acts and things done by them or any of them in the execution or intended execution in good faith of the trusts of the Fund as heretofore constituted.

11. *Costs of Act.*—THE costs charges and expenses preliminary and of and incidental to preparing and obtaining this Act shall be paid by the Corporation.

LABORATORY NOTES.

BENGER'S FOOD—ITS WIDER USES.

THERE is a saying that it takes fifteen years for a fact to become generally known to the medical profession, and though we are far from assenting to the proposition as stated in general terms, it is undoubtedly the case that to give a dog a good name imposes almost as many limitations as to give it a bad one. That is to say, that when a drug or preparation acquires a reputation under one set of circumstances, people are apt to overlook the fact that it may be useful in other very different ones. It is becoming a fashionable idea that one must go to a specialist for everything, and a general physician or surgeon finds if he gets a name for skill in some particular disease, the demand for his services gradually becomes confined to sufferers from that disease, the fact that he has a wide all-round knowledge of his profession being overlooked. So, too, with foods. Benger's Food has become a household word in connection with the feeding of infants and young children, and precisely for that reason the idea has grown up that it is "stuff for babies," and therefore not "stuff for men." Those who have used Benger's Food widely in various conditions do not need to be told that this is not so, that the range of "Benger" is coterminous with the range of enfeebled digestion, and that wherever the natural alimentary juices are lacking in strength, Benger's Food is able to reinforce them. The reason, of course, is that Benger's Food is, if one may use the term, a dynamic as well as a static food; it not only contains food elements, but ferments ready to act on them. Thus, besides an amylolytic ferment similar in action to the diastase of malt, it possesses also the power of digesting proteids, for to the food is added a proportion of pancreatic juice containing the natural proteolytic ferment, trypsin. Now the importance of a food such as Benger's is that it can be modified to suit any particular condition, and also used to modify the constituents of the milk with which it is prepared—in other words, Benger's Food is not only in itself a food, but it is a potential addition to milk whereby the defects of cow's milk as regards the human stomach can be removed, and its nutritive value reinforced to the extent which the medical attendant thinks desirable. In fact, Benger's Food can be prescribed with the accuracy of a tincture or extract, to meet all indications. All that is necessary is that the process of digestion (which begins when the food, after being rubbed up with cold milk, has boiling milk or milk and water added to it) shall be allowed to continue for the length of time necessary to complete the modification desired. When that point is reached, the food is quickly brought to the boil, the ferments are killed, and the reinforced and modified milk is ready. We lately took occasion to buy a tin of Benger at a shop, and after preparing it according to the directions for general purposes, made an analysis of the completed product. Thus we took a sample of milk from the Aylesbury Dairy Company, giving the following analysis:—

Specific gravity	1.0324	
Total solids	12.63	per cent.
Fat	3.78	,,
Mineral matter	0.78	,,

This milk we added to Benger's Food, according to directions on the tin—that is, after rubbing three-quarters of an ounce of the food into a paste with two fluid ounces of cold milk—we gradually added ten fluid ounces of boiling milk, stirring carefully the while. The whole was allowed to stand for fifteen minutes and then raised to the boil. The analysis was then proceeded with, and the following result obtained:—

Total solids	17.98	per cent.
Proteids	4.87	,,
Fat	3.90	,,
Carbohydrates	8.37	,,
Mineral matter	0.84	,,

From this it will be seen that a substantial addition was made to the total solids, especially as regards the carbohydrates, most of which, owing to the action of the amylolytic ferment, appeared in soluble form.

It is, however, important to remember that the directions on the tins are intended to guide unscientific people. A medical man in using Benger's Food can take advantage of the circumstances to give his patient any proportion of any particular ingredient he may desire, and that in almost any stage of digestion deemed suitable. For instance, if he desires a food poor in fat, he may prescribe Benger's Food either with milk and water or with skimmed milk, whilst if more fat than normal is necessary, a teaspoonful or more of cream may be added to the completed product. In one particular, however, Benger is of unexceptionable utility, namely, in being able to modify the proteids of milk. A short treatment with Benger's Food without converting much of the casein profoundly modifies it, so that it will no longer curdle in large masses. A more extended treatment will bring part of the casein into soluble forms, albumose and peptone, whilst by prolonged digestion it can be wholly converted.

In the preparation, however, of all modifications of milk and Benger's Food, it is necessary to bear in mind that in order to attain the temperature at which the ferments act best, ten ounces of boiling fluid—milk, milk and water, or what not—must be added to the two ounces of cold milk and food which have been rubbed up into a paste. It has been found by careful experiment that the resultant mixture attains a uniform temperature of about 158° F., and cools on standing—while the digestive process is going on—to about 125° F., and that it is between these points of the thermometer that the ferments act most vigorously. If larger or smaller quantities of fluid are used, temperatures unfavourable to ferment action are created.

With so polyvalent a food as Benger, with a food capable of modifying and being modified so profoundly, there is hardly a condition of immaturity or disturbance or disease of the stomach and digestive organs that cannot be catered for by prescription. In old age and in convalescence, no less than in infancy and illness, Benger's Food prepared with milk may be used to meet the particular circumstances of the case. But it is well that medical men who are in the habit of using the preparation should be acquainted with the modifications and modulations of which it is capable, and of the means by which they may be brought about.

REVIEWS OF BOOKS.

WHITING'S AIDS TO MEDICAL DIAGNOSIS. (*a*)

To compress within the limits of some 150 pages an account of medical diagnostics is by no means an easy task; yet the author of the volume before us has carried it out in a manner creditable to himself and pleasing to the reviewer. Dr. Whiting's method of treating his subject is "to start with the leading symptom or symptoms, and, after arranging the diseases presenting these symptoms in groups, to ultimately differentiate the members of each group as clinical entities." After an introductory chapter on the clinical investigation of medical cases, the writer goes on to deal with diseases of the various systems in a series of eight chapters. These are from his own pen, except that on infectious diseases, which has been ably written by Dr. Herbert Cuff.

Of course, in a small book such as this, it is easy enough to find defects. Many facts are wanting which might have been supplied had space allowed. What has been given, however, is correct, and that is the most important point in a book which will, we feel sure, be used by hundreds of senior students preparing for their final examination. Certainly the student who uses this book will find it a safe guide, and of inestimable value in mastering the essentials of medical diagnosis. Although its value largely depends on the smallness of its compass, we cannot but feel that its usefulness would be greatly extended were its size increased. With another hundred pages or so added we venture to predict that this "aid" would be the pocket companion of the general practitioner. As it stands, however, we can only say that we can confidently recommend it by reason of its accuracy of statement, its perspicuity of style, and its judicious arrangement of the subject matter. The publishers are to be congratulated on adding to their really valuable "Aids" series a volume so admirably put together and so well adapted for students' use.

WILLIAMS ON MINOR MALADIES. (*b*)

DR. LEONARD WILLIAMS has rendered a great service to the profession by the production of this handy and practical guide. The ordinary text-books deal very fully with all the serious diseases, but leave untouched the minor maladies of every-day occurrence—which are the cause of so much of the avoidable misery of life. The book before us fills in this lacuna in medical literature, for it treats very fully and adequately of colds, indigestion, headaches, goutiness, together with change of air and the problems of general health. All the statements are clear and explicit; there is no unnecessary verbiage, and many most useful prescriptions are given in full. We regard the book as of great value to the general practitioner, and to the young beginner in particular, and we cordially recommend it to the profession.

SUBMUCOUS EXCISION OF DEVIATIONS AND SPURS OF THE NASAL SEPTUM. (*a*)

DEVIATIONS of the nasal septum whenever they occur are very distressing, and frequently lead to mouth breathing and other unpleasant consequences. Mr. St. Clair Thompson has described very clearly a simple and somewhat ingenious method of operation for relieving this abnormal condition of nasal septum. Anyone contemplating operating on such a case would do well to carefully peruse beforehand this paper, which could be read in a few minutes, as it gives very clear instructions as regards remedying this malformation by operation, and several useful plates are given, with the histories of several cases.

NEW BOOKS AND NEW EDITIONS.

- BAILLIERE, TINDALL AND COX (London).
  - Lessons on Massage. By Margaret D. Palmer. Third Edition. Pp. 272. Price 7s. 6d. net.
  - Surgery of the Rectum. By Fred. C. Wallis, B.A., M.D., F.R.C.S. Illustrated. Pp. 168. Price 6s. net.
  - Clinical Lectures on Enlargement of the Prostate. By P. J. Freyer, M.A., M.D., M.Ch. Third Edition. Illustrated. Pp. 154. Price 6s. net.
  - War with Disease. By Frederick F. Maccabe, M.B. Second Edition. Pp. 125. Price 1s. net.
- CASSELL AND CO., LIMITED (London).
  - Tumours, Innocent and Malignant. By J. Bland Sutton, F.R.C.S. Fourth Edition. Illustrated. Pp. 675. Price 21s. net.
- CAXTON PUBLISHING CO., THE (London).
  - The Nursling: The Feeding and Hygiene of Infants. By Pierre Budin. Authorised Translation by Wm. J. Maloney, M.B., Ch.B. Illustrated. Pp. 199. Price 21s. net.
- CHURCHILL, J. AND A. (London).
  - Year-Book of Pharmacy. From July 1, 1905, to June 30, 1906. Edited by J. C. Braithwaite. Pp. 350.
- GRIFFIN, C., AND CO., LIMITED (London).
  - Practical Sanitation: A Handbook for Sanitary Inspectors and Others Interested in Sanitation. By George Reid, M.D., D.P.H., with Appendix on Sanitary Law, by Herbert Manley, M.A., M.B., D.P.H. Thirteenth Edition, revised. Illustrated. Pp. 352. Price 6s.
- THE HEALTH RESORTS BUREAU (London).
  - French Law and Customs for the Anglo-Saxon. By Arthur S. Browne. Second Edition. Revised and enlarged. Pp. 75. Price 2s. 6d. net.
- LIPPINCOTT, J. B., AND CO. (London).
  - International Clinics: A Quarterly. By A. O. J. Kelly, A.M., M.D. Vols. 2 and 3. Sixteenth Series, 1906. Pp. 302 each.
  - Pediatrics: The Hygienic and Medical Treatment of Children. By T. M. Rotch, M.D. Fifth Edition. Rearranged and Rewritten. Illustrated. Pp. 1,060. Price 25s. net.
- LONGMANS, GREEN AND CO. (London).
  - Sanitary Engineering with Respect to Water Supply and Sewage Disposal. By L. Francis Vernon-Harcourt, M.A., M.I.C.E. Illustrated. Pp. 419. Price 14s. net.
- MACMILLAN AND CO., LIMITED (London).
  - Anæsthetics and their Administration. By Frederic W. Hewitt, M.V.O., M.A., M.D. Third Edition, Illustrated. Pp. 627. Price 15s. net.
- METHUEN AND CO. (London).
  - The Control of Scourge; or How Cancer is Curable. By Charles P. Childe, B.A., F.R.C.S. Pp. 299. Price 7s. 6d. net.
- MURRAY, JOHN (London).
  - Recent Progress in the Study of Variation, Heredity, and Evolution. By Robert Heath Lock, M.A. Pp. 299. Price 7s. 6d. net.
- PENTLAND, YOUNG J. (Edinburgh).
  - The Edinburgh Medical Journal. Edited by Alexis Thomson, M.D., etc., and Harvey Littlejohn, M.B., etc. New Series. Vol. XX. Pp. 575.
- SAUNDERS, W. B., AND CO. (London).
  - The Technic of Operations upon the Intestines and Stomach. By Alfred H. Gould, M.D., Boston. Illustrated. Pp. 302. Price 21s. net.
  - Prevalent Diseases of the Eye. By Samuel Theobald, M.D. Pp. 551. Price 19s. net.
  - A Manual of Normal Histology and Organography. By Charles Hill, Ph.D., M.D. Pp. 463. Price 10s. net.
  - A Text Book of Obstetrics. By B. C. Hirst, M.D. Fifth Edition. Revised and enlarged. Pp. 915. Price 21s. net.
  - A Text Book of Pathology. By Alfred Stengel, M.D. Fifth Edition revised. Pp. 979. Price 21s. net.
  - Surgery: Its Principles and Practice. By various Authors. Edited by W. W. Keen, M.D. Vol. 1. Illustrated. Pp. 983. price 30s. net.
- SMITH, ELDER AND CO. (London).
  - Climatotheraphy and Balneotherapy. By Sir Hermann Weber, M.D., F.R.C.P., and F. Parkes Weber, M.D., F.R.C.P. Pp. 833. Price 15s. net.
- YEAR BOOK PUBLISHERS, THE (Chicago).
  - The Practical Medicine Series. Edited by Gustavus P. Head, M.D. 9 Vols.

(*a*) "Aids to Medical Diagnosis." By Arthur Whiting, M.D., M.R.C.P., Physician to the Tottenham Hospital and Assistant Physician to the Mount Vernon Hospital for Consumption and Diseases of the Chest, &c. Pp. x., 152. Fcap, 8vo, price 2s. 6d. London Bailliere, Tindall and Cox. 1907.

(*b*) "Minor Maladies and their Treatment." By Leonard B. Williams, M.D., C.M., M.R.C.P.Lond., Physician to the French Hospital in London; Assistant Physician, Metropolitan Hospital. Pp. 394. London: Bailliere, Tindall and Cox. 1907. Price, 5s. net.

(*a*) "Submucous Excision of Deviations and Spurs of the Nasal Septum." With a report of the first thirty operations. By St. Clair Thomson, M.D., F.R.C.P., F.R.C.S., Physician for Diseases of the Throat in King's College Hospital; Surgeon for Diseases of the Nose, Throat, and Ear, in the Seamen's Hospital, Greenwich. Pp. 48. London: Cassell and Company, Limited. Price 1s. net. 1906.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Infectivity of Malignant Diseases.—Gaylord (*British Medical Journal*, Dec. 1st, 1906) publishes two cases highly suggestive of the infectivity of malignant disease. He refers to similar observations by Hanau on carcinoma in rats, by Borrel and by Michaelis on carcinoma in mice, by Cooper and by Loeb on carcinoma in cattle, and by Pick on carcinoma of the thyroid in trout. One of Gaylord's cases is the direct sequel to the case recorded by Loeb in 1904. Loeb, in the years 1901 and 1902, had observed in rats three cases of "cystic sarcoma" which was shown to be capable of transplantation. Some three years later, in a rat confined in one of the cages made use of in the transplantation experiments, a tumour exactly similar in structure appeared. This form of tumour is apparently very rare, since Gaylord has been unable to find any record of such a tumour elsewhere. In the other rats in the same cage sarcomata also developed, though somewhat different in type. The second case is more striking still. In one particular cage in the establishment of a mouse breeder, no less than sixty tumours have been discovered in the course of three years. The tumours all occurred in females, and were identical in type—adeno-carcinomata of the breast. In no other cage in the establishment did any tumours occur, although there were constantly several hundred mice in captivity. That the occurrence of the tumours was not due to any hereditary cause is established by the fact that an entire change of stock made no permanent difference. Gaylord concludes that his observations, taken with those previously published, are sufficient to justify a belief in the occasional contagiousness of sarcoma and carcinoma. R.

Bacteriology of Rheumatic Fever.—Beattie (*British Medical Journal*, December 22nd, 1906) defends the position of the organism described by himself and Poynton (*micrococcus rheumaticus*) against hostile criticism. (1) It has been objected that the organism is not causal, but that infection by it is only terminal. Against this is the fact that cultures from the blood, taken immediately after death, are negative, cultures of the organism being got only from limited areas of the synovial membranes. (2) It has been objected that the organism is merely an attenuated *streptococcus pyogenes*. Beattie details many cultural and inoculation experiments performed with the two organisms, showing many marked differences. *Streptococcus*, for example, produced joint lesions—all definitely purulent—in 18 per cent. of the cases, and endocarditis (of an ulcerative nature) in 2 per cent.; on the other hand, *m. rheumaticus* produced joint lesions, always non-purulent, in 60 per cent., and endocarditis in 33 per cent. (3) The author shows that the organism is usually absent from the blood and joint effusions in simple cases, though in severe cases it may be found. R.

Experimental Arterio-Sclerosis. — Klotz (*British Medical Journal*, December 22nd, 1906), in the course of a general discussion of the pathology of arterio-sclerosis, describes the results of certain experiments in the artificial production of that condition. He concludes:—(1) The effect of the high-pressure drugs (adrenalin, digitalis, barium chloride) on the arteries is a degenerative one. (2) The muscle cells of the media are first attacked, the elastic fibres being involved later. (3) The change is a fatty degeneration, accompanied by calcareous deposits. (4) Occasionally the intima shows proliferative changes. (5) The effect of adrenalin is not abolished if the blood pressure be lowered by nitro-glycerin. (6) Aneurisms are produced as a result of the destruction of the media. (7) Diphtheria toxins act on the arteries in a similar way to adrenalin. (8) Typhoid and streptococcal infections produce little destruction of tissue cells, but tend to stimulate cell proliferation of the intima and of the inner layer of the media. R.

Rarity of Cancer in Central Africa.—Hearsey (*British Medical Journal*, Dec. 1, 1906) comments on the extreme rarity of cancer among the aborigines of British Central Africa. Although innocent tumours such as lipoma and fibroma are fairly common, only a few cases of malignant disease have been noticed. No case of cancer of the breast has yet been discovered. Hearsey suggests that the absence of epithelioma of the mouth may be due to the fact that the natives are not subject to irritation either by jagged teeth or by hot pipes. Again, as regards the breast, it is made to perform its physiological function of suckling, and is therefore not so subject to pathological processes. R.

Degenerations of Fibroids of the Uterus.—Noble (*Journal of Obstetrics and Gynæcology*, November, 1906) discusses at considerable length the various degenerations to which fibroid tumours of the uterus are subject. He collates with his own figures those of Martin, Watt-Keen, McDonald, Lauwers, and other observers, so that he is able to pass in review some 2,274 cases. In 95 of these, *i.e.* 3.9 per cent., malignant degenerations or complications were present; more than one-third of the malignant cases were sarcoma, most of the remainder being cancer of the body. In 119 cases (4.7 per cent.) there was necrosis, of which the precise nature is not stated. Cystic degeneration was present in 58, or 2.5 per cent., of the cases, myxomatous degeneration in 89, or 3.4 per cent., hyaline degeneration in 80, or 3.26 per cent., fatty degeneration in 7, or .3 per cent., and calcareous infiltration in 47, or 1.95 per cent. In only 8 of the cases is there mention of endometritis. By adding together the cases of malignancy and other dangerous complications, the writer finds that in 275 cases of the series, or 12 per cent., conditions were present which, apart from operation, would prove fatal. In 14 per cent. of his own cases a fatal result was, he believes, inevitable were it not for operation. In view of the more frequent association of cancer of the body than of cancer of the cervix with fibroids, Noble is persuaded that the presence of fibroids is a causal factor in the production of cancer of the body. The main conclusion arrived at by the author is that fibro-myoma of the uterus is a more serious disease than is generally recognised, and that no fibro-myoma which is causing symptoms should be allowed to remain. R.

The Effect of Lime Salts in Pancreatic Digestion.—Delezenne (*British Medical Journal*, December 22nd, 1906) relates that pancreatic juice obtained in an inactive form acquires a powerful proteolytic activity when incubated for some hours with a soluble calcium salt. Pancreatic juice prepared in this way dissolves cubes of albumin as rapidly as if mixed with enterokinase. This action of calcium must be regarded as peculiar to itself, since the salts of other metals of the same series have no such effect. R.

Movements of the Uterus.—Cushny (*Journal of Physiology*, December 29th, 1906) describes the result of investigations into the mechanism of movements of the uterus. His experiments were carried out on rabbits, cats, and bitches. The movements, both longitudinal and circular, were recorded by an ingenious attachment of levers to the horns of the uterus. Connection with the central nervous system was destroyed, and Cushny believes that movements of the organ can take place independently of the central nervous system. (1) In the virgin uterus no spontaneous movements were observed, whereas in animals in heat and after pregnancy spontaneous movements were generally present. The spontaneous movements of the longitudinal fibres were slow, rhythmical contractions, resembling the pendulum movements of the intestine. The period between successive movements varied from fifteen seconds to twelve minutes. (2) In addition to the contraction of the longitudinal muscle fibres, movements were caused by the contraction of the fibres of the broad ligament, throwing the uterus into a spiral or curved form. (3) The movements of the circular fibres were very similar to those of the longitudinal, but they did not occur simultaneously. (4) Mechanical or electrical stimulation of the uterus caused a powerful contraction, whether the organ were in a state of rest or undergoing spontaneous contraction. The virgin uterus was always less irritable than the pregnant or parous uterus. (5) Stimulation of the hypogastric nerve generally induced powerful contraction of the whole organ in the rabbit, while in the cat the effect varied with the condition of the uterus. Thus, the virgin uterus was inhibited, whereas the pregnant or parous uterus contracted with vigour. (6) The general result of anæmia was to cause an increased tone. (7) The effects of various drugs were tried. A first injection of nicotin caused powerful contractions, but further injections showed diminishing effects. Pilocarpin increased the rate and strength of contractions. Atropin had no effect, except that it antagonised pilocarpin in cases where the latter had been previously administered. The effects of adrenalin were identical with those of hypogastric stimulation. Quinine produced marked contractions. Aloin had a similar effect. Alcohol produced no effect, and ether and chloroform only very slight relaxation. Ergot caused prolonging of the contractions, but no acceleration. R.

Effects of Adrenalin Injection.—Elliott and Durham (*Journal of Physiology*, October 29th, 1906) report the results of a series of experiments on cats by the injection of adrenalin. They conclude:—(1) In no case was there any evidence of the production of any antibody to adrenalin. It is possible that this result may not be applicable to other animals. (2) The muscles of the circulatory system were unaltered. (3) The suprarenal glands were somewhat enlarged. (4) The liver and kidneys showed obvious signs of poisoning. Polyuria with sugar followed each injection. The liver showed shrinkage, with fatty degeneration of the cells. The kidneys showed enlargement, with fatty degeneration of the tubular epithelium. R.

The Pancreas in Cirrhosis of the Liver.—Laudo (*Zeitsch. für Heilk.*, Bd. 27, H. i.) has examined the pancreas in twenty-three cases of typical liver cirrhosis, and in all cases found a more or less abundant overgrowth of connective tissue, which was sometimes distributed intra-lobularly, but more often was interlobular. The head and the tail of the pancreas were always equally affected, and in pigmentary cirrhosis of the liver a deposit of pigment was found also in the pancreas. The cell-islets of Langerhaus showed change in many cases, but in no case as marked as is to be found in diabetics. The form of liver cirrhosis, whether atrophic or hypertrophic, did not seem to lead to any variation in the pancreatic condition, which was apparently almost entirely to be ascribed to the venous engorgement following portal obstruction. M.

The Position of the Heart in Pericardial Effusions.—Schaposchnikoff (*Rev. de Med.*, 1905, p. 789) adds to his earlier observations on this subject the record of twenty-six more cases of pericarditis that he has studied. He concludes that the heart does not sink in pericardial effusions, as, according to Skoda, it is bound to do owing to its weight, but that, on the contrary, it is raised up and floats on the top of the effusion. The position occupied is of great importance from the point of view of paracentesis, and the author is inclined to advise puncture to the right of the sternum. M.

The Proteolytic Ferment of Leucocytes.—Eppenstein (*Münch. Med. Woch.*, 1906, No. 45) points out that already a chemical distinction between lymphocytes and polynuclear leucocytes has been made by many writers, in that the polynuclear cells and also myelocytes are capable of peptonising gelatin. The proteolytic ferment of these leucocytes works best in a slightly alkaline medium, and at a temperature of 55 deg. C. At 70 deg. C. the action becomes weakened, and at 75 deg. C. it is completely lost. Blood plasma and serum have a restraining influence on the ferment, and lately, by the chloroform method of Delezenne, an anti-proteolytic ferment has actually been isolated. In some cases of myelæmia this last-named ferment persisted even in the serum obtained ten hours *post mortem*, but the ferment was invariably greatly retarded by a temperature of 60 deg. C. M.

Ehrlich's Diazo Reaction in Phthisis.—Weisz (*Weiner Klin. Woch.*, 1906, No. 44) has systematically carried out the Diazo test on the urine of 257 patients suffering from pulmonary tuberculosis. The longest duration under observation was seven months, and the shortest one month. As a result of these observations he states that a positive reaction may be regarded as a serious symptom, and that the seriousness is emphasised by a persistence of the phenomenon. Often a positive reaction can be obtained after tuberculin injections. The urine is the only secretion which gives the reaction, and it is only found in fairly concentrated urines. M.

Undulant Fever in South Africa.—Dr. Strachan contributes a paper on the occurrence of Malta fever in South Africa to the *South African Medical Record*, December 10th, 1906, p. 345. He points out that a few previous writers have urged that the disease is prevalent in South Africa, but that it has not yet been generally recognised, and that most cases are still diagnosed as enteric fever. Since his own attention was attracted to the subject, he has met with numerous cases that were clinically undulant fever, and states that during the last four years 138 cases of this fever have occurred in his practice, while during the same time he only met with 30 cases of enteric fever. His diagnosis was based both on clinical symptoms and on the serum reaction with typhoid and Malta fever organisms respectively. As far as the latter test was concerned, out of 34 sera tested in dilutions up to 1 in 50, 25 gave a positive reaction with the micrococcus melitensis, 3 with the bacillus of Eberth, while 5 were negative with both. In one case that presented cerebral symptoms, the micrococcus was isolated at the autopsy from the brain. The complications of the disease and the mode of transmission are discussed, and the conclusion is derived from an examination of the milk that goats are most probably the culprits in the latter respect. The most common complication was lumbago, which occurred in 63 per cent. of cases. M.

Agglutination in Pulmonary Tuberculosis.—Jessen has made 122 observations of the agglutinative properties of the blood serum in 86 cases of pulmonary tuberculosis (*Brauers' Beitrage zur Klinik der Tuberk.*, Bd. vi., Heft ii.). In most cases which the author treated in Davos at a height above sea level of 1,500 metres, he found that without any specific treatment the agglutinative properties were increased. Those treated with tuberculin did not react a higher grade than the untreated cases. Clinical improvement was noted in most cases who presented an increase of agglutinative power, while the cases that ran an unfavourable course showed poor agglutinative re-action. On this account some value, at most slight, as a prognostic sign can be placed on this property. A reaction in a dilution of one in twenty-five can alone be regarded as positive, and reaction in slighter dilutions is absolutely valueless from a diagnostic point of view. M.

MEDICAL NEWS.

British Gynæcological Society.

AT the annual meeting of this society, held on Thursday, January 10, 1907, the following officers and council were elected for the current year:—

Hon. President.—R. Barnes, M.D., F.R.C.P., F.R.C.S. (Eastbourne).

President.—*W. Dunnett Spanton, F.R.C.S. (Hanley).

Vice-Presidents.—T. Gelston Atkins, B.A., M.D., M.Ch. (Cork); William Duncan, M.D., F.R.C.P., F.R.C.S. (London); Bedford Fenwick, M.D., M.R.C.P. (London); *Clement Godson, M.D., M.R.C.P. (London); H. Jellett, M.D., F.R.C.P.I. (Dublin); *J. Furneaux Jordan, M.B., F.R.C.S. (Birmingham); R. P. Ranken Lyle, B.A., M.D., B.Ch. (Newcastle-on-Tyne); J. J. Macan, M.A., M.D. (London); *H. Macnaughton-Jones, M.D., M.Ch., M.A.O., F.R.C.S.I. and Edin. (London); W. H. C. Newnham, M.A., M.B., M.R.C.S. (Clifton); *W. H. Slimon, M.D., C.M., F.F.P.S. (London); R. T. Smith, M.D., M.R.C.P. (London).

Hon. Treasurer.—W. H. Slimon, M.D., C.M., F.F.P.S.

Council.—S. Jervois Aarons, M.D., M.R.C.P. (London) W. Alexander, M.D., M.Ch., F.R.C.S. (Liverpool); N. T. Brewis, M.B., C.M., F.R.C.P., F.R.C.S.E. (Edinburgh); *E. Stanmore Bishop, F.R.C.S., L.R.C.P. (Manchester); *W. H. Bourke, M.D. (London); *G. Roe Carter, M.R.C.P.I., L.R.C.S.I., (London); A. Donald, M.D., M.R.C.P. (Manchester); *A. E. Giles, M.D., B.Sc., F.R.C.S.E., M.R.C.P. (London); *F. Bowreman Jessett, F.R.C.S. (London); R. J. Kinkead, A.B., M.D. (Galway); J. Macpherson Lawrie, M.D. (Weymouth); *H. M. Macnaughton-Jones, M.B., B.Ch., M.R.C.S. (London); J. A. Mansell-Moullin, M.B., M.R.C.P. (London); F. R. Mutch, M.D., C.M. (Nottingham); J. J. Redfern, M.D., M.Ch. (Croydon); *C. Ryall, F.R.C.S. (London); Mary Anne Dacomb Scharlieb, M.D., M.S. (London); H. J. F. Simson, M.B., C.M., M.R.C.P., F.R.C.S.E. (London); *Heywood Smith, M.D., M.R.C.P. (London); J. H. Swanton, M.D., M.Ch., M.R.C.P. (London); J. W. Taylor, M.Sc., M.D., F.R.C.S. (Birmingham); J. H. Dauber, M.A., M.B., M.R.C.P., E. H. Tweedy, F.R.C.P.I. (Dublin); Hugh Woods, B.A., M.D., B.Ch. (London).

Editor of the Journal.—J. J. Macan, M.A., M.D. (London).

Assistant Editor.—J. H. Swanton, M.D., M.R.C.P. (London).

Hon. Secretaries.—Smallwood Savage, M.A., M.B., B.Ch., F.R.C.S. (Birmingham); H. Beckett-Overy, M.D., F.R.C.S. (London).

Auditors.—C. H. Bennett, M.D. (London); E. F. Travers, M.B.

Trustees of the Property of the Society.—G. Granville Bantock, M.D., F.R.C.S.; R. S. Fancourt Barnes, M.D., F.R.S.E.; Clement Godson, M.D., M.R.C.P.

The asterisk indicates the new names proposed by the Council for the respective offices.

Royal College of Surgeons, England.

THE following Courses of Lectures for 1907 have been arranged to all of which members of the profession are admitted free. The lecture hour is 5 p.m., *Erasmus Wilson Lectures.*—Monday, February 4th, Mr. Wilmott Evans, F.R.C.S., "Leucoderma, and Analogous Pigmentary Changes in the Skin." Wednesday, February 6th, Mr. R. C. Elmslie, F.R.C.S. "Injury and Deformity of the Epiphysis of the Head of the Femur; Coxa Vara." Friday, February 8th, Mr. K. W. Goadby, M.R.C.S., "The Ætiology and Pathology of Pyorrhœa Alveolaris; Rigg's Disease.'

Hunterian Oration.—Thursday, February 14th, Mr. Henry T. Butlin, F.R.C.S., at 4 o'clock, p.m.

Arris and Gale Lectures.—Monday, February 18th, and Wednesday, February 20th, Mr. J. F. Dobson, F.R.C.S., "The Lymphatic System of certain portions of the Alimentary Canal." Friday, February 22nd, Mr. Bertram Abrahams, M.B., "Some Clinical Applications of Physiology."

Hunterian Lectures.—Monday, February 25th and Wedneday, February 27th, Prof. W. Sampson Handley, "The Pathology of Melanotic Growths in relation to their Surgical Treatment." Friday, March 1st and Monday, March 4th, Prof. J. W. Thomson Walker, "The Renal Function in its relation to Surgery." Wednesday, March 6th and Friday, March 8th, Prof. J. Howell Evans, "Cysts and Cystic Conditions of Embryonal Origin." Monday, March 11th, Wednesday, March 13th, and Friday, March 15th, Prof. William Wright, "The Prehistoric and Early Historic Inhabitants of England." Monday, Wednesday, and Friday, March 18th, 20th, and 22nd, Prof. Cecil F. Beadles, (1) "Anatomical Variations in the Larger Arteries of the Brain and their Medical and Surgical Aspects." (2) "Aneurysms of the larger Cerebral Arteries with special reference to their possible Diagnosis and Treatment."

Munificent Gift to Aberdeen University

AT a meeting of Aberdeen University Court, held last week, it was announced that the Hon. A. M'Robert of Cawnpore, India, had founded a fellowship in connection with the University for cancer research. At Mr. M'Robert's death a sum of £10,000 is to be available for the purpose, but that the work may begin at once, he has undertaken to provide £400 a year until such time as the principal sum shall be paid over to the University, either by his executors at his death or earlier. The endowment is to be called the "Georgina M'Robert Fellowship," and it is founded in memory of Mr. M'Robert's wife. In the event of any epoch-making discovery in connection with the subject of cancer research, the Medical Faculty of the University is to have authority to allot all or any portion of the capital as a reward to the discoverer, and also to the investigator or investigators whose work had, in the unanimous opinion of the Medical Faculty, contributed to the discovery. Mr. M'Robert was most heartily thanked for his generous gift. At the same meeting a communication was also read from the trustees of the late Dr. John Wight, Aberdeen, intimating a legacy of £3,000 to found four or more medical bursaries in the University.

Army Medical Service.

IT is officially announced that the Secretary of State for War has approved of the amalgamation of the Army Medical Advisory Board, and the Army Hospital and Sanitary Committee. The reconstituted Army Medical Service Advisory Board is composed of the following members:—The Director-General, Army Medical Service (Surgeon-General Sir A. Keogh, K.C.B., M.D.), (Chairman). The Deputy Director-General, Army Medical Service (Vice-Chairman). Members: Brevet-Colonel D. Bruce, C.B., F.R.S., M.B., R.A.M. Corps (as Expert in Tropical Diseases); Colonel G. K. Scott Moncrieff, C.I.E., R.E., Assistant Director of Fortifications and Works; Lieut.-Colonel C. H. Melville, M.B., R.A.M. Corps (as Expert in Sanitation). Civilian Members: Sir F. Treves, Bart., G.C.V.O., C.B., F.R.C.S., LL.D.; Dr. J. Rose Bradford, F.R.S., F.R.C.P.; Dr. Louis Parkes, Consulting Sanitary Adviser to H.M. Office of Works; Dr. M. S. Pembrey, M.A. (Oxon); Sir Charles A. Cameron, C.B., M.D., F.R.C.S. (for sanitation in Ireland); The secretary will be Lieut.-Colonel C. H. Melville, M.B., R.A.M. Corps, and the India Office will be represented by Surgeon-General A. M. Branfoot, C.I.E., M.B. (retired Indian Medical Service).

Society of Apothecaries of London.

The following candidates passed the primary examination, Part I., January 9th and 10th:—Biology: I. M. Bernard and H. Cox. Chemistry: F. G. Carroll. Materia Medica and Pharmacy: R. C. Carey, E. M. Johnstone, G. F. Malden, and V. P. Norman.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs.15.12.

R. S.—The treatment of uncomfortable cardiac sensations not dependent on organic changes must, to a great extent, be by moral means, but in addition to the drugs you name as having been tried, it might be worth while considering pyrenol. Its action is tonic rather than otherwise, and it has been praised in the condition you describe.

Anthropos.—The Bertillon system (Bertillonage as it is called) does not in itself include finger-prints, but they are used to supplement the ordinary measurements. Bertillon's principal measurements are the length of the head, its breadth, the length of the left middle finger, of the left forearm, and of the left foot. The left side has been found less liable to vary than the right.

Dr. Law.—We hope to have space for your interesting case in our next.

Fatal Anæsthesia.—An original Paper on this subject has been received without the name of the author. We shall be glad if he will kindly communicate with us.

N. T. P.—'Twas ever thus, but we are not discouraged.

W. D. S. is thanked for his kindly note.

FIRE IN EDINBURGH.

A **correspondent** in Edinburgh sends us the following cutting from *The Scotsman* of Saturday last:—"Dr. and Mrs. ——— return most grateful thanks for many kind inquiries and offers of assistance in connection with the alarming and destructive fire at their residence. The present disorder of the house makes it difficult to send individual acknowledgment, and it is hoped that this expression of sincere gratitude will be accepted in lieu of more personal thanks." The correspondent considers this in the nature of an advertisement, and expresses surprise that it should emanate from a Member of Council of the R.C.Phys. of Edinburgh. Under the circumstances referred to in the paragraph we are unable to take the same view.

Connaught.—It is often quite impossible to tell the cause of death with only pathological evidence. Dr. F. J. Smith recently gave some figures from the London Hospital records. These showed that out of 2,123 carefully-performed post-mortems, in 102 cases no naked-eye pathologic appearances were found. The "vomiting and diarrhœa" class furnished the bulk of examples. In 115 cases of this complaint no less than 83 showed nothing abnormal in the organs.

F. H.—Hyoscyamin has been recommended in whooping cough, but we can only say that its administration would have to be carried out with the greatest care.

Meetings of the Societies, Lectures, &c.

Wednesday, January 23rd.

Hunterian Society (London Institution, Finsbury Circus, E.C.).—8.30 p.m.: Hunterian Lecture. Mr. M. Robson: Points in the Diagnosis and Treatment of Duodenal Ulcer.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. A. H. Tubby: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. A. E. Giles: Developments and Disasters of Extra-Uterine Gestation.

North East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Dermatological (Dr. Meachen), Ophthalmological (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Central London Throat and Ear Hospital (Gray's Inn Road, W.C.).—5 p.m.: Demonstration:—Dr. Abercrombie: Nose and Accessory Sinuses.

Thursday, January 24th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Mr. L. Mummery: The Special Features of Appendicitis in Children.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Gynæcological Operations (Dr. Giles), Medical (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Cliniques:—Medical In-patient (Dr. Chappel). 4.30 p.m.: Lecture:—Dr. Meachen: Demonstration of Selected Skin Cases.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Syphilis: Papular (I., Miliary; II., Lenticular; III., Squamous; IV., Moist, Pustular and Tuberculous).

Friday, January 25th.

Clinical School of London (20 Hanover Square, W.).—8 p.m.: Clinical Evening for the Exhibition of Cases, followed by Discussion. Patients in attendance from 8 to 9 p.m.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. S. Stevenson. Clinique. (Eye).

North-East London Post-Graduate College (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Clinique. Medical Out-patient (Dr. Auld), Ophthalmological (Mr. Brooks) 3 p.m. Clinique. Medical In-patient (Dr. Leslie).

Monday, January 28th.

Odontological Society of Great Britain (20 Hanover Square, W.).—8 p.m.: Dr. W. L. H. Duckworth:—A Note on the Dentition of Some New Guinea Skulls. Mr. H. Bellamy Gardner, L.R.C.P., M.R.C.S.:—Continuous Nasal Administration of Nitrous Oxide with Oxygen. Paper:—Mr. Philip Turner, M.S., B.Sc: Tumours of the Superior Maxilla.

Vacancies.

Carmarthen, Cardigan, and Pembroke Joint Counties Lunatic Asylum, Carmarthen—Junior Assistant Medical Officer. Salary £150 per annum, with furnished rooms, board, washing, and attendance. (no stimulants). Applications to W. Morgan Griffiths, Clerk to the Asylum Visitors, Carmarthen.

Newport Borough Asylum, Caerleon, Mon.—Assistant Medical Officer. Salary £150 per annum, with board, apartments, and attendance. Applications to the Medical Superintendent.

Rochdale Infirmary.—House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to Henry Booth, Secretary, Infirmary Offices, 58A, Yorkshire Street, Rochdale.

Cameron Hospital, West Hartlepool.—House Surgeon. Salary £100 per annum, with board, rooms, and washing. Applications to J. G. Taylor, Secretary.

West Riding Asylum, Menston, near Leeds.—Fourth Assistant Medical Officer. Salary £150 per annum, with board and apartments. Applications to the Medical Superintendent.

West Riding Asylum, Menston, near Leeds.—Second Assistant Medical Officer. Salary £200 per annum, with board and apartments. Applications to the Medical Superintendent.

Tunbridge Wells General Hospital.—House Surgeon. Salary £100 per annum, together with board, furnished apartments in the hospital, gas, firing, and attendance. Applications to the Secretary.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Resident Medical Officer. Salary £100 per annum, with board, residence, and laundry. Applications to W. M. Wilcox, Secretary.

Appointments.

Crossley, Leonard, M.D.Edin., Medical Superintendent of the Sanatorium at the Benenden Branch of the National Association for the Establishment and Maintenance of Sanatoria for Workers suffering from Tuberculosis.

Davis, William Herbert, L.R.C.P.Lond., M.R.C.S., Honorary Assistant Ophthalmic Surgeon to the Royal Albert Hospital, Devonport.

Drapes, Thomas Lambert, M.B., B.C.Cantab., L.R.C.P.Lond., M.R.C.S., District Medical Officer and Workhouse Medical Officer by the Chepstow (Mon.) Board of Guardians.

Fletcher, R. B., M.D., Ch.B.Vict., District Obstetric Officer to the St. Mary's Hospitals, Manchester.

Hay, John, M.D.Vict., M.R.C.P.Lond., Assistant Physician to the Royal Infirmary, Liverpool.

Marwick, R. Elrick, M.B., Ch.B.Edin., Senior House Surgeon to the Dumfries and Galloway Royal Infirmary.

McNaughton, J. G., M.D., M.R.C.P.Edin., Honorary Physician to Ancoats Hospital, Manchester.

Nunneley, F. P., M.B., B.S.Oxon., Certifying Surgeon under the Factory and Workshop Act for the Elstree District of the county of Hertford.

Phillips, Miles H., M.B., B.S.Lond., F.R.C.S.Eng., Honorary Assistant Medical Officer to the Jessop Hospital for Women, Sheffield.

Speirs, Henry, M.B., Ch.B.Edin., House Surgeon at the Chelsea Hospital for Women.

Westerman, Arthur, M.D., Ch.B.Aberd., Clinical Assistant to the Throat and Ear Department at the Brompton Hospital for Diseases of the Chest.

Births.

Edelsten.—On Jan. 15th, at 370 Brixton Road, London, the wife of Ernest A. Edelsten, M.B., M.A., of a son.

Hodgson.—On Jan. 18th, at Leyburn, 6 Mitcham Lane, London, the wife of Charles Hodgson, L.R.C.P.Lond., M.R.C.S.Eng., of a son.

Kempthorne. On Jan. 9th, at Lahore Cantonments, India, the wife of Gerard Ainslie Kempthorne, R.A.M.C., of a daughter.

Marriages.

Bisset—Jackson.—On Jan. 17th, at the East Church, Stirling, Archibald Grainger Bissett, M.B., Ch.B.Glasg., Rothes, Elginshire, to Charlotte Louise, third daughter of the late Surgeon-Lieutenant-Colonel T. W. Jackson, A.M.S.

Grant—Freyer.—On Jan. 19th, at All Saints', Margaret Street, London, Lieut. John Duncan Grant, V.C., 8th Gurkha Rifles, only son of Colonel Suene Grant, R.E., and grandson of the late Colonel J. M. Grant, R.E., to Kathleen, only daughter of Lieutenant-Colonel P. J. Freyer, M.D., late I.M.S., and now of 27 Harley Street, London, W.

Simson—Clarke.—On Jan. 17th, at St. George's, Hanover Square, London, W., Capt. Harold Simson, R.A.M.C., third son of Thomas Simson, of Blackheath, to Kate Litton, eldest daughter of Ernest Clarke, M.D., F.R.C.S., of Chandos Street, Cavendish Square, London.

Deaths.

Begbie.—On Jan. 15th, at Netley Hospital, Major George Edward Begbie, D.S.O., of the 71st Highland Light Infantry, younger son of the late James Warburton Begbie, M.D.Edin., aged 38.

Clinch.—On Jan. 18th, Thomas Aldous Clinch, M.D., D.P.H., elder son of Henry Clinch, of Weeley, Essex, aged 35.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, JANUARY 30, 1907. No. 5

NOTES AND COMMENTS.

Secretly or Corruptly.

THE coming into force this year of the Act prohibiting the taking of secret commissions will make very little, if any, difference to medical men. In many commercial circles where grafts, tips, bonuses, and other forms of reward or blackmail are the breath of the nostrils of business, an exceedingly wholesome change of tone may be looked for; indeed, there are few business people, from the fur-coated company-promoter in the City to the aproned domestic at the back-door, who do not give or receive, expect or demand, a share of the "swag" they are instrumental in obtaining for others. Every third scoundrel who appears in the police-court describes himself as an agent, and that blessed term covers a multitude of sins, expressed or implied, in commercial dealings. The world would be little poorer and probably considerably happier if agents disappeared and people transacted business directly with each other. However the millennium is not yet, and it is of the highest importance that every agent should have distinct and recognised limitations. In 1899, when the question of secret commissions was in the air, a gross calumny was perpetrated on the medical profession by a special committee of the London Chamber of Commerce, which was investigating the matter, for they asserted that the system existed of chemists paying medical men commissions on their prescriptions, sometimes to the extent of 25 to 50 per cent. It really is the height of cynical impertinence for a body representing the commercial interests of the City of London, where every kind of commission is given, to make such a reflection on a profession whose hands will compare favourably for cleanness with those of any body of men in the world, and we regret to see the accusation is now being re-made in certain quarters. The taking of commission from hotel-proprietors, chemists, undertakers, *et hoc genus omne*, is disgraceful conduct in the eyes of the profession, and would be treated as such were instances brought to light.

"Nourishment."

DOUBTLESS there are black sheep and spotted ewes in the medical profession, but there is no sort of doubt that professional feeling is totally opposed to those "sharing" practices which are the commonplaces of commercial transactions, and business men know that perfectly well. As to touting for patients, the feeling is equally strong, occasionally almost morbidly so, and when cases of such touting have been proved, the offenders' names have been removed from the *Register*. The bar is the only other profession in which the standard of ethics can compare with that obtaining among doctors, and even the bar is not without its loose fish and undesirables. If we were to believe the statements made by a barrister's clerk in an action brought against his employer last week, the standing of drinks to solicitors by barristers' clerks would appear to be nothing out of the way, and under the happy designation of "nourishment," money is disbursed by barristers for the purpose. In the case under notice, the barrister was prepared to deny the charges, but he was not called upon to do so. Still, the fact remains that even our lethargic General Medical Council could not let such charges against a medical man pass without enquiry. We do not believe that any such underhand dealings either are countenanced by the bar generally, or are carried on on a large scale; but no profession is without its less scrupulous members. The point is that whereas barristers and doctors will not tolerate grafts and commissions, in commerce they are not only tolerated but form part of its ordinary transactions. We trust the word "corruptly" will only allow any escape for those who violate the spirit of the new Act.

Two Persons and One Clerk.

THE facility with which Sir Richard Owen could reconstruct from an odd molar tooth or a long-lost fibula an "animal that was extremely rare," has passed into history. But it seems to be nothing compared to the ease with which a hypnotist can reconstruct the wanderings of a missing clerk. At a dinner of the Lyceum Club last week, a medical man is reported to have told a story in which romance and hypnotism were harmoniously blended. A clerk, so it runs, went out one day to lunch in the City and did not return. Usually in such cases the clerk turns out to have loaded himself with securities and bonds, but this clerk was not of the defaulting order. He took a walk in the park, visited some friends at Clapham Junction, stayed at a hotel there, and then went to Southampton. Four days later he returned home. This tale would not seem to provide very promising "copy" for the enterprising journalist, but it has gone the round of the journals with wonderful celerity. The point of the story is that the clerk was very distrait with his friends at Clapham Junction, and when he got home from Southampton he said he did not know where he had been. The wonders of hypnotism were, however, brought to bear, and in his trance the clerk remembered all that had happened and told it to the operator. The moral of the story is that the clerk was a "dual person," and the Dr. Jekyll part of him did not know when the Mr. Hyde part went to Southampton; moreover, that the two could only be introduced to each other by the hypnotist. The story is considered so wonderful that few have hesitated to believe it.

The Simplest Life.

ONE has heard *ad nauseam* of the simple life, which everybody talks about and nobody practises. Indeed, the simple life seems to resemble the "smart set" in being universally recognised as existing but never tangibly present. It is supposed to be somehow opposed to doctors, and the simple life advocates are the sworn enemies of medicine. Medical men are prepared generally to admit that if their patients all took to the simple life, their bills for attendance would be appreciably smaller, but yet the simple life seems to hang fire. So the British Nature Cure Association has been started, with the object of popularising the movement, and leading to what is called "the simplest life." This is not a reversion to the amœba-stage of existence, but the "practice of the gospel of pure simplicity and a glorious life on less than a shilling a day." Honey and nuts are to be the staple dietary, and cold water inside and out its leading feature, but we are not informed as to clothing to be adopted. Is that to be of the simplest nature, too, we wonder?

No Drugs, No Doctors.

MR. REID, the archbishop of the cult, is delightfully candid about the medical profession. In an interview last week, he informed his interlocutor that "our pet aversions are drugs and doctors. 'No drugs, no doctors!' is our battle-cry. We maintain that doctors are produced by negligence, and kept in being by negligence." It often occurs to us to wonder who are the medical attendants of these silly faddists. And what do they say to them when they are seriously ill? We have it on high authority that the devil when he is ill becomes a model patient, but we cannot help thinking the "no drugs, no doctor" gentlemen must look extremely foolish when they are obliged by stress of ill-health to invoke the aid of a medical man. At the present moment, Mr. Reid is pushing his glorious gospel by means of tracts and missionary nurses in various towns, and admits he is doing very well in the way of subscriptions. By way of showing the profession how tuberculosis should be treated his association have conceived the original idea that an open-air sanatorium would be a good thing, and they have collected £9,000 towards the £25,000 required for that object. This treatment is to be called "Natureopathy," and no doubt medical men will consider the propriety of following Mr. Reid's lead, and building a sanatorium or two also, as the plan is so striking a novelty.

LEADING ARTICLES.

CHANGES IN DUBLIN UNIVERSITY.

EVENTS have moved fast during the past few days with regard to university matters in Ireland. First came the Report of the Commission appointed by his Majesty last June to inquire into the affairs of Trinity College, Dublin, and the University of Dublin, and their relations to education in Ireland, and hard on its heels was the declaration of the policy of the Government made by Mr. Bryce. The Commission has certainly not been dilatory in presenting its Report, and no one who reads it can deny that the members have fulfilled their duty thoroughly and conscientiously. The task before them divided itself naturally into two parts—one dealing with what is known as "the Irish University question," the other with the internal affairs of Trinity College. With regard to the first question, the Commission has not been able to arrive at a unanimous conclusion further than that they "cannot hope to render the College [*i.e.*, Trinity College] acceptable to the Roman Catholic Episcopate by reasonable changes in its constitution." With regard to the alternative suggestions, four of the nine Commissioners are in favour of the re-constitution of Dublin University so as to include along with Trinity College a new college acceptable to Roman Catholics and to the three existing Queen's Colleges; three are in favour of the establishment of a college acceptable to Roman Catholics in the Royal University; and one thinks the demand for such a college is unreasonable. The remaining Commissioner thinks the re-constitution of Dublin University the ideal scheme, but in view of the avowed hostility to it of the staffs of all the existing colleges, he thinks it impracticable at present. With regard to questions of internal reform, which, however, sink now almost into insignificance, it is satisfactory that the Commissioners sign a unanimous Report. The recommendations made show a deep insight into the present cumbrous constitution of the College, and will undoubtedly, if carried out, make for efficiency in every department of College activity. Abolition of the Board, with the substitution of an elective body representative of both Fellows and Professors, and radical reform in the system of electing to Fellowships, are the main features. The need for further provision for scientific research is rightly emphasised. It is recommended that, as already agreed upon by the College, the College of Physicians, and Sir Patrick Dun's Hospital, the connection between these bodies shall cease. The King's Professors are to be appointed by Trinity College, instead of by the College of Physicians, and a fair division of the funds hitherto applied to their salaries is to be made. Sir Patrick Dun's Hospital is to be freed from the control of both colleges, and its Governors are to be its sole authority. We congratulate Trinity College on the splendid verdict pronounced that "as it stands to-day it is a noble institution for the maintenance of sound learning not unworthy of its great traditions and of the affection and veneration with which it is regarded by its children," and we hope with the Commissioners that "it will in the future increase in strength and usefulness." In the difficult days which await it in the immediate future, this statement from a Commission not altogether friendly must not be forgotten.

The most important point for Irishmen, however, is which of the alternative policies with regard to the University as a whole the Government intend to adopt, and if we are to accept the statement just issued by Mr. Bryce, the retiring Chief Secretary, they intend to unite four colleges in the University of Dublin, viz., Trinity College, a new college in Dublin for Roman Catholics, Queen's College, Belfast, and Queen's College, Cork. This scheme was condemned by four out of the nine Commissioners; it was recommended by four, and the ninth Commissioner, though in favour of it, said the time was not ripe for it. In the words of Sir Edward Fry, the Chairman of the Commission: "Trinity College rejects it. Lord Justice FitzGibbon, in refusing to accept it, speaks probably the general voice of his Protestant brethren. Mr. O'Reilly, expressing, as he believes, the opinion of the great mass of the Roman Catholic laymen of Ireland, considers it the worst of all proposals and intrinsically impracticable. The Rev. Dr. Delany, who may be taken to represent the higher Roman Catholic teachers in Dublin, reprobates it. The Rev. Dr. Hamilton, speaking for Belfast, Dr. Windle for Cork, and Dr. Anderson for Galway, are unanimous in their disapproval; and if possible still more important is the condemnation unanimously passed upon the scheme by the Senate of the Royal University at a large meeting of that body, which probably more thoroughly represents the higher education in Ireland outside Trinity College than any other body in Ireland."

SCHOOL BOARDS AND MEDICAL CERTIFICATES.

DURING the past few years the public has become familiarised with the complaints of Education Boards in various parts of the Kingdom as to the worthlessness of medical certificates. A typical instance may be offered in a reference from the Aberystwyth Committee approved by the Cardiganshire Education Committee, deprecating "the wholesale manner in which medical certificates were granted in trivial instances, as having a tendency to defeat the administration of the Education Act." In the accompanying discussion some hard things were said about the medical profession. The Rev. Daniel Evans observed, for example, that in the Llandyssul district "there were several children he knew of who went out to service, but who were certified by the medical officer as unfit to attend school." These words are taken from the *South Wales Daily News* of January 18th last, and constitute a grave charge either against the parents or against the competency or the good faith of a medical officer about whose identity there can, presumably, be no possible doubt. In either case the Rev. Daniel Evans should be called upon to justify or to withdraw a charge made in a public official capacity. If the officer concerned be a member of one of the medical defence unions, we should advise him to apply for counsel in the matter. Principal Bebb declared that "the wholesale manner in which medical certificates were granted in the county at present reduced the matter of education to an absolute farce, and it was time it was put a stop to." This general assertion, of course, stands upon a different footing from the direct charge of the Rev. Daniel Evans. It may be asked of the irate gentlemen who make these complaints have duly considered the question of school certificates. These documents are signed by members of a learned profession, and are absolutely necessary for the administration of any scheme of national education, inasmuch as no compulsory system could exist for a day unless exemption from attendance were made in the case of sick and ailing children. Yet these certificates are obtained from the medical profession without payment of any fee by the education authorities, or, in the vast majority of instances, by the parents. Why should an important professional service of this kind be exacted from the medical profession? The newspaper report upon which our remarks are founded speaks of certificates from "medical officers," but we presume that the term is applied to medical practitioners. Were they school medical officers, the board would not need to comment adversely upon the conduct of their own officials. We conclude, therefore, that Cardiganshire is simply acting upon the old tradition that local authorities are entitled to free medical certificates. School boards, as well as other public and private bodies and individuals, not to mention patients, are constantly applying to hospital physicians for gratis certificates. We contend that such an application is absolutely unjustifiable and unworthy. The honorary staffs of medical charities give their services to the sick and suffering, and their duty ends at that point. Take one specific instance. Every day in London many non-attendance certificates are granted in the case of children suffering from ringworm, and these are renewed from time to time. Why should the School Board of London, which disburses huge sums annually, be permitted to obtain this important service without adequate payment? A firm, concerted action on the part of hospital boards of the Metropolis could put a stop to the abuse in a week, and in a similar manner the free education certificate could be banished throughout the United Kingdom.

WE understand that the well-known disinfectant "Okol," of the Sanitas Company, is now being put upon the market with a guaranteed germicidal efficiency of 22, as compared with carbolic acid.

CURRENT TOPICS.

The Local Government Board in Action.

The supine attitude of the Local Government Board as a great central authority has often been commented upon in our columns. When some public scandal arises, and not until then, the Board holds an official enquiry and proceeds to act with more or less thoroughness and decision. With the elaborate machinery of inspection at its command, we have often insisted that the L.G.B. officials must have been in possession of the facts of such scandals long before they attained publicity, but had failed to exercise the function of a central controlling body. In this connection it would be interesting to note previous reports upon Prestwich Workhouse, where a grave scandal has recently been disclosed. It appears that on July 21st last a man was removed to the workhouse, and in the following week was transferred to the asylum, where he died the next day. At the instigation of the Lunacy Commissioners, a Local Government Board enquiry was held in October. The report finds grave laxity of administration on the part of the officers responsible for dealing with lunatics at the workhouse. They find that the allegation that the death of deceased was accelerated by injuries received prior to his removal from Prestwich Workhouse was borne out by the evidence, and that the injuries were due to direct violence. The Board could not avoid the conclusion that they were inflicted by Attendant W. F. Watts, and that the Head Attendant, T. Snape, and J. Haslam have been shown unfit to hold office. The medical officer is seriously censured. He is found to have delegated too much of his power to the head attendant, and in this particular instance not to have visited the deceased until he had been 54 hours in the workhouse, most of the time in the padded room. Later, neither he nor the master appear to the Board to have been informed that the patient had to be forcibly fed. Further, they find the medical officer added to deceased's examination on discharge, "Fracture of ribs (doubtful)," but admitted the words were appended the day following discharge, when the asylum report of fracture was received. It is satisfactory to know that the L.G.B. is not afraid of acting on an enquiry report. It would be still more encouraging were such irregularities to be checked before the occurrence of scandals. What reports and recommendations have been furnished by L.G.B. inspectors of Prestwich Workhouse during, say, the past ten years ?

Insurance Companies and the Hospitals.

The Workmen's Compensation Act, which comes into operation in July next, will, it is calculated, extend the benefits of accident insurance to 6,000,000 people who have not enjoyed that advantage previously, and all employers who are wise will rush to insure their risk under the Act with some sound company. These companies' business will be proportionately extended, and as all those doing accident work are proprietary and not mutual societies, the profits of the holders of insurance shares will rise proportionately. Without wishing in any way to decry this beneficent form of commerce, it is nevertheless pertinent to point out that accident companies benefit very largely from the work of the hospitals, and though we believe some of them subscribe to hospital funds, it is a question whether their obligations to hospitals should not be more generally and substantially recognised. It is a great and patent advantage to a company which has to pay a workman's sickness allowance while he is ill that such workman should have the best and most skilful treatment, and such can undoubtedly be obtained, gratis, at a hospital. As a rule—there are some exceptions, of course—the workman, the employer, and the insurance company give nothing to the hospital, though they all benefit directly or indirectly from hospital work. Moreover, the insurance companies avail themselves without stint of the opinion of hospital medical officers as to workmen's condition, progress, and fitness for work, and for these services they pay nothing. Now, it would seem that when hospitals are one and all suffering from lack of funds, it is not fair or just that proprietary companies trading for profit, and paying handsome dividends to their shareholders, should obtain charitable advice and treatment for nothing for those on their books. How far the articles of association of the companies allow them to contribute to hospitals is probably a difficult question, as is also the apportionment of the amount that should be contributed by each company to each hospital. But that something should be done is obvious, and the matter should be gravely considered by hospital boards and the companies themselves.

Gambling and Climate.

The bitter cry of the British spa may assume a less plaintive note in the future if the present French Government adhere to their intention firmly to enforce their new anti-gambling law. It has always been easily explicable on rational grounds why English people should prefer the Riviera and Algiers to their native watering-places in the winter, but it has been somewhat less obvious why they should spend their summer and autumn at many inconvenient, over-crowded, and not particularly salutary spas. The waters have been the ostensible excuse, but even the most scientific analyses have frequently failed to demonstrate that there is any overwhelming virtue in some of the springs that have contained calcium chloride or sodium sulphate in the similar proportions to those that bubble out of the bowels of our own territory. The explanation in many cases, of course, is that roulette, baccarat, or petits chevaux have been allowed as pastimes, and even the most gouty and hypochondriacal dyspeptic realises the difference in the degree of mental exhilaration derivable from those amusements and that drawn from the drawing-room "music" or the wheezy orchestra of the British hydro. On moral grounds we must commend the latter, but on medical ones it is not a little questionable whether some patients might not be drawn out of themselves more by a course of *rouge-et-noir* and *pair* and *impair*. However, the first attempts to suppress gambling in the pleasure resorts in France have been partly repulsed, and it may be the Government's courage will ooze out if its finger-tips when it comes to a fight. If, however, gambling is finally suppressed, hydro shares may rise.

Disease and the Churches.

LAST week's issue of the *Church of Ireland Gazette* contained a letter signed "Æsculapius," in which, under the heading of "Cleanliness and Godliness," the writer draws attention to the neglect of the clergy to wipe with a napkin the cup used in administering the Sacrament. He goes on to call attention to the fact that, while successful efforts were being made to banish the kissing of the Testament in law courts, nothing has been done by the clergy to remove what is undoubtedly a most dangerous source of infection in churches. He then continues: "On Christmas Day some 150 to 200 communicants attended the 8 a.m. service in the church to which I belong. Immediately preceding me was a poor woman whose mouth I could not possibly help observing was in a neglected condition; and her state was nothing in comparison to that of patients of my own who attend Communion during (and I hope afterwards) their physical illness." We desire to associate ourselves with the observations of "Æsculapius." It is little short of appalling to contemplate what might any day be the result of the present manner of administering the cup during the Sacrament. Any medical man, or any clergyman, can, without difficulty or exaggeration, summon up in his mind a picture of the terrible results that might happen in a family because the mother with chapped lips received the Sacrament after a person with a syphilitic ulcer of the tongue or lips. The churches we are glad to say, are in many ways taking a very active course in the spread of the knowledge of hygiene, and some of the simpler forms of preventive medicine, but what is the use of this if, in their own practice, they do not conform to the most elementary principles?

Nitrogen from Air.

To obtain nitrogen from the atmosphere as nitric acid has long been a dream of the scientific chemist. From a recent announcement made exclusively by the *Daily Chronicle* we learn that a method has at length been perfected by Sir William Crookes. If so, his discovery may possibly be one of the greatest economic value ever yet placed by science in the hands of mankind. It will mean that the great envelope of air around the globe will be made henceforth to contribute largely to the production of food. It is hardly necessary to recall the fact that the remunerative raising of successive crops from any given area of cultivation is possible only by the systematic supply of nitrogenous manures, of which the most valuable is afforded by the nitrate beds of South America. The demand upon the latter, however, has been so great that before many years these deposits must be exhausted. Should it be possible to obtain unlimited quantities of nitric acid at a sufficiently cheap rate, an alternative supply of nitrates would be available for agricultural purposes. So long ago as 1892 Sir William Crookes proved that nitric acid could be obtained from air, and he has been superintending a series of investigations for the last six years at Freibourg. The confirmation of this discovery would place his name upon one of the highest pinnacles of fame as a scientific benefactor of mankind, especially if nitrogen were given freely to the world at large.

Centralisation of Liverpool Hospitals.

The Liverpool hospital world has been thrown into a state of unusual stir and activity. Last week a dinner was held to celebrate the establishment of a United Clinical School in connection with the local University. The advantages of such a scheme are obvious, especially when we learn that in so large a centre of population about 40 per cent. receive gratuitous medical relief. On the day of the dinner the City Council reduced the estimates for the Corporation (infectious) hospitals by £10,000. The chief public interest, however, has been centred upon Professor Paterson's suggestions that all the voluntary medical charities should join their forces under one central control. He claims that increased efficiency as well as economy would be secured thereby, but he proposes to include in the cooperation scheme the poor law infirmaries. At present they are excluded from such association by the law, but the amount of clinical material obtainable from their field of work may be estimated from the fact that the poor law institutions have 3,000 beds and treat annually more than 10,000 patients. The opening up of the whole question of hospital administration in Liverpool is a sign of the times, and it seems not unlikely that the citizens of that great city will be the first to test some well-considered scheme of local hospital centralisation. The subsequent course of events with regard to its administration, its social and its educational aspects, deserves the close attention of medical men generally, inasmuch as their interests are vitally concerned in the question of hospital reform.

MR. PIETRO MICHELLI, C.M.G., Secretary to the Seamen's Hospital, is to be entertained at dinner at the Trocadero Restaurant on February 15th, in celebration of the honour recently conferred upon him.

DR. BAYLISS, F.R.S., will deliver a course of lectures to medical men on Certain Fundamental Problems in Physiology Common to Animals and Plants. The lectures will take place on Wednesdays at 5 p.m., at the London University.

DR. JAMES J. FITZGERALD, has been appointed Medical Superintendent of the Cork District Asylum, although a previous election had been disallowed by the Lord Lieutenant of Ireland.

PROFESSOR MCKENDRICK is to receive a testimonial from Glasgow University in recognition of his long and distinguished career. It is not yet decided what form the memorial shall take.

A CLINICAL LECTURE

ON

CHRONIC NON-SUPPURATIVE DISEASES OF THE MIDDLE EAR. (*a*)

By MACLEOD YEARSLEY, F.R.C.S.Eng.,

Senior Surgeon to the Royal Ear Hospital.

The subject upon which I have to speak this afternoon is one of very great interest and considerable difficulty, not only on account of the various forms under which chronic non-suppurative disease of the middle ear makes its appearance, but also from the confusion which the various writers upon the subject have brought into its classification. Indeed, the student who has read all that the different text-books have to say upon the matter finds that his ideas as to these conditions have only been rendered more hazy and that he knows, possibly, less than before as to the true classification of the forms of non-suppurative disease which give rise to chronic deafness.

At the same time, it is undoubtedly a fact that, during the last ten or fifteen years, considerable progress has been made in the elucidation of this problem of otology, and this progress has been most striking in two ways—the recognition of the causes which lead to chronic non-suppurative middle-ear disease and the work which has been done in the segregation of its forms.

One of the greatest difficulties in the way of investigation is the lack of pathological material wherewith to differentiate the various conditions, especially in their early stages. Persons suffering with chronic deafness due to non-suppurative middle-ear changes do not die from their disease, whilst, should they succumb to other causes during the early stages of the ear malady, it is extremely unlikely that it has been diagnosed, at any rate the chance of a competent pathologist and otologist obtaining their temporal bones is extremely small. This is especially the case with that insidious malady termed "otosclerosis," or rarefying labyrinthitis. Although we know considerably more than we did ten years ago, we still are greatly in the dark as to the true etiology and pathology of this bugbear of otology.

There is great diversity in the classification of these forms of deafness in the text-books, and in systematic teaching it is a matter of some difficulty to put a good arrangement, clear and understandable, before the student. The one I have decided to adopt commends itself for simplicity and comprehension. This classification recognises two main forms of chronic non-suppurative middle-ear disease as follows :—

1. Hypertrophic catarrhal deafness.
2. Otosclerosis (rarefying labyrinthitis).

Of these the first—hypertrophic catarrhal deafness—is the most common. It is inflammatory in nature and its pathology is better understood than is that of the last form—otosclerosis—which is probably more of the nature of a trophoneurosis. Some confusion has arisen between these two forms because, in the first place, there is a good deal of similarity as regards symptoms between the later stages of the two diseases, and in the second place, they may both be co-existent in the same patient.

The secret of the successful treatment of hypertrophic catarrhal deafness lies in the treatment of abnormal conditions of the nose and throat and in catching the condition early. Unfortunately, persons suffering from gradually increasing deafness do not seek skilled help early enough in the majority of cases, generally because they hope to get well by themselves, often because it is only by the second ear becoming attacked that they realise that the other has become seriously involved.

Let us this afternoon consider in detail the first of the two conditions I have enumerated, viz. :—

HYPERTROPHIC CATARRH.

The majority of these cases begin in early life, the reason being that adenoids, which is essentially a disease of that period of our existence, is one of the most fruitful causes of the condition.

Etiology.—The primary cause is catarrh of the upper air passages ; therefore anything which promotes this condition will act as a subsidiary cause. Some people like to have arranged for them a long list of causes, divided into local and general. In the case of hypertrophic catarrh such a list can be easily made up as follows :—*General* : 1. Exposure to wet and cold ; (2) anæmia and plethora ; (3) diathesis (gout, rheumatism, syphilis, &c.) ; (4) exanthemata ; *Local* ; (1) Hypertrophy of the lymphoid ring of Waldeyer (adenoids, enlarged tonsils) ; (2) secondary syphilis ; (3) œdema and hypertrophy of the turbinal bodies ; (4) atrophic rhinitis ; (5) nasal polypi, &c., (6) suppuration in accessory nasal cavaties ; (7) irritation of nasal mucosa by smoke, dust, &c.

The most important of the foregoing causes are adenoids, enlarged tonsils, and other forms of nasal obstruction. These conditions act by keeping up the catarrhal state rather than mechanically, although they also act in the latter manner sometimes, chiefly by interfering with the proper working of the palatal and tubal muscles. One of the best proofs of the way in which nasal obstruction acts in keeping up the catarrhal condition is to be found in the persistence of adenoids in the adult. The rapid enlargement of the nasopharynx at the onset of puberty generally leaves the pad of adenoids which formerly filled the cavity much smaller, although the difference is really more apparent than real. Hence the symptoms of obstruction (assuming that there is no concomitant nasal hypertrophy) become ameliorated, whilst the ear condition progresses on account of the frequent attacks of nasal catarrh induced by the presence of the adenoids.

Pathology.—The pathological changes in hypertrophic catarrh may be divided into four stages : (1) chronic congestion and exudation ; (2) pro-

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(*a*) Being the first of two Post-Graduate Lectures delivered at the Royal Ear Hospital on December 13th, 1906, and January 3rd, 1907.

liferation; (3) fibrous contraction; (4) cicatrisation ("post-catarrhal").

We have only to consider for one moment the peculiar anatomy of the tympanic cavity to realise the effects of catarrhal inflammation upon it and upon the proper working of the various ossicles and muscles contained therein. In the attic, surrounding the articulation of the ossicles and intervening between their ligamentous attachments, are tiny pouches of mucous membrane, in which even a small amount of swelling is a serious matter for the efficient working of the auditory mechanism.

Let us take these four stages in more detail, although the time limit prevents our entering deeply into them.

In the *Stage of Congestion* there is engorgement of the vessels, with exudation into the subepithelial layer. Occasionally this exudation is sufficient to pass into the tympanic cavity, forming a serous, mucous, or sero-mucoid accumulation. Such a condition is uncommon in this country, although it is very common in America. If resolution occurs, the vessels are relieved and the exudation is carried off by the lymphatics; if there is no such happy ending, engorgement and exudate remain, and the condition passes into the *Stage of Proliferation* of cell elements, in which new fibrous tissue is formed in the subepithelial layer as a result of the chronic inflammation. As this developes, the new tissue commences to contract and the *Stage of Contraction* is reached, resulting in the binding down of ossicles and muscles by bands of adhesion, the reduction of the lining membrane to a mass of contracted fibrous tissue, and the narrowing of the Eustachian tube. Finally this third stage passes insensibly into the *Stage of Cicatrisation*, or post-catarrhal condition.

(The lecturer then went on to detail the effects of these changes upon the membrana tympani, and described the appearances of the thickened and indrawn membrane).

We must now pass on to *Symptoms*. These may best be discussed according as the disease affects the Eustachian tube most or as it affects the whole tympanic tract. Let us take the former first.

(*a*) CHRONIC CATARRH OF THE EUSTACHIAN TUBE.

When the condition chiefly affects the Eustachian tubes the symptoms are almost wholly referable to the obstruction thus caused. The tube may be affected at its pharyngeal opening only, or in its whole length, and a tube affected in the first manner may later be involved throughout its length by the spread of the catarrh. There is marked deafness on one or both sides, with generally irritation in the tubal region. On swallowing or blowing the nose there may be an amelioration for a few moments, heralded by a crack in the ears. With the deafness is more or less tinnitus, usually of a dull, rushing character, with a full, oppressed feeling in the head, and autophony, or the hearing of one's own voice in the ears, as if the head were shut up in a box. As the causative cold becomes less the hearing may be restored with a sudden crack, due to the parting of the opposed surfaces of the tubal mucous membrane. In first attacks this restoration, or the effect of inflation, is immediate and permanent, but in later attacks it becomes less and less, until the patient reaches a stage when the deafness is more or less always with him. The *diagnosis* and *prognosis* of tubal obstruction depend mainly upon the result of inflation and the appearances of the membrane, which is indrawn and, when the catarrh affects only the tube, normal in texture and lustre.

The *treatment* of Eustachian catarrh resolves itself into that of the *cause* (removal of the conditions leading to catarrh of the upper air passages and general constitutional measures) and that of the *effect*. This resolves itself into inflation, the use of the Eustachian bougie, and intra-tubal injections As regards inflation, let me say one word. I have personally long given up the use of the Politzer bag, save in a few isolated cases. It is a dirty method. One never knows—even if the nasal passages be first carefully cleansed—what one may blow into the ears, nor the exact force one may be using. I have seen a house surgeon rupture an atrophic membrane by too forcible Politzerisation, and I feel sure that the superfluous force which the Politzer bag requires is spent in overstretching the drum-head. I habitually use the Eustachian catheter for all inflations. It is clean, one can regulate the force of inflation to a nicety, and one can, further, pass through it a bougie, or make by its means an intra-tympanic injection.

Eustachian bougies are made of celluloid, and, after dipping in parolein or similar oily fluid, are passed along the catheter into the Eustachian tube. When in position they should be allowed to remain for a couple of minutes. They are then withdrawn and inflation performed. Whether the bougie be used or not, it is well to inject through the catheter a few drops of parolein, preferably containing 5 per cent. of menthol. Two or three drops should be introduced into the wide end of the catheter, and inflation performed. By this means the fluid is sprayed into the Eustachian tube and, by its oily nature, prevents the opposed mucous surfaces becoming again adherent.

(*b*) CHRONIC CATARRH OF THE WHOLE TYMPANIC TRACT.

The signs and symptoms of this condition depend upon the stage at which the malady has arrived. In the *Congestive Stage* the severity of the symptoms is dependent upon the amount of exudation. As I pointed out above, cases which exudate in the tympanic cavity are decidedly uncommon in this country; indeed, during an experience of over fifteen years, I have not seen enough cases to count on my ten fingers. When, however, exudation is marked, there is a feeling of fulness, marked deafness, with bubbling, tinnitus, autophony, and general vertigo. In the absence of fluid exudation in the tympanum, the symptoms are less severe, there is deafness and tinnitus, with crackling, and the improvement upon inflation is more marked than in the former type of case. Upon examination, in cases of exudation, the membrane of Shrapnell and the manubrial plexus are injected, and the exudation shows itself as a dark line running across the membrane in a slight curve with the concavity upwards. When this exudate is very fluid, the line may vary with the position of the patient's head. It may contain bubbles of air which can be seen through the semi-transparent membrane, sometimes giving it almost the appearance of Gruyère cheese. When there is no exudation, the membrane appears slightly injected along the handle of the malleus, and may be also slightly indrawn.

The treatment of the congestive stage of chronic catarrh affecting the whole tympanic tract is both causative and local. Any condition in the nose or naso-pharynx which is likely to bring about a continuance or a fresh attack of the trouble should be sought, and the patient made to fully understand the necessity for removing it. If operation is undertaken, it should be postponed until the aural condition has been ameliorated somewhat, especially in cases with marked exudation. During this time a nasal alkaline douche should be used daily. In both varieties of case inflation should be practised. When there is exudation of a very fluid character, it may be evacuated by inflation with the patient's head inclined to the opposite side, but when it is mucoid and tenacious it is not so easy to remove. This may sometimes be accomplished by means of an intra-tympanic injection of a warm, mild, alkaline solution, but it is occasionally necessary to incise the drum and remove the exudate by mopping with a wool-armed probe. The question of incising and then blowing out the exudate by inflation is a debated one. Personally, if there is any difficulty, I do not see that there is any risk, provided the inflation is done through a clean catheter through a previously carefully cleansed nose. It may be sometimes sucked out by means of a Siegle pneumatic speculum. After the removal of the exudate, counter-irritation behind the ear is of advantage.

In the *Stages of Proliferation and Contraction*, the symptoms of which may best be taken together, the history is usually one of repeated attacks of deafness, generally due to colds, the first attacks interrupted by periods of good hearing, but each succeeding attack being longer in duration, and less perfectly recovered from. A stage is reached when the deafness becomes permanent and is worse after each fresh cold. The deafness is accompanied with varying tinnitus, and there are in these late stages certain added symptoms. Chief among these is *Paracusis Willisii*, or hearing better in a noise. There are several theories as to the exact meaning of this symptom, the older one is that it is due to torpor of the auditory nerve from disuse, a louder noise waking it up, so to speak, and enabling it to distinguish lesser sounds. Another theory makes it due to anchylosis of the ossicles, the loud noise shaking them free enough to respond to other sounds. Personally, I am inclined to think that the real cause may be ultimately found to lie in changes in the intra-labyrinthine fluids, about which we know very little indeed at present. Most otologists look upon Paracusis Willisii as a very bad symptom from the point of view of prognosis, but the more advanced among us are beginning to consider it as rather an indication for treatment. *Otomyasthenia* is another symptom of the later stages. It is due to implication of the intra-tympanic muscles, according to Rumbold, who looks upon these structures as accommodating the ear to different sounds. Otomyasthenia means practically the loss of the ability to distinguish one sound among many others; thus, when carrying on an individual conversation in a room where a number of other persons are talking, the patient suffering with otomyasthenia will be unable to pick out his companions' words from the buzz that is going on round them.

Diplacusis, usually disharmonic, is a third symptom. *Tinnitus* varies; it may be incessant, marked, or slight, and is usually of a rushing, roaring, or machinery-like character.

On examination the membrane may be found to be markedly indrawn, or but slightly so. As a rule it is dull, whitish, and thickened. It may contain calcareous deposits, and present local atrophies. It is most important to further examine it with the Siegle pneumatic speculum, in order to obtain information as to its mobility, and that of the ossicles. It may be found that the handle of the malleus does not move at all.

Tuning fork tests (already described to you in an earlier lecture by Mr. Lake) give the reactions common to disease of the sound-conducting portion of the ear. Gelle's test will give information as to the fixation or not of the stapes.

(*To be continued*).

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Macleod Yearsley, F.R.C.S.Eng., Senior Surgeon to the Royal Ear Hospital, London, the subject being "Chronic Non-Suppurative Diseases of the Middle Ear." Part II. A post graduate lecture.*

ORIGINAL PAPERS.

VENTRO-FIXATION OF THE UTERUS IN THE TREATMENT OF ITS BACKWARD DISPLACEMENTS. (a)

By HENRY BRIGGS, M.B.Edin., F.R.C.S.Eng.,
Surgeon to the Liverpool Hospital for Women, &c., &c.

The exemption of the "blooming, happy, and fertile" woman from any treatment whatever was claimed.

During the child-bearing period of life he advocated the limitation of pessary treatment to recent cases of retroversion or retroflexion, after manual reduction of the displacement, and for chronic backward displacement of the uterus with complications he urged the superior position of ventro-fixation, and founded his opinion upon the clinical records and the after-histories of 203 cases treated by him during the past seven years. In all the 203 cases the patients recovered. The after-histories of all the patients, with the exception of the nine unobtainable and a few too recent to be of value, were added. An analysis of the cases of the five groups A, B, C, D, E, illustrated the extent and character of the complications of backward displacements of the uterus:—

Table A.—98 cases of backward displacement before operation were characterised by—

(*a*) uterine descent in a minor degree in all of them;
(*b*) ovarian prolapse, on one side 13, on both sides 26;
(*c*) inflammatory cystic changes in the ovary, 3;
(*d*) apoplexy and thickened capsule of ovary, 6;

and were treated by ventro-fixation of the mobile uterus; the relief afforded was complete in 64, partial in 22, and disappointing in 7 patients; one single woman, æt. 23, who had suffered from distressing dysmenorrhœa since puberty, was totally unrelieved by ventro-fixation performed after a previous dilatation and section of the cervix had also failed to relieve her.

Table B.—41 cases, ventro-fixation with perineorrhaphy, colporrhaphy, trachelorrhaphy, dilatation and curettage, *i.e.*, a combination of two or more operations of which one was ventro-fixation showed relief complete in 24, partial in 9, and disappointing in 5 patients.

(a) Abstract of paper read before the Liverpool Medical Society, anuary 17th, 1907.

Table C.—24 cases, ventro-fixation with separation of adhesions and in seven instances salpingostomy (conservative operations); recorded relief complete in 13, partial in 8, and disappointing in 1 patient.

Table D.—31 cases, ventro-fixation with removal of one tube and ovary: relief complete in 20, and partial in 7 patients.

Table E.—9 cases, ventro-fixation with removal of both appendages: relief complete in 7, partial in 1 patient.

Complete relief after ventro-fixation persisted throughout all the groups in almost the same proportion of cases; that is substantial evidence of a pathological element in the aggregate of the backward displacements in Table A. The lowest proportion of complete relief followed the totally conservative treatment of pelvic peritonitis due probably to obscure active or latent germ infection (Table C); in 24 cases pregnancy is unknown after operation, except in one instance.

The author explained his preference for purely parietal peritoneal fixation at the summit of the empty bladder at the lower end of a 2-inch abdominal incision ending one inch above the pubic symphysis. The Trendelenburg position enabled the operator to suture closely this central lowest portion of the parietal peritoneum to the middle two-fourths of the lower half of the anterior surface of the uterine body in which the sutures were planted through muscle one-eighth of an inch deep. No. 2 Chinese silk was used for the fixation; Dr. Briggs said he had discontinued, since 1903, catgut for this purpose only. The abdominal wound was closed in three layers by catgut sutures: the finest catgut always for the skin.

The advantages of peritoneal fixation were the slight uterine mobility it ensured; in the latter advantage Dr. Briggs agreed with Küstner, and the further advantages of less inconvenience to the bladder and the ease and safety of subsequent labour and pregnancy were realised. Dr. Russell Andrews, in his digest in 1905 of all ventro-fixations then published, had found the least interference with labour after peritoneal fixation. Amongst Dr. Briggs' cases in Table A. alone 22 women had borne 32 children; normal labour was the rule, and easy forceps delivery the exception. In one patient who has had five children (twins once) since the operation, uterine inertia during the third stage has been observed, and was not noted before operation by Dr. Masson, of St. Helens.

Dr. Briggs said that cervical and intra-uterine, vaginal and perineal complications were advisedly treated, if necessary, before the abdomen was opened; that abdominal section dealt with the peritonitic bands and their causes; and ventro-fixation completed a safe and satisfactory operation for retroversion or retroflexion during the child-bearing period of life.

AT a London coroner's court last week, a medical witness produced his own copy of the New Testament, upon which he was duly sworn. The incident is not without its suggestive value as to a means of smoothing over a difficulty that is always apt to involve more or less unpleasantness to the objector.

INFECTIVE BRONCHITIS AND ITS RELATION TO CONSUMPTION.

By R. PROSSER WHITE, M.D., M.R.C.S.

Life Vice-President and Hon. Physician to the Royal Albert Edward Infirmary, Wigan, etc.

WITH the essential features and cause of tuberculosis all are familiar, and there is no fact more certain than that the pathological entity we call tuberculosis only exists in the presence of, and is due to the growth and reproduction of the bacillus of tubercle with the resultant biological and chemical changes it produces upon the tissues it invades.

Certain morbid conditions simulating those found in the presence of this organism, but without its actual discovery in the part affected, are termed tuberculides. These are supposed to represent conditions set up by the toxines, or morbid products, generated by this bacillus.

So far the concensus of medical opinion is in agreement, and does not admit of dispute. It is far otherwise when we come to weigh up and estimate the preliminary causes which permit, or encourage, the growth of this organism upon the mucous membrane of the respiratory tract.

The same considerations hold good with bronchitis, which Osler maintains and most of us hold to be in the majority of cases a microbic disorder, although in our present state of knowledge the exciting organisms would appear to be more varied, less specific, and well determined, than those which we know to be responsible for tuberculosis.

My present purpose does not include the consideration of alexines, opsonins, and other anti-bodies, whose *rôle* at the present moment looms so large in the etiology of immunity from disease. I rather desire to draw attention to some more obvious clinical observations, which have reference to the catarrhal or coryzal conditions which so frequently usher in, and are the first incitants of these serious maladies.

It is generally admitted that the only avenues of microbic infection are the skin and the mucous membranes, and if these surfaces are healthy they are impervious to the inroads of infective disease. Pre-existing foci of disease may of course be present in the body, and are liable to be disseminated by the blood or lymph streams. The former leads to a generalised infection, the latter usually producing a slowly progressing and more localised infection. But with this aspect of the subject of infection we are not dealing, excepting that when either of these channels is affected, the progress of a disease becomes more rapid. Even when disseminated by such channels attacking organisms find resistance at every point, and the defensive powers of the body show a distinct tendency to seal up the avenues of approach to prevent further extension.

In discussing the ætiology of bronchitis from an extrinsic point of view only, we must first exclude from our consideration the following intrinsic varieties:

Toxæmic bronchitis, as seen in Bright's disease, gout, and rheumatism.

The syphilitic bronchitis of Graves, Stoke, Munck.

Vasomotor bronchitis, as occurs in asthma.

Bronchitis which arises in the course of typhoid, typhus, malaria, measles (?), scarlet fever (?), and whooping-cough (?).

Also these extraneous varieties:—

Primary mechanical bronchitis caused by traumatism, chemical action, hot steam, air at a low temperature; *e.g.*, such temperatures as are not experienced in ordinary circumstances. The inhalation of mechanical dust, micro-organisms included, but, of course, antecedent to the biological, and chemical changes they produce in the tissues.

With the ætiology, arrangement, and classification of these different forms of bronchitis all will in the main agree. There is, independent and exclusive of these, a bronchitis to my mind the most common, which we may properly and with advantage include under the name of a "direct infective" variety.

Upon this point there will inevitably arise some difference of opinion; in fact, the very existence of an "infective bronchitis" may be denied.

. Among infective causes of bronchitis most medical men include measles and whooping-cough. And secondly, but to a minor degree, that consequent upon true influenza. Of undeniably influenzal bronchitis—that is, where the "Pfeiffer's bacillus" has been found to be the predominating organism in the sputa when examined bacteriologically—my experience has been small, only two cases having come under my personal examination. The first was a subacute case in a middle-aged lady who had never suffered previously from any bronchial affection. The second occurred in a man, a chronic bronchitic subject, troubled also with bronchiectasis and emphysema of many years' standing. In both these cases the sputum was found swarming with Pfeiffer's organisms. In both cases the course of the illness was unduly protracted, and in the case of the man the symptoms and course were unusually severe. The bacteriological examination in the latter case was confirmed at the public health laboratory at Bournemouth, and in the case of the lady by Dr. Murray, now associated with Dr. Bashford in cancer research. But the existence of a true infective influenzal form of bronchitis, when influenza is epidemic, hardly admits of doubt.

Let us now exclude all these recognised types or forms of bronchitis and ask ourselves what is the origin of the ordinary or usual bronchitis? This question is highly important because in my opinion not one attack in ten seen in daily practice can be referred to any one of the above-mentioned list cf causes. I believe that "the every-day bronchitis," tracheal and bronchial, so-called catarrhal, which affects so many of the population young and old, severely or lightly, will eventually be found directly and solely due to the passage of the same organisms, which are the exciting causes of our "common colds." In my book upon catarrhal fevers I have endeavoured to shew that all true colds are directly infective, are passed on from individual to individual, and this, if not the only method of propagating the disease, is undoubtedly the principal and chief method of its distribution, and that for practical purposes all other so-called and reputed causes may be ignored.

It must at the same time be admitted that out of the large number of organisms found in the secretions of ordinary colds, the actual one responsible has not been definitely proved.

I wish particularly to accentuate this fact, which must have been experienced, but is usually overlooked by medical practitioners, that every ordinary case of bronchitis is preceded by, and can be traced to, an attack of catarrhal fever in the individual. I believe, further, that bronchitis cannot be extended cr augmented without the occurrence of a further attack of catarrhal fever. The proof of my contention bacteriologically is, I know, lacking, but the clinical evidence in its favour is overwhelming. What is most usual is that the fever is epidemic in the family, or in the associates of the person affected, and from one of them he becomes infected. It must always be remembered that the coryzal and nasal symptoms in ordinary colds may have been so slight in a particular individual as to require careful and perhaps expert examination to detect. The close mutual and necessary dependence of bronchitis on ordinary colds is shown in the examination of any large series of cases of common colds. These will invariably be found accompanied with tracheo-bronchitis, more or less severe. In certain favourable subjects, especially children and old people, or persons the subjects of previous attacks, the early catarrhal condition passes sc rapidly along the trachea to the medium, cartilaginous, and terminal bronchioles, setting up so serious an illness as leads us to ignore its possible connection with the organism responsible for a "simple cold."

The action of the organisms associated with simple cold weakens the mucosæ, destroys the ciliated columnar epithelium, and paves the way for secondary micro-organisms, which, finding a suitable medium, develop and multiply, and pass to the lung itself. Shannon, in the "Encyclopædia Medica," says "bronchitis is probably antecedent to broncho-pneumonia, and the bronchiolitis is of a catarrhal nature."

Dr. Ewart remarks in "Allbutt's System of Medicine," "tracheo-bronchitis is essentially a recurrent disease."

Unfortunately, it is indisputable that text-books and authority are as yet against my proposition. For instance, Watson Williams says "bronchitis is generally associated with exposure to cold." When speaking of bronchitis in children he somewhat qualifies this opinion, stating "that it is in the poorly clad, underfed, ill-housed, with dirty and ill-ventilated rooms, that the worse forms are seen. That notwithstanding the researches of bacteriologists, I am convinced that exposure to cold is the immediate cause of bronchitis."

Dr. Ewart, in "Allbutt's System of Medicine," remarks: "The usual proximate cause is a chill; the patient is said to have caught a cold." Later on he appears to find it hard to accept this explanation *in toto*, or to reconcile it with clinical experience, for he further proceeds: "The precise meaning of this phrase is obscure. So long as the adaptive mechanisms are in full efficiency mere extremes of temperature do not constitute a danger to the mucous membranes. Even infants and old people can weather cold air with impunity so long as they are properly clad, and in good health, liability to catching cold is an individual peculiarity." He then continues: "We know very little of the aerial mucous membrane analagous to the heat-regulating mechanism of the skin for temperature." He further quotes Rossbach's experiments which show that the application of cold to the skin is felt in two to three minutes by the reflex contraction of the tracheal vessels, and a little later, by venous congestion and an increased flow of mucus; he concludes thus: "A bronchial catarrh is due to some weakness or fault which leaves the bronchi unprotected against the physical results of exposure to extreme cold." Arguing from this, he accepts the popular idea, and admits that cold draughts, inefficient wraps in night air, wet clothes, and damp feet, are the causes of bronchitis. Personally I have rarely come across attacks of bronchitis without being able to detect infective catarrhal fever previously existing in the same household, and in the same person.

Again, what are the conditions we find conducive to attacks and recurrences of bronchitis? Precisely those which are associated with frequent cold-catching. For instance—

1. Density of population, people who live in towns are more liable than country folks.

2. Sedentary occupations, indoor and crowded rooms and dwellings; people who live out of doors are not affected in the same degree as those who are more intimately associated with their fellows in houses. Ewart says: "Bleakness and exposure to strong winds, especially east and north, are not prone to set up bronchitis; the eastern, northern, and midland counties show more favourably in this respect than the south-western, and those with a higher mean temperature."

It is a recognised fact that neither sailors and passengers at sea, or those who live in the higher Alps, are liable to bronchitis. If the former are affected, it is coincident with the touching at some port, or if the latter from the catching of an "infective cold" by mixing with their friends in the hotels and *pensions*. Osler supports this view, and states: "Indeed, we find it is not those whose daily life constantly exposes them to cold or even rapid changes of temperature, who are most prone to attacks of bronchitis."

There is little, if any, reliable evidence to show that the symptoms of bronchitis are made worse by exposure to cold, though this is both a popular and a professional belief. The only evidence pointing to varying or extremes of temperature in any way contributing to their increasing severity or recrudescence, are the experiments of Rossbach just quoted upon the subject. Whilst, on the other hand, there is the universal testimony and experience of travellers, that in the Arctic regions, in the open-air life at sea, or in any place where the organisms excitive of catarrh are absent, bronchitis cannot occur, and the attacks cease.

I am pleased to find that Sir Lauder Brunton, in the *Lancet* of November 17th, in describing the travels of an infective cold in his own person, supports this view. He says: "The catarrh started in one nostril, then crept round the posterior nares and affected the other nostril, passed on to the trachea, and finally to the bronchi." He also suggests the possibility of those who are in constant attendance upon cases of bronchitis of conveying the germs to others. This suggestion is only partially correct, because in the latter stages of bronchitis the primary infection is swamped and extinguished by the secondary or pyogenic organisms. These latter organisms are themselves virulently infective in suitable circumstances, but require the exciting or symbiotic action of pre-existing organisms to enable them to gain a foothold upon the respiratory mucous membranes. In this sense the latter stages of bronchitis are probably not specifically infective. The distinctly infective stage is the early one where the essentially infective nature of the organisms common to both common colds, and bronchitis is evident and predominant. Referring to this matter, I may mention that I know of a matron who holds advanced views upon this subject. She has charge of aged people in a sanatorium for convalescents. Her practice is, to immediately confine to bed, and to isolate entirely, any of her charges who show the least signs of nasal or bronchial catarrh. The result is that these aged people rarely suffer from bronchitis, or other lung troubles common to those in advancing years. Precautions like these are well worthy of imitation.

Idiopathic bronchitis, acute or chronic, may thus be defined as a disease of the bronchial tubes due to the manifestation of the progressive activity of the catarrhal organisms, to which most of its specific manifestations are directly due. It is chiefly fostered and extended by those circumstances which promote the close and direct association with the agent-carrying individual.

TUBERCULOSIS AND COMMON COLDS.

A serious question for consideration is the following: "Is there any relation, causative, promotive, or repellent, between common colds and tuberculosis?" Both diseases are expressions of microbic infection, and both are fostered by unhygienic conditions such as overcrowding, vitiated atmosphere, lowered vitality. Dr. A. Ransome says "that phthisis occurs least where the population is scantiest." Temperature has no influence upon phthisis, as Dr. Hirsch has proved. I am of opinion that these remarks equally apply to common colds. As in all other zymotic affections, though all persons are probably subject to direct inoculation at one time or another, all do not succumb. There must, therefore, be an individual susceptibility or the reverse. This vulnerability, or immunity in the case of respiratory tuberculosis depends upon the resisting power of the mucous membranes to the invasion of the organism. In the skin a primary lesion of tuberculosis cannot develop without a break in its surface; into this the bacillus can obtain a foothold. This is occasionally seen in the direct inoculation of men by the handling of tuberculous meat, such as butchers. Foci of lupus may also infect through other accidental lacerations of the epidermis, such as the bites of insects. An uninjured mucous surface is likewise probably invulnerable to a casual tubercular infection, just as is the skin. Infection, once through the skin or mucous membrane, passes by the lymphatics and blood vessels to the different parts of the body, and thus the usual manifestations of tuberculosis can be traced. The depredations of the organisms of catarrh affect and restrict their action to the local mucous membrane, and their toxines are confined to and are destroyed in the lymphatic system. We see this in all cases of common colds, as we invariably get a lymphatic extension of a reactive inflammatory nature; but we have little evidence of the further pathological change they bring about in the body. The danger of catarrhal infection appears to lie in its selective affinity for the mucous membrane of the respiratory tract; it finds here its most suitable pabulum upon which to develop. It here produces changes which pave the way for further infections of a more virulent type. Clinical evidence warrants us in believing that the catarrhal state tends to promote, or has a symbiotic action upon the growth of the tubercle bacillus. In a similar manner either of these infections appear to favour the growth of the pyogenic organisms. This is more easily observed in what may be termed primary infection—that is, direct superficial extension or inoculation, as distinguished from secondary—that is, particulate—infection, carried and deposited by the lymphatics or blood stream. These terms, primary and secondary, are, perhaps, somewhat artificial distinctions, but serve a useful classification. It is especially common to find phthisis following upon diseases of the respiratory tract, which exhibit a catarrhal method of extension. Whereas respiratory diseases caused by secondary infections, that is, those carried by the blood current are most rarely followed by phthisis. Kidd says: "It is infinitely rare for phthisis to follow pneumonia, or traumatism of the lungs." Rokitansky makes the same remarks about pleurisy. R. W. Phillips says: "Pleurisy is never the cause though often the sequence of phthisis." "Pneumonia," he remarks, "probably never ends in phthisis, but basal pneumonia is often mistaken for it." Quite different are the results following upon diseases which show a specific primary catarrhal inflammatory action upon the bronchial tubes. Dr. Kidd says: "Pulmonary tuberculosis often appears after measles, influenza, and whooping-cough." And R. W. Phillips admits that the unhealthy catarrhal state of the mucous membrane following upon measles or whooping-cough prepares the way for the tubercle bacillus.

But the majority of cases of apical or catarrhal phthisis have not been the victims of either measles or whooping-cough, and I think most medical men look for and expect to find some predisposing or active inciting cause for the deposition of tubercle in these cases. How then are we to explain their frequent occurrence? My own belief leads me to think that it is due to the great prevalence of catarrhal fever. Catarrh of the bronchi is a very frequent concomitant and forerunner of this form of consumption. That it is constantly aggravating and increasing the condition is surely common experience, both lay and professional. All sufferers volunteer the statement that they have caught fresh colds, and in consequence their cough and general symptoms are worse. Personally I am convinced that the chief beneficial effect of the treatment of consumption in sanatoria is due to the avoidance of catching infective catarrhs. It is a well-accepted fact that in all well-conducted institutions "common colds" are practically unknown. It is quite extraordinary to my mind how writers still misconstrue these facts and their importance; thus Phillips in the "Encyclopædia Medica" says: "It is of the first moment that every individual should understand that consumption is not got by exposure to cold; the bogie of 'catching cold' has done infinite mischief." I believe that the bogie of "catching cold" is very real and a most serious danger. "Infinite harm" is but a mild expression to use when estimating the consequences of "catching cold," that is "infective cold," upon the subjects of either phthisis or bronchitis. At the same time I entirely agree that exposure to cold—that is exposure to changes of temperature, or lowness of temperature—has no connection or causal relation whatever with "catching cold." It is the infective catarrh that we must beware of. At the same time we all of us see so many cases of bronchitis (and bronchitis we believe to be due to the direct passage of catarrhal germs) which pursue the even tenour of their way without ever having grafted upon them tuberculosis, as to cause us to pause over Dr. Phillips's words when he says "great reservation must be adopted before we can accept the dictum of bronchitis as necessarily leading to tuberculosis." Dr. Howship-Dickinson, on the other hand, says, "the vulgar notion of a cold which settles on the lungs and ends in tuberculosis has a profound truth at the bottom of it." Dr. Sims Woodhead declares "a perfectly healthy lung is seldom if ever primarily affected by the tubercle bacillus; the beginning is always a catarrhal affection."

It is well known that the ciliary movements of the epithelium and the vital resistance of the healthy cells of the respiratory tract present a powerful defence against the successful inoculation of bacilli upon its surface.

Chronic or repeated catarrhs, as Hamilton and Socoleff have shown, cause degeneration in these cells, which lessens their activity, and interferes with their power of opposition to foreign inimical agents. It is easy to see how in such cases the tubercular organism can penetrate to the infundibula or the smallest bronchi, where there is no muscular coat to eject, or ciliated epithelium to remove the offending intruder. Dr. Shannon says that "a broncho-pneumonia always precedes the deposit of tuberculosis in the apex of the lungs."

A tuberculosis which enters the lungs by the respiratory tract is well known to be one of the most slowly progressive and chronic forms of tuberculosis, as it is also the most amenable to treatment, because of its catarrhal nature. Apical catarrhal phthisis is recognised by its characteristic slight fever, its crepitations and prolonged expiration. The crepitations are usually said to be due to the forcing apart by the incoming air of the moist cell tissue. A more likely reason to my mind is the passage of air through the moist mucus in the smallest bronchioles and the infundibula. If this latter explanation is correct we may take heart from the observations of Hamilton, who has shown us that the basement membrane in these regions subserves a very important function, inasmuch as it imparts a superficial character to the pathological process, permitting only the passage of fluids through its substance, and allowing no particulate material or organisms into its structure.

The value of this finding lies in its permitting only a local action to the organisms deposited upon its surface, barring their passage to the lymphatics and blood stream, and thus preventing the more rapid modes of dissemination to the surrounding tissues. At the same time it encourages us to believe that the possibilities of prevention and local treatment can be largely extended. The prospect of this disease thus becomes distinctly hopeful, because both prophylaxis and treatment can be made effective.

CLINICAL RECORDS.

A CASE OF SUFFOCATIVE HYDROTHORAX IN WHICH THE PLEURÆ WERE TAPPED SEVERAL HUNDRED TIMES.(a)

Under the care of J. F. O'CARROLL, M.D., M.Ch., F.R.C.P.I.

Physician to the Richmond, Whitworth and Hardwicke Government Hospitals.

The case is that of a man, aged sixty-five, robust, cheery, amiable, and intelligent, who entered hospital in May, 1906, suffering from great distress in breathing and epigastric pain. Considerable swelling and tenderness in the epigastrium led me to think that the patient had some epigastric tumour. The urine, small in quantity and dark in colour, had a fair amount of sugar in it, and it was thought probable that the pancreas was involved. A leisurely examination revealed a systolic apex murmur, faint, and not transmitted very far, together with some dulness in both pleuræ. A month afterwards the right pleural cavity was tapped, and 40 ounces of fluid withdrawn. Two days later the left pleural cavity was tapped, 76 ounces being withdrawn. By way of corroboration of a recantation of the first diagnosis already made, the liver receded up under the lower ribs, and from that time onwards there was no further suspicion of any abdominal mischief, although the epigastric distress recurred whenever the pleuræ became full. The sugar in the urine diminished at every tapping, and frequently disappeared, and seemed to be more or less referable to the amount of dyspnœa and cyanosis present from time to time. Occasionally, as might be suspected, there was a trace of albumen in the urine. A slight purplish tinge was visible through the patient's natural ruddiness, and the veins in his neck were slightly more prominent than they would ordinarily have been. He had also at first some œdema of the legs. Tapping had to be resorted to to such an extent that within the first six months in hospital 60 tappings were actually recorded, and probably some tappings which were not noted. The œdema disappeared, and the abdomen became normal, but subsequently, when the effusions were becoming considerable, the epigastrium swelled out again with the original tenderness. From about the third or fourth month of his residence the conclusion had been arrived at that he had some obstruction of the vena azgyos major, and the diagnosis rested there to the end. It was confidently believed, on purely anatomical grounds, that the mischief must reside there. During the first four or five months the pleuræ were tapped almost alternately. Thereafter the right one was tapped about twice for every time the left was tapped, and this proportion was maintained till March, 1902, when the left pleural cavity ceased to secrete, as the result of an adhesive pleuritis. He had then to be tapped twice as often on the right side, and this went on, practically every second day, to the amount of fifty, and sixty, and seventy ounces till the beginning of May, 1903, almost three years after his admission. Then the right pleura began to show signs of not yielding as much fluid as formerly, and of being annihilated by adhesive pleuritis of rapid course. He died when this was complete, practically as if he had been garotted in such a way as to stop the venous flow into the heart without obstructing the trachea, the process lasting about two days. He had spent three years all but five days in hospital, had hardly lain down in bed for more than two or three hours nightly all that time, but had retained weight, appearance, and good spirits up to the fatal and final closure of the right pleural cavity three days before death.

At the *post-mortem* examination it was difficult at first sight to find any abnormality to account for the clinical history. Oval or roundish plaques of ossifying fibrocartilage were found at the sides of the intervertebral discs in the lower half of the dorsal and in the lumbar region. These may have been attributable to a chronic rheumatoid condition, of which, however, he showed no other sign, or have been caused by his having to sleep in a chair at night during the three years in hospital. On examining the heart and slitting up the vena cava superior, a distinct prominence was noticed, which appeared to bulge forward the posterior wall of the cava and to turn off with an L shape into the posterior wall of the vena azygos. This was an aggregation of tubercular glands of no great bulk, but the real mischief was caused by an actual fusion of the gland mass with the azygos wall exactly at its outfall into the cava. At this very point the azygos was closely adherent to the gland capsule in a crinkled depressed scar, of slate colour, corresponding to that of the gland beneath. The girth of the vein at this point was half that immediately to the right of it. The total amount of fluid withdrawn during the three years was computed to weight about three-quarters of a ton.

(a) **Read before the Royal Academy of Medicine, January 4th, 1907.**

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

CHOLECYSTOSTOMY FOR OBSTRUCTION OF THE BILIARY PASSAGES CAUSED BY CHRONIC PANCREATITIS.—Mr. BATTLE operated on a woman, æt. 34, who had been admitted for pain in the region of the gall-bladder. Five months before the patient had had attacks of jaundice; she did not lie up for them but got about most of the time at her work. There was no pain at the onset, and after getting better she continued to be more or less jaundiced. Two months ago she was suddenly seized with severe pain in the right hypochondrium, which travelled round to the back. She had several attacks and became very jaundiced. A fortnight ago she had a very severe attack and had been laid up ever since. The urine had a specific gravity of 1012, it was acid and contained no albumen. On admission she was found to be slightly jaundiced; there was marked tenderness over the region of the gall-bladder, where a rounded tumour could be made out; the area of hepatic dulness was increased. Cammidge's test for bile pigments was negative. At the operation Mr. Battle made an incision through the rectus muscle over the gall-bladder, an air bolster having previously been placed under the patient's back. The gall-bladder was readily found, and presented no evidence of previous inflammation. Having packed the surrounding structures away from the gall-bladder by means of strips of sterilised gauze, it was opened at its fundus and its contents evacuated. These consisted of inspissated bile and biliary sand to no great extent; no portion of this sand was sufficiently large to deserve the name of calculus. After thorough cleansing of the gall-bladder, a bullet probe was passed into the cystic duct and from thence to the duodenum without encountering any definite obstruction. The edges of the opening into the gall-bladder were afterwards stitched to the peritoneum, and a small tube left in reaching from the gall-bladder to the surface. The swelling which had been felt before operation in the epigastrium was an enlargement of the head of the pancreas of a somewhat doughy character, and was probably of inflammatory nature. It was evident, Mr. Battle said, that the patient's attack of pain had been due to biliary colic, and the repeated attacks of pain in the same region made it probable that the cause of this pain was the presence of biliary calculi. The nature of the swelling felt in the epigastrium was not very clear before operation, but it was probable, he thought, that the enlargement of the head of the pancreas had caused pressure on the common bile duct and so brought about these intermitting pains, and the jaundice which was still evident at the time of operation. It was quite apparent, he pointed out, from the feel of the pancreatic enlargement, that it was inflammatory and not due to new growth. It was interesting, he remarked, to find such a condition of the pancreas in which Cammidge's test gave a negative result.

Drainage was kept up for some weeks after the operation, during which time the patient improved rapidly, putting on flesh and losing her jaundiced appearance. She left the hospital three weeks after the operation. The last time she was seen the epigastric swelling had very much diminished, and there was neither jaundice nor pain.

TOTTENHAM HOSPITAL

OPERATION FOR REMOVAL OF TUBERCULOUS GLANDS IN THE MESENTERY.—Mr CARSON operated on a girl, æt 10, who had been admitted to hospital with an abdominal tumour and a four months' history of wasting and abdominal pain. The mother stated that the child had been losing flesh rapidly of late, and that the pains in the abdomen, while of short duration, were frequently repeated. There had been no vomiting, but the bowels were rather loose. No blood had been noticed in the stools. On examination the child was thin, but bright and cheerful. The abdomen was retracted, and a hard, irregular tumour could be felt beneath the umbilicus and extending more towards the left than the right. The tumour did not move on respiration, and was not tender. It could be moved within limits from side to side, but not in the long axis of the body. There was no free fluid in the abdomen nor could anything be made out amiss on rectal examination. The lungs were not affected, nor was there any enlargement of the superficial glands (neck, axillæ or groins). The family history was unimportant. A diagnosis of tuberculous mesenteric glands was made, and the abdomen was opened. The tumour consisted of a mass of enlarged and caseating glands in the mesentery, the distance from its edge to the nearest portion of small intestine being 2½ inches. It was about the size of a tangerine orange, and was covered by peritoneum, which was adherent to it, but had not given way at any point. The mass was removed entire, but it was not possible to shell it out from its peritoneal covering on all sides. During removal several vessels, chiefly veins had to be secured, and a fear was expressed that the damage to the blood supply might injure the nutrition of the segment of intestine involved. The abdomen was closed without drainage. Mr. Carson pointed out that the recognition of enlarged glands in the mesentery was not always an easy matter. They were generally secondary to tuberculous ulceration of the intestines, and therefore a history of wasting and diarrhœa with occasional slight hæmorrhage might be obtained. Pain was a common symptom, and this was probably due to the dragging on the intestine causing interference with the free passage of flatus, since tuberculous glands themselves, though perhaps tender, were rarely painful. A diagnosis had to be made between the condition under notice and appendicitis, localised tuberculous peritonitis, fæcal masses and even intussusception. The absence of an acute onset and the chronic nature of the illness would help to exclude the first and last, and a careful examination would readily suffice to distinguish between glands and fæcal masses. The diagnosis from a localised tuberculous peritonitis was more difficult, but the points of most importance were that tuberculous glands formed a hard, definitely localised, fairly movable tumour which presented many points of difference from a typical tuberculous localised peritonitis. Mr. Carson emphasised the value of the treatment by excision, and briefly reviewed the possible terminations in an untreated case, referring particulary to the occurrence of general tuberculous peritonitis and intestinal obstruction due either to kinking of the intestine by the puckering of the mesentery in the process of healing, or to the adhesion of a distant portion of intestine or mesentery to the primary seat.

The patient made an excellent recovery, and is putting on weight steadily.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD JANUARY 25TH, 1907,

The President, Mr. **Clutton**, in the chair.

Dr. **Seymour Taylor** showed a

CASE OF ACROMEGALY.

The patient, a woman of 32, had suffered from increase in the size of her hands and feet for five years. The case was typical in all respects.

Dr. F. **Parkes Weber** showed a case of

CONGENITAL HEART DISEASE WITH CYANOSIS.

The patient was a girl, æt. 17. When the patient lay on her back a harsh systolic murmur could be heard all over the heart, but when she stood upright the murmur almost completely disappeared or became much fainter and markedly influenced by the respiratory movements, being best heard during inspiration.

Mr. **John R. Lunn** showed a case of

FRACTURE OF TARSUS.

The patient was a man of 22. Some doubtful crepitus could be felt on admission on May 2. He stated that he had jumped a depth of fifteen feet, landing on his left foot. The X-rays revealed a fracture of the astragalus, and a piece of the bone was projecting on the dorsum of the foot. The foot and ankle were put up in a plaster-of-Paris splint, which was removed on June 10th, when there was good movement of the ankle. The patient was discharged on July 15th walking well.

Mr. **John R. Lunn** also showed a case of

ACHONDROPLASIA.

The patient was a male of 53. Intellect good. Height 4ft. 11in. The forehead was prominent, the bridge of the nose rather deficient, the eyes deeply set. The legs are very bowed, there being great curvature of the tibiæ. The feet were short and square, with all the toes nearly the same length. There was very little curvature of the bones of the upper limbs. The fingers are more nearly the same length than normal. The middle and ring fingers diverged at the first interphalangeal joint.

Mr. **Scanes Spicer** spoke of the cases of achrondroplasia that came to the rhinologist with the diagnosis of adenoids on account of the depressed nose and peculiar facial features.

Dr. **Bertram Abrahams** showed an

UNUSUAL CASE OF ENLARGEMENT OF THE HEAD IN A CHILD.

Patient was a male, æt. 3. Nothing wrong was noticed with the head till the age of eight months. It then began to swell, and continued to do so for some four months. Dilatation of the vessels at the root of the nose was first noticed at eighteen months, and has progressed since. *Present condition.*—An intelligent and well-developed child. Head was very large, bulging particularly above and to the back. Greatest circumference 25in. On auscultation a systolic bruit is heard all over the head. The right fronto-parietal fissure is closed, but the left, both coronals, and the frontal portion of the sagittal are patent. The left occipito-parietal region is larger than the right. There is venous dilatation over the glabella, involving the left upper eyelid, and descending to within three quarters of an inch of the tip of the nose. The appearance simulates that of a cirsoid aneurysm. There is no other abnormal physical sign excepting a systolic bruit over the whole præcordia, loudest in the mitral area, and conducted into the axilla.

Dr. **William Ewart** pointed out that the head was not of a hydrocephalic shape, as it retained the normal form.

Mr. **H. L. Barnard** showed a case of

SUCCESSFUL PLASTIC OPERATION FOR A SYPHILITIC PERFORATION OF THE HARD PALATE ON THE LEFT SIDE THE SIZE OF A SIXPENCE.

The patient was a man of 28. The perforation had been present six months. August 16th, 1906.—An L-shaped flap was turned in from the right side of the palate and sutured to the freshened edges of the perforation. The flap was about three times the area of the perforation. Healing occurred well.

Mr. **Barnard** remarked that the experience of modern rhinologists controverted the older views about the tendency of such operation wounds not to heal.

Mr. **W. G. Spencer** thought that the truth lay between the two extremes, and that one could not always expect good results. He described a method that had proved very successful in his experience.

Mr. **Charter Symonds** described a modification of the operation. He was sure the results were much better than was previously considered to be the case. However, some forms gave very bad results; such were those in which the alveolar plate was destroyed, and those in which the perforation was situate in the soft palate.

Mr. **H. L. Barnard** showed a case of

REMOVAL OF A STONE FROM EACH URETER FOR DOUBLE PYONEPHROSIS.

The patient, a woman, æt. 41, had renal colic on both sides, but chiefly on the left, for four years. Attacks of cystitis and pyrexia for three years. Radiographic report: (1) A stone the shape and size of an almond in the right ureter opposite the fourth lumbar vertebra; (2) another, smaller, in the pelvis on the left side, opposite the fourth sacral. October 14th, 1904.—The right ureteric calculus was removed through a loin incision. Wound in ureter closed with catgut, drainage, no leakage of urine. December 5th, 1904.—The left ureteric calculus was removed through an incision in the left fornix of the vagina. Ureter not sutured. Tube in broad ligament for three days. Urinary fistula closed in ten days. *Present condition.*—Well and strong. Weighs 9st. 10½lb. Urine slightly turbid, contains pus, acid, 1016, trace of albumen.

Mr. **W. G. Spencer** discussed the difficulty of closing the ureter through the vagina.

Mr. **Barnard**, in reply, mentioned a case in which Mr. Furnival had pulled down the ureter with a hook into the vagina, and closed the opening in it. It was important in such an event to use catgut, for it had been found that if silk were used another stone often formed at the site of the ligature. Replying to a question of Mr. Fagge's, he said that he had not employed the separator in this case.

Mr. **H. L. Barnard** showed a case illustrating

A METHOD OF DIMINISHING THE RAW SURFACE AFTER REMOVAL OF HALF THE TONGUE.

Patient was a woman, æt. 55. The right half of tongue removed by Whitehead's method. The half of the tongue remaining was doubled back so that the tip was brought in contact with the posterior third. Three catgut sutures were inserted. *Advantages of method.*—(1) Rapid healing and diminished raw surface; (2) smooth and rounded edge to tongue; (3) small scar. *Disadvantages.*—(1) Local recurrence if it occurred would be in the middle of tongue; (2) the sensation of the tip of tongue being down the throat, but it has now moved round to the front.

The **President** said that he had employed this method for twenty-three years, and was satisfied with the results thus obtained. Unfortunately it was rare to get cases early enough for the operation to be suitable for them.

Mr. **C. B. Keetley** remarked that an additional advantage of the operation was the diminished tendency to recurrence. The sooner and better a wound healed the less was the chance of recurrence.

Mr. **Charter Symonds** said that he usually employed the method of stitching the edge of the wound to the mucous membrane on the dorsum of the tongue.

Mr. **H. L. Barnard** showed

A PROSTATIC KNIFE FOR INCISING THE FLOOR OF THE BLADDER IN TOTAL SUPRAPUBIC ENUCLEATION OF THE PROSTATE.

The knife was similar to an adenoid finger curette, but terminated in a blunt, rounded blade. It fitted on the index finger. This was one method of overcoming the difficulty of cutting on the prostate whilst two fingers of one hand were in the rectum.

Mr. C. H. Fagge showed a case of

CARCINOMA OF JEJUNUM; OBSTRUCTION; RESECTION OF PIECE OF JEJUNUM AND ADHERENT TRANSVERSE COLON; DOUBLE LATERAL ANASTOMOSIS WITH MURPHY'S BUTTONS.

The patient, a woman of 33, was now quite well, thirteen months after the operation. The buttons were both passed within six weeks of the operation.

Mr. Fagge, in reply to a question from Mr. Raymond Johnson, said that microscopically the growth proved to be a columnar cell carcinoma, with an unusually great amount of fibrous tissue.

Mr. W. F. Brook showed a case of

MULTIPLE CHONDROMATA OF METATARSAL BONES AND FIRST INTERMETATARSAL SPACE.

Patient was a male, æt. 50. Fifteen years ago right "great toe joint" was crushed. This was followed by occasional painless swelling, which in the course of a few years become permanent. He was first seen in February, 1904, when the condition differed from that now presented in the following respects:—The general swelling was less and not so tense. The calcareous or cartilaginous deposits about the bone were more movable, and the outline of the more superficial ones, which was irregular, was easily recognised. The movements of the joint were scarcely impaired. In the more recent skiagram, as compared with the earlier one, is seen (1) the increasing amount of the calcareous or cartilaginous deposit in the tissues of, and further widening of, the first interspace, and increasing distortion of second metatarsal bone; (2) the slow but progressive destruction of first metatarsal bone; (3) the appearance of chrondromata in the other metatarsals. One of the isolated growths, about ½in. in diameter, was recently removed from the web of the interspace. It was not encapsuled, and upon examination by Mr. Shattock was reported to consist of hyaline cartilage, in which small areas of mucous metaplasia occurred.

Mr. Barnard queried whether the growths might have originated in the tendon sheath.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Pathology.

President: Joseph O'Carroll, M.D. F.R.C.S.I.
Sectional Secretary: Professor A. H. White, R.C.S.I.

Meeting held Friday, January 4th, 1907.

Dr. J. F. O'Carroll, President of Section, in the Chair.

UNCINARIA DUODENALIS FROM ST. VINCENT (WEST INDIES).

Professor McWeeney, through Dr. Farnan, exhibited specimens of the above sent to him by Dr. Branch, Government Medical Officer at St. Vincent, where the parasite was a regular plague. The exhibit consisted of the washings of the intestine of a child. Two sorts of worms were present—viz., *trichocephalus dispar* in large tufted masses, and *uncinaria* (*ankylostoma*) *duodenalis*. The male and female trichocephalus are very different. The male and female uncinaria are not very unlike each other. The difference was shown by microscopic slides. The male uncinaria was smaller than the female. One measured 7.5 mm. long by 0.47 mm. thick (Manson gave 6 to 11 mm. by .4 to .5). Its remarkable copulatory organ consisted of 2 spicules, beautifully striated under a high power, surrounded by a sort of umbrella-like arrangement supported by 11 ribs. The female was longer and thicker than the male. One measured was 17 mm. long, but was thinner than the male (.37 mm.). However, it may have been a damaged specimen. Manson gives 1 mm. Another measured .469 in width, so that the females did not seem to agree in width with Manson's average. A new species of uncinaria, called *U. americana*, parasitic in man, was described in 1902 by Stiles, and is now made into a new genus called *necator*. It hails from the same neighbourhood as *U. duodenalis*, and does a fearful amount of mischief especially to children, causing great retardation of development, anæmia, and cachexia. The specimens shown, however, seem to be the ordinary *U. duodenalis*. In Europe the worm chiefly attacks miners, and attention was first called to it in connection with the boring of the St. Gothard tunnel in 1880, when it caused a serious outbreak of a "pernicious" anæmia amongst the workmen. It has recently occurred in England amongst the tin miners of Cornwall, and Boycott and Haldane have written two interesting papers about it in the *Journal of Hygiene*. It causes a marked eosinophilia. He also exhibited a small piece of duodenum showing exceedingly minute black spots, almost needing a lens to see them. These were the bites of the uncinaria, whose organs of attachment and piercing, four hooks and two teeth, are in the interior of a sort of "mouth capsule," and require patience and strong magnification in order to make them out.

Dr. O'Carroll read an interesting case of

SUFFOCATIVE HYDROTHORAX,

which will be found under the heading of "Clinical Records," page 120.

Dr. Martley instanced a case bearing some similarity to that described by Dr. O'Carroll.

SPECIMEN AFTER TALMA-MORRISON OPERATION.

Dr. Moorhead exhibited a specimen of above. The patient, a girl, æt. 22, was admitted to hospital in April last suffering from ascites, which had developed in a couple of days. After tapping, an operation was decided upon. The liver was found to be enlarged, firm, and hard. The surface was scraped, and the great omentum was stitched to the abdominal wall. After the operation the patient was tapped at intervals of ten days, 200 ounces of ordinary ascitic fluid being got. About two months ago she began to lose weight. It was decided to see what could be done to establish a permanent drain to the peritoneum, but no improvement took place, and the patient afterwards died. The interest of the specimen was in showing the results of a Talma-Morrison operation six months after its performance. On making the autopsy he found adhesions across the anterior abdominal wall, and along these could be seen the development of new veins, chiefly between the two peritoneal surfaces. There was no engorgement of the deeper vessels. The ones that had increased in size or number were the superficial ones. So far as concerned what they had hoped to do the operation was successful—*i.e.*, new collateral channels had been established. That it was not more so was probably due to the fact that the patient, in addition to cirrhosis, had a nutmeg liver. At the *post-mortem* they found no valvular lesions to account for their first idea that the heart might be partly the cause of the ascites, but the right ventricle was intensely fattily degenerated. In most cases of cirrhosis some alcoholic history could be obtained. This patient, however, had been a teetotaler all her life, but on inquiry he found that part of her occupation was the putting of photographer's negatives into methylated spirits, which might have something to say to the case.

Dr. Wheeler instanced a case in which, after finding an enlarged liver roughened on the surface, he performed a Talma-Morrison operation. That was two years ago. The patient was tapped once after the operation, but never since. He has been extremely well, and has gained three or four stones in weight. The other day he came to show himself; no tapping was required, but on examination the urine showed a good deal of albumen, giving signs of a cirrhosis of the kidneys. Ninety per cent. of cases in which there were no complications had been cured of ascites by the Talma-Morrison operation.

Dr. Earl said he had been struck with the fact that an alcoholic history was out of the question in many cases of cirrhosis—such as cirrhosis occurring in children. A great number of the patients met with in hospital practice drank all they could get, and if there was any intimate connection between alcoholic indulgence and cirrhosis of the liver, it should be one of the commonest affections, which it was not by any means.

The Chairman thought it hardly possible to be sure of the histological condition of the liver through such an incision as is made in most laparotomies. Outside inspection of the liver did not show the condition of the inside or of the capsule. He was therefore somewhat sceptical when he heard the liver accurately described on the basis of an incision for a Talma-Morrison operation, and he was not sure that the evidence did not indicate that the ascites would have disappeared eventually without any operation.

Dr. Farnan and Dr. Gunn also spoke, and Dr. Moorhead replied.

TRAUMATIC RUPTURE OF HEART.

Dr. Wheeler showed a ruptured heart. The case was that of a young actor, who was killed by a motor-car in August. The heart was absolutely torn in two.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held January 8th, 1907.

Mr. G. Pernet in the Chair.

A paper was read by Dr. G. D. Hawthorn entitled

PROTECTION OF RHEUMATIC CHILDREN.

Could anything be done to prevent or limit the occurrence of cardiac disease in children who are known to be liable to such disease as a result of a rheumatic inheritance or proclivity. Irreparable damage was frequently inflicted on the cardiac tissues by the rheumatic poison almost or altogether apart from incidents popularly recognised as rheumatic. The disproportionate frequency of heart disease in children may be due to the absence of arthritis in them, causing the patient not to be kept at rest for a sufficient time. It is necessary to educate the public as to the value of rest, and when this is done there may be some diminution in the incidence of heart disease in young subjects with its results of diminished usefulness of the individual.

Dr. Porter Parkinson fully agreed with the writer of the paper as to the value of rest in such cases, but till the profession were unanimous he was afraid there was little chance of it being enforced.

Dr. Ewart considered it was chiefly a matter of toxines and of individual resistance.

The Chairman pointed out that there were a variety of toxic conditions in children which gave rise to pains in the joints and muscles which had no relation to rheumatism. He doubted the existence of rheumatic inheritance.

A case of *Volvulus of the Small Intestine round a Caseous Mesenteric Gland* was read by Mr. Lockhart Mummery. It occurred in a boy, æt. 7, with symptoms resembling appendicitis. Operation showed a complicated volvulus of the ilium close to the cæcum; it was gangrenous, and on the point of giving way at several places. This was resected and the cut ends united with a Murphy's button. The case resembled appendicitis, the classical symptoms of acute obstruction of the small intestine being not at all prominent. Vomiting was a marked feature early, but had ceased when the child came to the hospital, and was never fæcal in character. There was no distension of the abdomen.

Mr. Jaffrey recorded a similar case in an adult, but had never seen it in a child. He discussed the difficulty of diagnosis.

Mr. Skelding had seen many such cases, and thought many cases of mild obstruction might be due to enlarged mesenteric glands.

A case of *Dilatation of the Stomach* of doubtful causation in a boy, æt. 12, and a patient showing the result of an operation for extreme depression of the frontal bone, were shown by Dr. C. O. Hawthorne.

A case of *Diabetes Insipidus* was shown by Dr. Cautley. The patient was a girl, æt. 9 years, who had had nocturnal enuresis for two years and enuresis diurna as well for six moths, with much thirst and excessive appetite. The urine varied from 46 to 262 ounces a day, was pale, acid, 1005 sp. gr., and contained 0.5 to 0.9 per cent. of urea. Adrenalin and atropin had effected no improvement, but valerianate of iron and quinine, with strychnine were more successful, the polyuria and thirst diminishing, and the patient gaining weight. There was no exciting cause discovered, and there was no sign of chronic interstitial nephritis.

Dr. Sutherland considered such cases were probably of neurotic origin.

Dr. Parker Weber called attention to the theory that diabetes insipidus was due to inability of the kidney to excrete salts in the normal way.

Dr. Clutterbuck had observed a similar case in which iron and ergot effected considerable improvement.

A case of *Premature Development* in a child, æt. 2½, was shown by Dr. Poynton. The remarkable growth began at a year old, when pubic hairs and sexual development were noted. The weight is now 3 stones 1 pound. Circumference of head 20 inches, of thorax 20½, of abdomen 23 inches. Length of the whole arm is 12 inches, and of leg 17 inches. The voice is deep, and memory good. Aspect rather suggests acromegaly. There is no suprarenal tumour to be felt. The parents are small and healthy.

A case of *Friedreich's Disease* in a girl, æt. 9, was also shown by Dr. Poynton. Five years ago she had measles, with severe cerebral symptoms, and had not been well since. She had now well-marked ataxy of legs and inco-ordination, with tremor of hands. Doubtful nystagmus. Knee-jerks abolished. Right plantar reflex extensor, but the left is flexor in type. Some lordosis of upper dorsal spine; double pes cavus; speech slow; no optic changes.

Œdema in an Infant was shown by Dr. Geo. Carpenter. It was 14 months old, and weighed 7 pounds. The œdema affected the face and limbs, and followed an attack of diarrhœa. The child was anæmic and the temperature subnormal. The urine contained no albumen.

A case of *Webbed Penis* was shown by Mr. Lockhart Mummery. The penis was enclosed within the skin of the scrotum right up to the tip; there was no other abnormality, and no history of similar defects in the family.

A case of *Congenital Cerebellar Ataxy* was shown by Dr. Sutherland. The boy, æt. 3, had suffered from general ataxy for eighteen months. He was healthy at birth, but had convulsions when six months old. At two years he was unable to sit or stand unsupported, and the limbs were tremulous and ataxic. The speech and intelligence were very backward. The knee-jerks were very active. There was double internal squint, and the optic discs were pale, but not definitely atrophic. The condition has remained the same for the past nine months, except that the child can now sit unsupported.

Dr. Sutherland thought it probable that the case was one of birth palsy following meningeal hæmorrhage, and probably involving the cerebellum.

A case of *Congenital Deformities of the So-called Mongolian Type of Amentia* was shown by Dr. Sutherland. The girl, æt. 8, showed the shortening and incurving of the little fingers and the oblique palpebral tissues so characteristic of the Mongolian type of imbecility; but this patient was perfectly intelligent, and had no cranial deformities. She was under treatment for fibroid phthisis.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, January 17th, 1907.

The President, Frank T. Paul, in the Chair.

ACUTE HÆMORRHAGIC PANCREATITIS.

Mr. W. Thelwall Thomas read a short note on three cases of acute pancreatitis, operated upon, with two recoveries. The first case, female, æt. 56, was *in extremis* thirty-five hours after the onset of acute abdominal pain with vomiting, quickly becoming fæcal. On incision, under eucaine, blood-stained effusion escaped from the abdomen, and the omentum was in a condition of fat-necrosis. The patient succumbed a few hours later. *Post mortem*, hæmorrhagic pancreatitis was found. The second case occurred in a girl, æt. 21, in whom the symptoms resembled perforation of a gastric ulcer, but with temperature. The condition became rapidly worse, and on operation fat-necrosis of the omentum was found with copious effusion of blood-stained material into the peritoneal cavity. The lesser peritoneal sac was drained by a loin drain and an anterior tube, as well as a tube into the pelvis. Thirty-five gall-stones were removed from the gall-bladder, and the latter drained. The pancreas was much enlarged without hæmorrhages. The patient made an uneventful recovery. The third case occurring was that of a man, æt. 40. The onset was acute, and a diagnosis of intestinal obstruction was made. The temperature rose, there was slight vomiting, and the abdomen became rigid and tender. On incision, thirty-six hours after onset, fatty necrosis in the extra-peritoneal tissue, omentum, and mesentery, was found. The gall-bladder, which was full of inspissated bile and the peritoneal sac were drained as in the previous case. The pancreas, which was very much enlarged and hæmorrhagic, was incised. The patient made a good recovery, but with a pancreatic fistula which remained open for six weeks. Mr. Thomas then discussed the etiology and treatment of the disease.

The cases were discussed by Mr. R. W. Murray, Dr. Stansfield, and Dr. A. G. Gullan.

THE ETIOLOGY OF INGUINAL AND FEMORAL HERNIA.

Mr. R. W. Murray read a note on the etiology of inguinal and femoral hernia, based on a series of *post-mortem* observations made upon 200 persons in whom, during life, there was no evidence or history of hernia. Among the 200 bodies examined, 68 peritoneal diverticula were found, 52 in the femoral and 13 in the inguinal region. Arguments were advanced in favour of the saccular theory of hernia, and Mr. Murray contended that all the evidence we at present possess was in favour of the belief that a pre-formed sac is the essential cause of inguinal and femoral hernia at all periods of life.

Dr. T. R. Bradshaw said that granting that an oblique hernia came down the inguinal canal, a direct inguinal hernia could not have such an origin. One important clinical fact made it difficult for him to accept the view that the tunica vaginalis was frequently found communicating with the peritoneum in persons who were not the subjects of herniæ, viz., the extreme rarity with which the fluid of ascites was found in the tunica vaginalis. He had only once seen such a case, more than twenty years ago, and in that case the fluid could easily be made to pass from the tunica vaginalis into the abdomen, or *vice versa*, by changing the patient's position.

Mr. Murray's paper was also discussed by the President, Mr. F. C. Larkin, and Mr. K. W. Monserrat.

VENTRO-FIXATION OF THE UTERUS.

Dr. H. Briggs read a paper on the above subject, of which an abstract will be found on page 116.

In the discussion following,

Dr. T. B. Grimsdale thought that the title of the paper was singularly unhappy, as it exaggerated the importance of the backward displacement of the uterus, and seemed to imply that all the symptoms were due to the backward position of the uterus, whereas all of the cases referred to showed other pathological conditions which were in all probability responsible for the symptoms present, the backward displacement being merely an incident in the case. As to the operation of ventro-fixation itself, it was safe and effective if properly performed, though the holding capacity of the bladder seemed to be slightly diminished by it.

Dr. W. Blair Bell thought that the pathology of retroversion and retroflexion was not always the same. He had applied his own views to Dr. Briggs' statistics and found there much to support them. For instance, he found that of the total failures 75 per cent. were in single women, and, further, that of the cases, whether single or married, complaining of menorrhagia, 85 per cent. were completely cured, while only 62 per cent. of the total number of cases were cured. These facts he considered important, as were some others to be deduced from the figures. He (Dr. Blair Bell) thought all forms of ventro-fixation unsurgical and dangerous, particularly the operation of peritoneal attachment described. He much preferred Gillian's operation, which he had now performed in a modified form for over a year ; or one of his own, first performed in March last, in which a loop of round ligament on each side was brought through the broad ligament and fixed behind the uterus—an operation which had been recently independently described.

Dr. Arthur Wallace remarked that ventro-fixation was not a scientific procedure, but in default of a better it was satisfactory in that it relieved the patient. The principal drawback was that between the utero-parietal attachment, the abdominal parietes, and the bladder there existed a potential opening or tunnel through which a loop of intestine might pass and become strangulated. A perfect procedure should bring about the formation of a complete peritoneal septum between the uterus, bladder, and abdominal wall. When the direct utero-parietal attachment stretched a little, as it appeared to do usually, there would result a kind of anterior mesometrium dividing the utero-vesical pouch into two halves, without any opening through which intestine might pass.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Jan. 27th, 1907.

Treatment of Heart Disease.

The heart can be weakened from three causes—troubles of the innervation of the heart, of lesions of the cardiac muscles, and from obstacles of the periphery. The two first causes are the most important, the third is the consequence of the two first. A healthy heart, says Professor Huchard, one of the greatest authorities on cardiac disease, is generally uninfluenced by an obstacle ; it is only when the nerve centres are touched or that the muscle is somewhat degenerated, that its resistance commences to yield.

The influence of the nervous system on the heart was fully described by Cyon two years ago, and confirmed by clinical observations.

An agreeable emotion is sometimes sufficient to set right a heart that had begun to vaccilate. A quiet life, a comforting word, agreeable impressions, can go far in strengthening a weak heart. The moral action of a medical attendant has a very salutary effect on patients with heart disease.

Depressing emotions or violence diminishes considerably, on the other hand, the vital energy. Instead of being affected by moral emotions, the cardiac nerves may be irritated by certain toxic substances—tobacco, alcohol, or infectious maladies. Among the first might be ranked asystole following attacks of tachycardia. Here digitalin is indicated when signs of cardiac insufficiency, mitral souffle, venous pulse of the jugulars, big liver, &c., make their appearance, the use of digitalin in small doses producing a sedative action much appreciated by the patient. During four or five days ten drops of the solution cf digitalin (1—1,000) might be given, or a pill containing $^1/_{200}$ gr. each day for four days, and renewed every fortnight, braces up the heart.

The same cardiac irregularity is met with in exophthalmic goitre, and is due to some trouble of the thyroid secretion. Here also the same treatment will be found beneficial, but the malady can be generally avoided by treating the cause. Faradic currents, one electrode on the back of the neck, the other onthe goitre, ten minutes each day and continued for a year, and the internal administration of quinine, remove all danger from the heart.

The treatment of cardiac asystole varies as to the cause and the importance of the lesions. In acute infectious affections, the application of the ice-bag to the heart, injections of camphorated oil, caffein, spartein, or strychnine constitute the best treatment.

Besides these acute maladies, two groups of cardiac affections may exist. In the first, the valves are taken and subsequently the muscle; the second comprises the group of chronic myocarditis and arterial disease. Here the contrary obtains; the muscle yields first, and valves follow, and although both the mitral and aortic valves may be affected in the first group, it is the aortic valve that is especially diseased in the second. The treatment is different, for the myocardium is but little altered in valvular disease, while it is absolutely degenerated in aortic lesions. Consequently, large doses of digitalis might be given in the former, and very small doses or perhaps none at all in the latter.

In mitral disease, at the outset Professor Huchard recommends the following treatment:

Rest, because rest is the digitalis of the heart; milk or vegetable diet from which chloride of sodium should be excluded as much as possible. The second or third day a brisk purgative (scammony or jalap), and wet cupping over the liver to deplete the venous system. Bloodletting might be practised if the patient was cyanosed. The day after the purgative, and for *one day*, 50 drops of the solution of digitalin in one dose, or perhaps better, 20 drops the first day, 10 drops for three successive days, after which the patient is allowed to rest for fifteen days. At the end of that time, the remedy might be ordered again at the dose of 10 drops for four days so as to maintain a cardio-tonic action.

During the periods of suspension, strophanthus or spartein might be given more to content the patient than with a view of replacing the digitalin, as their effect on the heart is problematic.

Chronic myocarditis and arterial disease affect generally persons of advanced age where the cardiac muscle is profoundly altered. Wet cupping over the liver and even the heart is useful. In certain cases of incurable dilatation of the cardiac cavities, M. Huchard derived great benefit from wet cupping over the heart practised every day for a week. A milk regimen is ordered as in the previous case, but the patients would do well not to exceed a quart and a half of any liquid during the day. Diuresis by reduction of liquids is an important clinical fact which should be borne in mind. Digitalin in five-drop doses of the solution once a day and continued for ten or fifteen days, followed by suspension for five, ten, or fifteen days, will regularise the rhythm of the heart, give amplitude to the pulse, and reduce the bruit de galop.

These results are especially favourable when the digitalin is given concurrently with theobromin, which is the best of our diuretics and a first-class dechloriding agent. Patients formerly condemned by brutal treatment of large doses of digitalis, thanks to the employment of very small doses of digitalin combined with theobromin, can live and return to their occupations for years. The theobromin may be given in ten-grain doses morning and evening before meals, and continued for months.

When the asystole is of peripheric origin, the obstacle may be found in hard œdema of the lower limbs or a certain degree of embonpoint of the individual. The œdema will disappear by acupuncture, and an appropriate *regime* will decrease the obesity and thus relieve the heart.

As prophylatic treatment, small doses of digitalin should be given during the first ten days of every month.

GERMANY.

Berlin, Jan 27th. 1907.

At the Verein für Innere Medizin, Hr. Ism. Boas related a case of

SPONTANEOUS EXPULSION OF AN INTESTINAL LIPOMA.

A man, æt. 55, consulted him in October last on account of recurrent violent abdominal pain. The patient had travelled in South-West Africa shortly before; he there had malaria, and on his return had had a sharp attack of blackwater fever. He was not emaciated, but was so much incommoded generally by his pains that he was unable properly to fulfil his duties as member of Parliament. On examination, a swelling of the liver was found, which the speaker attributed to his malaria. There was no splenic enlargement, and examination per rectum was negative. A Carlsbad course of treatment was recommended, and this was carried out in the neighbourhood of Berlin. A fortnight later a letter was received from the patient, in which it was stated that he had been made worse by the treatment rather than better, and that the general condition had got distinctly worse. Then one day, when the pain was very bad, he felt as if something had given way, and shortly afterwards a tumour was passed per rectum. The tumour was the size of a couple of walnuts, and proved to be a lipoma.

These tumours were great rarities; up to the present only forty-five of the kind were known. The spontaneous expulsion of such a tumour was a still greater rarity, and only six other cases were known. The tumours were generally situated in the colon, rarely in the small intestine, and two distinct forms could be differentiated: (1) Such as grew from the surface of the bowel towards the abdominal cavity (two such cases had been described by Virchow in his work on tumours); (2) such as sprang from the submucosa and grew into the lumen of the intestine; they might attain a tolerably large size. The latter form mostly gave rise to invaginations and obstructions. In this case the tumour had a pedicle, and this was torn through, the patient suffering severe pain. The Carlsbad treatment, by increasing the peristalsis, had contributed to this event. (The tumour was shown.)

Hr. Wohlgemuth discussed

EXAMINATION OF A MAN WITH FISTULA OF THE PANCREAS.

He said that but little was known about the activity of the pancreatic gland during digestion in the human subject, whilst Pawlow's studies in respect to such fistulæ in the dog had given accurate data. Similar investigations had been made by Plessner and Ellinger. In both of the patients made use of for the investigation, however, the secretion of pancreatic juice was so irregular that the authors named could draw no satisfactory conclusions. The activity of pancreatic juice depended, as was known, on its three digestive ferments: the proteolytic (albumen digesting), lipase (fat digesting), and diastase (carbohydrate digesting). Lipase was not all active, but the inactive portion was rendered active by the accession of bile. The proteolytic ferment was made active by intestinal secretion and by bile, and according to the speaker's own investigation, also by expressed juice of the liver and aminic acid. The question whether pancreatic juice contains a ferment capable of coagulating milk he could answer in the affirmative, but this was only the case after stimulation.

He had carried out the following inquiries on a patient with a pancreatic fistula sent to him by Karewski. He gave the patient a fixed quantity of food from the groups of carbohydrates, albumens and fats, and from hour to hour collected the pancreatic juice. From this it appeared that the quantity secreted was greatest with carbohydrates, smaller with albumen, and smallest with fats. The secretion was most active in the second hour usually. According to Pawlow's experiments, the pancreas always acted as if with an aim—*i.e.*, the special secretion was according to the particular kind of food. Thus, when food rich in albumen was given, the proteolytic ferment was in greatest quantity, &c. This held good in the speaker's case also.

He also tried the effect of hydrochloric acid, and found that the pancreatic secretion was heightened by it.

From the results observed it was intended to reduce the secretion as much as possible by giving an anti-diabetic diet—free albumen and fat, with as little carbohydrates as possible. The diminution of the secretion was also aided by sod. bicarb.

Hr. Karewski observed that fistulæ of the pancreas were very difficult to treat successfully. In the case before them, a boy, æt. 16, had got his fistula from being crushed by being run over. He had lost as much as 400 ccm. of pancreatic juice through the opening, and had lost seriously in weight, and the greatest care in feeding did not compensate for the loss. Gradual contraction of the orifice had been attained by the diet suggested by Wohlgemuth. After removal of the drain after eight weeks the condition was tolerable, and the concentrated secretion reaching the stomach sufficed for digestion and even for restoring the body weight.

Hr. Biekel remarked that the manner of secretion described by Wohlgemuth corresponded to that given by Pawlow as regarded the dog. It might be assumed therefore that the other results obtained were also applicable to the human subject.

Hr. Fulda, said that the measurement of the digestion of albumen by the proteolytic ferment after the method of Metzschen was not accurate. He asked, further, how hydrochloric acid acted on the pancreatic secretion.

Hr. Wohlgemuth, in reply, agreed with Fulda's remarks, and then said that hydrochloric acid acted in the first place reflexly, and in the second by exciting secretion from the duodenum. The two actions were, however, separate and distinct.

AUSTRIA.

Vienna, Jan. 27th, 1907.

Ulcerative Endocarditis.

Zemann showed the heart of a young man, æt. 19, who died from acute ulcerative endocarditis in which was also present a cicatrised stenosis of the left conus arteriosus. The stenosis he considered was the primary cause of the ulceration of the endocardium, and appeared to him to be of a congenital nature.

Sternberg gave a short clinical history of the heart during life, which he took from the journals: Over the manubrium sterni about the level of the second rib, as well as the left intercostal space, a loud whirring sound could be both heard and felt, which could not be localised to the ostium cardii. The apex beat was felt between the fifth and sixth intercostal space outside the mammary line. In auscultation there was a rough protracted systolic murmur, while the second sound was scarcely audible.

About this time the patient had a rigor followed with remitting fever, enlarged spleen, and a great number of polynuclear leucocytes. At this stage of the disease septic endocarditis was diagnosed at the base, which was suspected to be congenital in origin. Sternberg thinks that Kurt's method of palpating the heart is the best for diagnosing these cases, the use of which he thinks is far too seldom practised.

Broncho-Stenosis.

Weinberger exhibited an anatomical preparation which he preserved from a case brought before the society three months ago, where there was left-sided broncho-stenosis caused by an aneurysm on the aorta, which displaced the heart and mediastinum into the left side of the thorax. The *post-mortem* confirmed the diagnosis arrived at then, viz., chronic endarteritis of a syphilitic nature in the ascending and arch of the aorta, where a large aneurysmal sac pressed on the isthmus of the aorta, also compressing the recurrent nerve, pulmonary artery, and bronchus of the left side. It was further shown that the displacement of the bronchus was the cause of the heart and mediastinum being so far set out of place, which could not be demonstrated with the Röntgen rays, and led to speculation during life. Hofbauer reminded the members of a similar case of displacement of the heart into the abdominal region from simple pleuritis. He thought this case of Weinberger demonstrated clearly how far the heart can be displaced by morbid changes. He would also like to draw their attention to another form of these respiratory excursions of the heart and mediastinum where no difficulty is experienced in breathing from broncho-stenosis although the displacement is as great as shown in cases that Holznetz and himself had exhibited at former meetings. Schrötter confirmed this opinion by cases he had also shown.

Gangrene of the Extremities.

Foltanek showed a child, æt. 3 weeks, with gangrene of the right foot, which he considered to be of an embolic nature, but refused to offer any opinion of the primary cause of the embolism. Escherich showed a cast of another similar case in a young child, but was unable to throw any light on the origin of the disease

Hochsinger remembered meeting with a similar condition in a new-born child four years ago, a description of which he published at the time. The necrosis seemed to point to some interference in the thoracic artery which was confirmed in the *post-mortem* room by an embolus firmly impacted in the long thoracic artery.

Recurring Parotitis.

Reuss recorded the history of a girl, æt. 5½ years, with a chronic recurring enlargement of the parotid gland, which commenced when she was æt. 2. The unusual character is its disappearance in the summer, but immediately winter sets in the gland enlarges with hard marble-like swellings over the surface, but without pain. No other morbid changes are present.

Kummel is the only one in our literature who describes a similar condition in an adult.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Death of the Oldest Practitioner in Scotland.—The late Dr. Alexander Peddie, Edinburgh, whose death was alluded to last week, was born in 1810, and had thus reached the great age of 96. During his long life he had witnessed many changes, and played his part in many of them. His contributions to medical science are for the most part more than half a century old, and though forgotten by many at the present day, they and his other work commanded the respect and attention of his contemporaries. In 1854 he advocated the view that inebriety should be considered as a manifestation of a form of insanity, and his paper on the subject "The Pathology of Delirium Tremens and its Treatment without Stimulants or Opiates" constituted a considerable advance on the practice of the time. He was a recognised authority on this and cognate subjects, and in 1872 gave evidence before Parliamentary and departmental enquiries on the treatment of habitual drunkenness. Dr. Peddie was in active practice in Edinburgh until about fifteen years ago. He began his career by being apprenticed to Syme, then conducting his own hospital and surgical school at Minto House. Dr. John Brown, the author of "Rab and His Friends," was third on the list of apprentices, Dr. Peddie was thirteenth. A life-long friendship was struck up between the two lads, and Peddie became known to a wider public as the biographer of John Brown than as the author of professional treatises. Apart from his professional abilities, he was one of the best-known among Edinburgh citizens and having spent all his days in his native town he was a link between the society of to-day and that of our grandfathers.

The Compulsory Notification of Phthisis.—The Leith Town Council are promoting a Provisional Order, in which there is a clause relating to the compulsory notification of phthisis. The Local Government Board take exception to this, as a retrograde step, and express the opinion that local authorities ought not to promote local acts when the powers they desire are contained in general statutes. The Local Government Board contend that the clause in question is not necessary, being incorporated in the Public Health and Notification Acts. Special provisions already exist for the extension of the Notification Act to diseases other than therein specified, including pulmonary tuberculosis. The action of the Local Government Board in this matter is not without interest, because it was strongly urged by some at the recent discussion on the compulsory notification of phthisis in Edinburgh that the proper course for the city to adopt was to act by Provisional Order, not, as was alternately decided on, by an extension of the existing Statute.

Proposed Memorial to the late Dr. Finlayson.—At a largely attended meeting held in Glasgow on January 24th, it was unanimously decided to form a lectureship on medicine and cognate subjects, to be called the Finlayson Memorial Lectureship. In this way it would be possible to bring original workers and men of distinction from other places to give the practitioners in the West of Scotland an account of their researches. An executive committee was formed with Sir Hector Cameron as convener, Dr. Gourlay as treasurer, and Drs. Duncan, Macfarlane, and Freeland Fergus as honorary secretaries.

British Medical Association, Scottish Branch. The members of the Edinburgh Southern division held their first annual dinner on January 19th. Among those present were Dr. Norman Walker, the direct representative on the General Medical Council. In replying to the toast of the Magistrates and Corporation, Councillor Cullen, M.D., said that in the administration of the notification of phthisis the Town Council would never apply the drastic clauses of the 1897 Act, if the public did not wish it; they would always study the opinion of the medical profession on these matters. A very pleasant evening was spent by the members. The tendency to develop the social side of membership of the British Medical Association is growing somewhat, and this seems one of the best ways in which that body can promote the solidarity of the profession.

Action against Dr. Adam, of Forres.—An action has been entered in the Elgin Sheriff Court at the instance of William Kessack, of the town of Forres, against Dr. Adam, for damages in respect of his alleged illegal and unwarrantable action in making a *post mortem* examination on the remains of the wife of the pursuer. The pursuer prays the Court to ordain the defender to pay to the pursuer the sum of £50, with interest and expenses for loss, injury, and damage to his feelings. Dr. Adam denies the relevancy and conclusions drawn therefrom.

BELFAST.

Death of Dr. J. C. McCleery.—One of the oldest medical men in Ulster died last week :—Dr. James C. McCleery, of Belfast, who had reached the good age of 83. He took the licence of the Royal College of Surgeons of Ireland in 1847, and at one time had a large and lucrative practice in Belfast, but about twenty years ago he retired from active practice, and since then has lived very quietly on the outskirts of the city, seldom or never taking part in any public affairs. He was genial and courteous with those who knew him, but reserved and retiring with most.

Derry Borough and County Infirmary.—The annual meeting of the Committee of Management of this Hospital was held last week, when the medical report was read by Dr. J. G. Cooke, the resident surgeon. The intern patients last year numbered 1,371, a daily average of over 50, the operations performed numbered 298, and anæsthetics were given 212 times. With the help of a ball, a bazaar, and a donation of £500 from the Hon. the Irish Society, the finances of the hospital are in a satisfactory state.

Cerebro-Spinal Meningitis. Following the death of a medical student from cerebro-spinal meningitis as reported in this column last week, there have been several other cases in the city. Twelve cases had been admitted to the Fever Hospital at Purdysburn up to Saturday, of which four had proved fatal, and several others appeared likely to do so. Besides these, at least five fatal cases had occurred outside the Fever Hospital. In one instance a family of five children were attacked within twelve hours of each other, and four died, indicating a degree of virulence hitherto unknown in this affection. Two of these last cases died at home after only a few hours' illness, and an inquest was held, at which Professor Symmers gave evidence, and the publication of this in the daily papers will no doubt tend to the discovery of other cases.

The Irish University Question.—Very deep interest has, of course, been aroused here by Mr. Bryce's statement regarding the Irish University question, just published, but no one cares to commit himself to a definite opinion till further details are forthcoming. To those who wished for an Ulster University, the scheme outlined by Mr. Bryce is, of course, a disappointment, for it is realised that a large national university is much less likely to split, or be split, into several local universities, than would be a reformed and enlarged Royal University from which Trinity College was excluded. If a liberal equipment is offered to Queen's College, Belfast, it will no doubt go a long way towards making the scheme acceptable in the North. The appearance of the promised Bill will be awaited with interest on all sides, more especially as there is a tendency to believe that it is pretty sure eventually to become law.

LETTERS TO THE EDITOR.

THE CASE OF EDALJI.

To the Editor of The Medical Press and Circular.

Sir,—Though not belonging to the medical profession, I ask space for a few remarks on the case of Edalji. A good deal has been made of the fact that no evidence of his defective sight was given at the trial. But there was no reason why it should have been given. The case for the prosecution was that Edalji killed the horse during a walk which he took on the evening of August 17th, and as his sight did not prevent him from taking this walk, it could hardly be alleged that it prevented him from killing a horse while taking it. Mr. Distoumal went so far in his opening speech as to say that Edalji wore the incriminating coat during this walk, although no evidence was given to that effect. Even in the examination of a policeman who saw the horse at 11 o'clock p.m., long after Edalji had returned from his walk, Mr. Distoumal elicited that the night was so dark that the horse might have been injured at the time without his perceiving it. It was only when the veterinary surgeon who saw the horse in the morning declared that the injury was too fresh to have been committed during the walk in question, and evidence was given that the prisoner had worn a coat of a different colour during the walk, that Mr. Distoumal fell back on the theory that Edalji had slipped out of the house during the night, which was very dark as well as wet, and committed the outrage. The condition of the prisoner's eyesight only became important in connection with this theory.

I do not believe that the writer of the anonymous letters had any connection with the outrages, none of which occurred while the letters were going on. But the writer was aware of the condition of the prisoner's eyesight. One of the letters stated that Edalji had killed a horse on April 11th *at full moon*. Why at full moon ? Plainly because he thought the prisoner would be able to disprove the charge if he had mentioned a dark night. As a matter of fact, no horse was killed at full moon that April, but one was killed when the moon was nearly full in the following May. The writer, whose knowledge of the outrages was of a vague and general kind, and whose only object was to incriminate Edalji, made a mistake in the date, and invented a gang to account for the outrages which occurred on dark nights. A curious circumstance, however, is that after Edalji's conviction an outrage, evidently belonging to the series, was committed almost at full moon. I mean that on Stanley's horses on the night of November 2nd.

I am, Sir, yours truly,
A Barrister.

CONGRESS OF CLIMATO-THERAPY AND HYGIENE.

To the Editor of The Medical Press and Circular.

Sir,—I should like to call attention to the fact that those who have never visited the Riviera will have an opportunity of doing so under very favourable circumstances during the coming Easter. The third French Congress of Climato-Therapy and Urban Hygiene will be held this year on the Mediterranean seaboard, It assembles at St. Raphael on April 1st (Easter Monday) and lasts for a week. Those who take part will have exceptional opportunities for seeing Cannes, Nice, Beaulieu, Monte Carlo, Mentone, and other well-known places. The programme also includes a trip to Corsica, with which it is proposed to wind up the proceedings. This, however, is an "extra" which will probably not appeal to those with whom time is an object. I shall be happy to supply any further information to those of your readers who are interested in the matter.

I am, Sir, yours truly,
Leonard Williams.
8, York Street, Portman Square, W.
January 23rd, 1907.

ABOUT UNTAXED ALCOHOL.

To the Editor of The Medical Press and Circular.

Sir,—The uses of alcohol in medicine are endless, but its employment for external application, in dermatology, etc., must be largely limited by the prohibitive price caused by the tax of 16s. per gallon.

The Continental practitioner orders it largely for bed sores and sprains, and a host of skin affections, because he enjoys the use of the article free of duty, whilst we must in similar cases use methylated spirits, which, containing 10 per cent. of wood naphtha as well as paraffin, is far too crude, irritating and unpleasant for effective administration.

The Revenue Authorities, impressed by the injustice done to the manufacture of fine chemicals in Britain by the alcohol tax, have recently allowed the use of pure spirit without paying duty, for scientific purposes, under the title of "Industrial Alcohol." As this is practically a pure 90 per cent. alcohol, it would do admirably for therapeutic external purposes; but, so far, the Revenue Authorities do not permit its use by doctors.

There is reason to believe that if a strong and united demand were made by medical practitioners for the use of Industrial Alcohol, for external purposes only, in the prescription of doctors, the Inland Revenue authorities would permit it under restrictions. This demand ought therefore to be made at once.

I am, Sir, yours truly,
J. C. McWalter, M.D.(Brux.), D.P.H.

CONTINENTAL HEALTH RESORTS.

To the Editor of The Medical Press and Circular.

Sir,—On page 99 of The Medical Press and Circular, January 23rd, 1907, your Continental correspondent has made some observations on the advantages of the Riviera coast in the winter months which for some reason seem to have been disregarded of late. Some years ago I spent a winter at Cannes, and for want of some interesting occupation, I gave up my time to looking into the questions which interest us when we are dealing with the value of any locality or country in its influence on disease. It was useful to me then to have some knowledge of geology, chemistry, and physics, for they helped me much in carrying out observations properly, and saved me from being misled by the interested and exaggerated statements which are so common when we are discussing the merits of a place in regard to invalids, and when there are interested motives sometimes for extolling the characters of such place. What impressed me greatly and what I have never forgotten was the extraordinary difference in the middle of November between the wretched state of London, when we left it, and the brilliant warmth and colour of that coast of the Mediterranean between Marseilles and Cannes. I remember well how on Christmas Day I found the sea was really warmer for a bath than I had ever found it in midsummer in England. Now the question of chief interest as we travel along that coast is the variation in the geology—that is, in the character of the earth or soil. On these depend chiefly the character of the atmosphere, its dryness or humidity, and it is easy to see how Hyeres, Cannes, Mentone, San Remo, and other places differ from one another, when we know the nature of the stratum on which they are located.

I will not venture, however, to intrude upon the patience of your readers by saying more than that the remarks of your Continental correspondent might have been much stronger than they are on the value of the Riviera to invalids and how heartily I agree with him, after having walked along that North Coast and down from Genoa along the Spezzian shore, in his opinion that comparison between our country and the Mediterranean in the winter season is simply ridiculous, and is evidence of something worse than ignorance.

I am, Sir, yours truly,
Robt. J. Lee, M.D.Cantab.
Pwllheli, North Wales, Jan. 27th.

OBITUARY.

CHARLES JAMES OLDHAM, F.RC.S.Eng., L.R.C.P.

A well-known member of the local medical profession died on the 24th inst, in the person of Mr. Charles James Oldham, of Hove, at the age of 60. He received his professional training at Guy's Hospital, where he held various resident appointments. He was a Member and eventually a Fellow of the Royal College of Surgeons (England), and was also L.R.C.P. (London) and L.S.A. He came to Hove in 1870, and enjoyed a large practice, more particularly by reason of his skill as an oculist. The Sussex Eye Hospital loses in him a honorary surgeon, and he was also consulting surgeon to the Brighton, Hove, and Preston Dental Hospital. Apart from his professional career, he devoted himself to music, and his enthusiasm for the art was notably demonstrated in the collecting of rare instruments. Among his treasures are five most valuable "Strads"—three violins, a viola, and a 'cello. For the last-named he paid a price which ran into four figures; and one violin and the viola formed part of the set of instruments which Stradivarius made for the King of Spain of the time. Another of the violins once belonged to Rode, a great violinist of his day. Mr. Oldham was a director of the Royal Academy of Music, and locally will be most widely remembered as the very active President of the Brighton Sacred Harmonic Society. The news of his death will be received with deep regret by all who enjoyed his friendship or acquaintance.

THOMAS GOWANS MACCORMACK, M.A., M.B.Edin.

We regret to record the death in the 17th instant, of Dr. Thomas MacCormack, of Newport. Deceased came to that town some twelve years ago, and took a prominent local position. He was a strong advocate of the open-air treatment of phthisis, and was at one time president of the Newport Medical Society. For many years he was honorary surgeon to the Outdoor Department of the Newport Hospital. He was educated medically at Edinburgh, where he graduated M.A., M.B. and C.M. in the year 1893.

SPECIAL ARTICLES.

ROYAL COMMISSION ON TRINITY COLLEGE, DUBLIN, AND THE UNIVERSITY OF DUBLIN.

THE final Report of this Commission was presented and published during the past week. It is a most important document, though in some respects its conclusions are too wanting in unanimity to enable a definite answer to the vexed Irish University Question to be obtained therefrom. In another place we comment editorially on the Report, and here we merely publish a *résumé* of those features which are of most interest to medical men.

The Commission sat on 21 days, and heard 44 oral witnesses, besides receiving a number of written statements from persons and bodies interested. In their Report the Commissioners commence by making a general statement of the present condition of Trinity College and of the University of Dublin. They then deal with the place which Trinity College and the University hold as organs of the higher education in Ireland, and inquire whether there are any steps proper to be taken to increase their usefulness to the country with reference to the claims of His Majesty's subjects of the Roman Catholic faith. They subsequently inquire into the other matters mentioned in the terms of reference, including the propriety of recommending changes in the institution for reasons disconnected with the religious question.

The Report concluded with a summary of the general conclusions and recommendations arrived at by the Commission. The following are the most important of these conclusions:—

1. That Trinity College has been and is a satisfactory organ for the higher education of the Protestant Episcopalian population of Ireland, but that it has never been, and is not now, to an extent adequate to the reasonable requirements of the country, an organ for the higher education of the Roman Catholic population.

2. That while the Commissioners are divided in opinion in regard to the merits of the various schemes proposed to them involving the creation of a new College in Dublin acceptable to Roman Catholics, they, with one exception, recommend the establishment of such a College in Dublin.

3. That it is impossible to recommend any such changes in the constitution of Trinity College as would render it acceptable to the Roman Catholic Episcopate.

4. That there shall be included in the Statute or Charter regulating the future constitution of Trinity College, express powers to make certain special arrangements for Roman Catholics, Presbyterians, Methodists, and other religious bodies.

5. That in the event of a new College being founded in the University of Dublin or in the Royal University, there shall be power to establish a system of intercollegiate co-operation between that College and Trinity College.

6. That the Board or Governing Body of Trinity College shall ultimately consist of not more than fifteen nor less than nine members, who shall be approximately divided as follows:—One-fourth to be the Provost and other *ex-officio* members; one-half to be elected by Fellows and Professors voting together, from among the Fellows; and the remaining fourth to be elected in the same way from among the Professors who are not Fellows; and that various standing and other committees shall be appointed for conducting the business of the College.

7. That the existing Council shall be abolished, and that in its place there shall be substituted an Academic Council and Boards of Studies; that the professors and lecturers in each Faculty shall constitute a Board of Studies for that Faculty; and that the chairmen and vice-chairmen of the several Boards of Studies, together with the Provost, shall constitute the Academic Council; that it shall be the duty of the Boards of Studies to report to the Academic Council on all matters pertaining to the Faculties; and that it shall be the duty of the Academic Council to report on these matters to the Governing Body.

8. That no change shall be made as to the constitution or powers of the Senate.

9. That ultimately the present distinction between Junior and Senior Fellows shall cease, and that the total incomes of the Fellows shall be arranged on a more equitably graduated system.

10. That it shall be permissible for a candidate at the ordinary annual fellowship examination to present for consideration any dissertation or published or unpublished work; that the Governing Body shall elect the candidate who in their judgment is best fitted for a Fellowship in the College, but it shall not be incumbent on them to make any election; that election shall be for three years, during which period the Fellow shall remain a Probationary Fellow, and that at the end of that period he shall be eligible for a full Fellowship without examination. That the tenure of a full Fellowship shall be until death, retirement, incapacity, or grave fault.

11. That a fixed number of Fellowships, terminable with the office, shall be assigned to Professors.

12. That the Governing Body shall have the power of electing, without examination, to an occasional Fellowship, any person whom they desire to employ in the educational service of the College.

13. That the whole body of Fellows shall have a power to make formal representations to the Governing Body about important questions of policy or administration.

14. That the scope of studies in Trinity College might with advantage be widened in many directions.

15. That the public examinations in Trinity College are too numerous.

16. That the appointment to each of the more important professorships shall be made by an electoral Board selected from without as well as from within the College, the minor chairs to be filled by election by the Governing Body after receiving the recommendations of the respective Boards of Studies; that the tenure of professorships shall be until death, retirement, incapacity, or grave fault.

17. That, as regards the Medical School, effect shall be given to the agreement embodied in the Joint Statement of the Board of Trinity College and the President and Fellows of the College of Physicians, as submitted to the Commission.

18. That encouragement shall be afforded to research, and that special courses for degrees for research shall be established.

19. That the Governing Body, with the assent of a majority of the Fellows, shall have the power to make ordinances for the government of the College, subject to certain conditions.

20. That no candidate shall be admitted to graduation unless after study for some specified period within the College, or an equivalent attendance at lectures given by teachers recognised by the University.

The foregoing is a brief summary of the more important recommendations of the Commission. Some of them possess no special interest as such for medical men, whilst others are of considerable interest, and therefore we reproduce those portions of the Report on which these more interesting conclusions are based. With reference to the step to be taken to increase the usefulness of the College and University with reference to the religious difficulty, the Commissioners report as follows:—

"It will be convenient to state at once the principal schemes which have been suggested to us for the solution of the religious difficulty. They are:—

i. Such a modification of the constitution of Trinity College as shall make it satisfy the claims of the Roman Catholic Hierarchy.

ii. The establishment in the University of Dublin of a College which, whilst imposing no tests on the students or professors, shall yet be so constituted as to satisfy the Roman Catholic Episcopate that it created no danger to the faith or morals of the Roman Catholic students.

iii. The establishment within the University of Dublin of three or perhaps four addtional residential Colleges, namely, the Queen's Colleges at Belfast, Cork, and perhaps that at Galway, and a new College suitably equipped in Dublin without tests but intended to give adequate security against danger to the faith and morals of the Roman Catholic students.

iv. The establishment of a new University acceptable to Roman Catholics and with a similar constitution as to tests and the security of faith and morals, with or without the establishment of another University in Belfast.

v. The establishment in the Royal University reformed on the lines indicated in the report of the Commission of 1901, of a duly equipped College with the absence of all tests, but with the needful security as to faith and morals.

"We are unanimously of opinion that it is impossible to recommend any such changes in the constitution of the College as would render it acceptable to the Roman Catholic Episcopate. Inasmuch as the Standing Committee of the Roman Catholic Bishops in the document sent by them to us have assured us that the Catholics of Ireland "would on no account accept any scheme of mixed education in Trinity College, Dublin," we cannot hope to render the College acceptable to the Roman Catholic Episcopate by reasonable changes in its constitution. In the above conclusion the Commission are unanimous. The Bishops, in the document before mentioned have in fact disclaimed any desire on the part of the Roman Catholic people to have changes made in the constitution of the College for their sakes. Meanwhile there is a considerable body of Roman Catholic laymen in Ireland who would gladly send their sons to Trinity College if they could do so with the approbation of their Church; and their views have been presented to us in evidence.

"In particular we have very carefully considered certain proposals made by a group of Fellows and Professors in the hope of rendering the College more acceptable to Roman Catholics, but whilst we recognise the liberal and generous spirit which prompted the attempt, we are bound to say that at the present moment we cannot hope for a solution on these lines. We nevertheless think that it would be desirable that the College should continue to hold out the welcome which it extended by the resolutions of the Board of November, 1903, and that it should do so even more emphatically than it has already done; and for that purpose we *recommend* that there shall be included in the Statute or Charter regulating the future constitution of the College, express powers at any time to carry into effect the proposals made by the resolutions referred to, and to extend these or similar offers to the Methodists and other religious bodies in Ireland in addition to the Roman Catholics and Presbyterians; and also to make any arrangements which may render the College more acceptable to members of the Roman Catholic Faith who desire to enter within its walls.

"Many, or perhaps all, of these things may be within the powers of the College without further authorisation; but our suggestion is that the powers should be expressed in the constituent Charter or Statute by way of a permanent offer, of which, in the future, advantage may possibly be taken.

"On another point we are in practical agreement. Whatever may be said for or against the creation of a new University in Dublin acceptable to Roman Catholics, yet looking at the question as a practical one, we have the greatest doubts whether the creation of such a University would at present be feasible.

"If we thus lay aside the schemes for the entire modification of Trinity College and for the erection of a new University, we come to consider the creation of a new College and the three schemes which have that feature in common, and here we are not in agreement. Of the Commissioners, four (the Lord Chief Baron, Sir Thomas Raleigh, Dr. Douglas Hyde, and Dr. Coffey) are of opinion that the University of Dublin should be remodelled so as to contain five Colleges within it, viz., Trinity College, a College acceptable to Roman Catholic students in Dublin, and the three Queen's Colleges; one of the Commissioners (Professor Jackson) thinks that such a reconstruction of the University of Dublin would be the only satisfactory solution; but in view of the hostility of the Colleges concerned, is not prepared to recommend an immediate attempt to realise the scheme; three (Sir Edward Fry, Sir Arthur W. Rücker, and Mr. Butcher) think that in the circumstances the reconstruction of the Royal University so as to become a teaching University comprising four constituent Colleges, viz., a new College in Dublin acceptable to Roman Catholics and the three Queen's Colleges, would be the best solution of the difficulty, and that therefore no additional College should be introduced into the University of Dublin; and one (Mr. Kelleher) is of opinion that no new College should be created. Four Commissioners are therefore in favour of remodelling the University by the admission of additional Colleges and four are against it, and one, though in favour of it, does not recommend immediate action."

With reference to the Medical School, the Commission reports as follows:—

"Amongst the Professors of the School of Medicine are four King's Professors of the practice of Medicine, of Materia Medica and Pharmacy, of the Institutes of Medicine, and of Midwifery, respectively. These Professors are elected, not by the Board of Trinity College, but by the President and Fellows of the Royal College of Physicians of Ireland, and they each receive the sum of £100, Irish, or £92 6s. 2d., English, from the income of the estate of Sir Patrick Dun, of which the College of Physicians are the trustees. The will of Sir Patrick Dun was proved in 1713, and the foundation thereby created has been the subject of legislation by the Statutes of the 15th George II. (Ireland), 1741; the 25th George III., cap. 42 (Ireland), 1785; the 31st George III., c. 35 (Ireland), 1791; the 40th George III., c. 84 (Ireland), 1800; the 25th Vic., cap. 15, 1862; and the 30th Vic., cap. 9, 1867. The present position of matters in relation to Sir Patrick Dun's foundation is shortly as follows:—The College of Physicians are still the trustees of Sir Patrick Dun's estate and the electors to the four King's professorships in Trinity College; a hospital known as Sir Patrick Dun's Hospital has been erected and is maintained and managed by a body of Governors, and in this hospital clinical instruction is given by a staff of medical teachers. The estate of Sir Patrick Dun may be estimated to produce £1,000 a year: out of that sum the four King's Professors in Trinity College receive yearly £369 4s. The salary of librarian and clerk and other minor matters absorb a sum of over £100 a year, leaving about £500, which is paid to the Governors of Sir Patrick Dun's Hospital.

"The connection thus existing between these bodies—viz., Trinity College, the College of Physicians, and the Governors and staff of Sir Patrick Dun's Hospital, all more or less directly interested in the same estate, has not always been found to work smoothly, and a desire has for some time past arisen for the severance of the tie. In November, 1906, an agreement was arrived at by the two Colleges and the Governors of the Hospital, the terms of which will be found in the joint statement of the two Colleges. Under this agreement, if sanctioned by Parliament, the right and duty of electing to the King's professorships will be transferred from the College of Physicians to Trinity College; one-half of the estate of Sir Patrick Dun will be transferred to the Governors of the Hospital, a sum which will yearly produce £200 Irish will be transferred to Trinity College, and the residue of the estate will remain in the hands of the College of Physicians.

"We think that it will be very beneficial to the College to obtain the right of electing to the four King's professorships, and we are of opinion that the compromise arrived at by the two Colleges is upon the whole a wise one. We therefore *recommend* that the agreement embodied in the joint statement shall receive parliamentary sanction, and that so far as is necessary the existing legislation relative to Sir Patrick Dun's foundation shall be repealed."

(*Résumé to be concluded in our next.*)

CORONER MAITLAND AND HIS COURT.

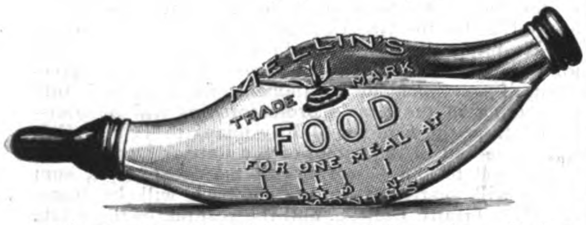
A resumed inquest was held on the 24th inst. at Normanton on the body of the illegitimate child of Annie Scruton, a single woman living at Bradford. The child was born at the home of a nurse at Southport, and died at Normanton Station on Christmas Day, seven days after its birth, as it was being conveyed to Bridlington by Mrs. Mary Ellen Robson, who had "adopted" it. The coroner, according to the newspaper report of the transactions, said the child's death was due to exposure caused by neglect." A witness stated that before the birth of the child arrangements had already been made for the "adoption" of the child *with a premium of* £10. In the report there is no evidence whatever that the child did die from exposure, and no evidence to prove that it did not die from poisoning. The coroner should have had proof before him that the death was not due to poison before he assumed that it was due to exposure, and to distribute censures in accordance with a bare assumption. The mere fact that £10 was given to the witness Robson to take charge of the infant permanently makes it look suspiciously like a baby farming case. How many children had Robson of her own, and how many had she "adopted" for £10 or for money at all before the present case? What more likely than that "something" was given to keep the infant quiet before its journey began, and that that something proved fatal? Was a *post-mortem* examination made with an analysis of the contents of the stomach? To talk of the child dying of exposure when "well wrapped up, fed, and well taken care of," as the doctor said, and carried in the woman's arms, getting warmth both from the arm around it and the body to which it was held, is nonsense; there must have been some other cause. Did the doctor express any opinions respecting the woman Robson? Whether he did or not, the coroner "entirely disagreed" with them.

As far as appearances go, the matter should not rest. There is a *prima facie* case for a further inquiry, not by the Society for the Protection of Children, but by the Home Secretary. The woman Robson has so far done well out of the transaction. She gets her money and has to give very little in return for it.

LABORATORY NOTES.

MELLIN'S FOOD—ITS ADMINISTRATION AND ITS COST.

Mellin's Food, like all other good things, is likely to fall into discredit unless used in the proper manner, and in order to do away with the gravest source of error in its administration, namely, the improper feeding-bottle, the firm have just brought out a special pattern which combines the best features of the latest bottles with some original ideas of their own. The bottle is roughly boat-shaped, with a rubber cork at one end and the teat at the other. It is so made that the bottle must be tilted up before the child can use it, and therefore milk and air cannot be sucked in together. At the far end of the bottle is a valve which prevents milk spilling, and only admits air when the milk is being sucked out. Of course, the whole bottle can be cleaned with the greatest facility. Messrs. Mellin, finding it persistently asserted that artificial foods are expensive, and that the cost of feeding a child with them is too much for the poor, have drawn up a leaflet, comparing the cost of feeding a child on Mellin's Food, combined with milk in due proportion, with that of feeding one on "municipal milk" alone. This shows that only in the third month do the figures approximate, the advantage up till then being decidedly in favour of Messrs. Mellin. They point out, moreover, that Mellin's Food not only enriches but also modifies cow's milk till it becomes closely analogous to human milk, whereas municipal milk is only modified by sterilisation and the addition of extra ingredients, such as lactose, salt, lime-water, or sugar.



NEW TABLOIDS.

A new "Tabloid," brought to our notice by Messrs. Burroughs and Wellcome, is "Xaxa," a name adopted to designate their preparation of acetyl-salicylic acid. This drug has already attained some reputation as a substitute for salicylic acid and its salts, and it is said to be equally effective with them in the treatment of gout, rheumatism, and allied affections, without possessing unpleasant after-effects. "Xaxa" contains no free salicylic acid, and beside the ordinary range of usefulness of the salicylates it has been found useful in neuralgia, glycosuria, and the pains of tabes.

We tried it in a recent case of influenza, in which the patient complained of severe pain in every joint. In this there was undoubtedly latent rheumatoid arthritis and the value of this tabloid was at once apparent.

Another useful "Tabloid" is Eucaine Lactate. It seems probable that the lactate will eventually supersede the hydrochloride in minor surgery, as it is readily soluble, non-irritating, and staple in solution.

A NEW PURGATIVE WATER.

Villacabras is a new purgative water, whose chief constitutent is sulphate of soda. It comes from the Chinchon district of Spain, and it is claimed that it does not possess so bitter a flavour as other waters. Owing to filtration according to the Pasteur system before bottling, the sulphureous smell which is the principal objection to waters of this class is eliminated, and the dose required is smaller than with the majority of purgative waters.

Medical News in Brief.

Annual Dinner of the British Gynæcological Society.

After some twenty-one years of existence, the British Gynæcological Society is about to merge its separate existence by amalgamating with the Obstetrical Society. This fact made the recent annual dinner on January 17th an occasion of unusual interest, as being probably the last to be held by the Society. The Chair was occupied by the President, Mr. F. Bowreman Jessett. Mr. Henry Morris, President of the Royal College of Surgeons, responded for that body to the toast proposed by Mr. W. D. Spanton. The toast of the Society was proposed by Dr. F. H. Champneys, who maintained there could be no serious opposition to the amalgamated societies. The Obstetrical Society was eloquently proposed by Dr. Macnaughton-Jones, and other able and interesting speeches were contributed by Dr. H. R. Spenser, Dr. Clement Godson, Director-General Ellis, R.N., Surgeon-General Sir Thomas Gallwey, A.M.S., and others. An excellent musical entertainment was provided, and the whole affair reflects great credit upon the honorary secretary, Mr. H. Overy.

Motor Omnibuses and Other Street Noises.

An influential deputation waited on Mr. Gladstone at the Home Office on Thursday last (among whom were several representative members of the medical profession), for the purpose of seeking an abatement of street noises in London and other large cities. The principal points put before the Home Secretary referred to (1) *Motor Omnibuses and Traction Engines.* The noise, speed, weight, smell, and danger from skidding and careless driving of these vehicles, and the absence of police powers to define routes and regulate the hours of running; the damage to property caused by vibration and the necessity of the police having power to proceed against offenders. (2) *Organs and Street Cries.* Mr. Gladstone stated in his reply that he fully admitted the desirability of abating the nuisances complained of, and promised that no effort should be spared to bring about the needed reform.

Royal College of Surgeons in Ireland.

The annual dinner of the Royal College of Surgeons was given on Saturday evening in the Examination Hall of the College, and was honoured by the presence of His Excellency the Lord Lieutenant. The Honorary Fellowship of the College was conferred on Mr. Priestley Smith, Professor of Ophthalmology in the University of Birmingham, before dinner. Amongst the after-dinner speakers were the Lord Lieutenant, the President, R.S.I., the President, R.C.P.I., Lord Grenfell, Commander of the Forces in Ireland, and the Attorney-General. We regret that owing to the pressure on our space, caused by the University Report, we are unable to notice the proceedings at greater length.

Action Regarding the Sale of a Medical Practice.

A CURIOUS action between two medical men relative to the sale of a practice was heard in the London courts, when Dr. Francis Whitaker sued Dr. Charles Harold Walker M'Cullagh, to recover £325, balance of the agreed price of a medical practice in the Hornsey road, which plaintiff sold to the defendant. There was a counterclaim for alleged slander. From the statement of counsel for the defence it appears that the plaintiff had sold his practice and joined a Religious Order in Ireland. The defendant had been attached to a North-West London hospital for ten years. In 1905, in reply to an advertisement, he saw Dr. Whitaker with regard to his practice, and ultimately bought it

Dr. Francis Whitaker, the plaintiff, said that he himself worked up the business in Hornsey. In May, 1905, he decided to join a religious order in Ireland, and determined to sell his practice, which brought in about £780 a year, excluding the appointment of St. Pelagius' Home. He told Dr. M'Cullagh that if he took the practice it would probably decline at first to £500 a year, and he agreed to sell it to the defendant for £650, a reduction of £100 on the price first asked. Witness said he did all he could to secure for defendant the various appointments he had held.

The jury found for the plaintiff on the claim and the counterclaim.

The Derbyshire Parliamentary Vacancy.

Dr. J. Court, undaunted by the three defeats he has sustained in the constituency, is to stand as Conservative candidate for North-East Derbyshire, and intends to make another bid for victory. He has lived and worked in that mining district for the greater part of his life, and has carefully studied the diseases peculiar to miners. On these and other grounds the miners have high appreciation of his work. Dr. Court is an honorary member of the Derbyshire Miners' Association, and consulting surgeon for that body in arbitration cases. He was born in Warwick in 1841, and his early studies were at the King Henry VIII. School in that town, and subsequently his medical course was continued at Guy's Hospital. Dr. Court's connection with Derbyshire dates back to 1864, when he commenced to practise at Staveley, at which place he has since resided. He is a licentiate of the Royal College of Physicians, and a member of the Royal College of Surgeons.

Sickness on Board Ship.—Failure to Report.

At a meeting of the Manchester Port Sanitary Authority recently, a long discussion took place in connection with a steamer at the Salford docks. A sailor who had left the vessel at Salford was found five days later to be ill, and nine days from leaving the vessel he was removed to the Ladywell Sanatorium suffering from typhoid fever. The inspector to the authority had gone over the vessel in port, and had received no information of sickness on board. The captain, written to subsequently, said the man left the ship well, and rode home on his bicycle. Dr. Dearden, medical officer to the authority, mentioned a worse case which had recently occurred, and said it was regrettable that captains were not bound to report sickness. In his monthly report Dr. Dearden stated that he was endeavouring to devise a scheme for obtaining notification of all cases of sickness of whatever nature, and added: "The slackness which exists among ships' officers on so serious a matter as proper investigation into the nature of sickness before anyone affected can leave the vessel is lamentable. In the interests of the public it is highly important that this state of affairs should be remedied." Several members expressed the opinion that in bad cases a notification should be sent to the port for which the vessel had left that the particular vessel had had on board a case of infectious disease. An arrangement for the interchange of information on these lines was suggested as a partial remedy.

A State Medical Service for Ireland.

THE Leinster Branch of the British Medical Association at its last meeting adopted the following resolution proposed by Dr. James Craig, and seconded by Sir J. W. Moore:—"That the Dublin Division of the Leinster Branch of the British Medical Association offers its congratulations to the members of the Viceregal Commission on the Irish Poor-law system on the ability and care displayed in the drafting of this report, the suggestions of which are made in a broad and statesmanlike manner, and that the Dublin Division heartily approves the formation of a properly remunerated State Medical Service of the entire Poor-law Medical Service, as it is certain to be a distinct advantage to the treatment of the sick poor in Ireland." The Central Council of the British Medical Association also adopted a somewhat similarly worded resolution.

Royal College of Physicians and Surgeons, England.

The following candidates passed the second professional examination in anatomy and physiology, held on the 3rd to the 8th January, by the Conjoint Board, viz.:—

Guy Oldham Chambers, John Joseph Clake, William Thomas Clarke, Henry Gray Woodhouse Dawson, Henzell Howard Dummere, Frederick Dunphy, Edwin Charles East, Alfred James Graves, Geoffrey Richard Heard, Gilbert Percy Humphrv, Roger Percival Jones, Fritz Kahlenberg, James Arthur Richard Lee, Charles Eric Lowe, Alexander Ernest McKenzie, John Charsley Mackwood, John Mitchell Mehaffey, Douglas Ashley Mitchell, Leonard William Mortimer, Humphrey Neame, Richard Alfred Parsons, Richard Biddulph Phillipps, Edward Holmes Rainey, Harold Thwaite, Francis Christopher Tibbs, George Ernest Vilvandré, John Glegg Watson, Charles FitzGerald Willes, Sydney Williams, Charles Stewart Wink, Duncan Wood, and Charles Reynolds Woodruff.

Conjoint Examinations in Ireland.

THE following candidates have passed the First Professional Examination:—J. H. Barry, J. Boyce, H. J. Burke, P. J. Burke, F. Cassidy, Miss M. M. S. Coghlan, J. J. Foran, R. A. W. Ford, P. Grace, H. A. Harbison, C. Lenahan, H. C. Smyth,

The following have passed the Second Professional Examination:—E. A. Gregg (with honours), R. Charles, T. M. Duncan, J. W. Flood, A. E. Moore, W. Mulcahy, T. McDonald, W. P. H. Parker, C. O'B. Ryan, D. K. Seaver, O. H. Woods.

The following have passed the Third Professional Examination:—P. H. Black, R. J. Bonis, F. Byrne, A. Curry, H. E. Davis, M. B. Dooley, P. A. Doyle, J. J. Dwyer, J. A. J. Flannery, G. A. Finegan, P. Harrington, M. J. Hawkshaw, P. Maguire, A. E. S. Martin, P. McCarthy, D. McCormack, P. J. Timoney, E. C. Wallace, J. F. Walsh, A. Warnock.

Society of Apothecaries, London.

THE following candidates, having passed the necessary examinations, have received the L.S.A. Diploma of the Society, entitling them to practise medicine, surgery, and midwifery: O. P. N. Pearn and D. E. C. Pottinger.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

Chylous Dropsy.—Sonmer (*Deut. Arch. Klin. Med. Leipsig*, 1906) relates a case of profuse milky effusion requiring repeated tapping in a woman of 51. A carcinoma was found in the ovary, and, in the apparently intact walls of the thoracic duct, nests of cancer cells were found, explaining the permeability. D.

Coagulating Power of Blood Serum in Epileptics.—Besta's researches (*Riforma Med. Naples*) confirm those of Ceni in regard to the specific modification of the composition of the blood in epileptics. The modification seems to be constant in the individual, not varying with the seizures, consequently the latter cannot be regarded as the explosive throwing oft of morbid products. The proportion of fibrin ferment in the blood is much below normal, according to his experience, and as the fibrin ferment is an organic compound of lime, it follows, he thinks, that the epileptic may be suffering from a lack of lime. D.

Differential Diagnosis of the Diseases Hitherto Grouped Together as Rheumatoid Arthritis.—Nathan (*Am. Journal of the Medical Sciences*, Dec., 1906) divides diseases hitherto grouped under the name of rheumatoid arthritis into two classes—(1) those which begin acutely, the inflammatory or infectious forms; and (2) those of insidious onset, the trophic forms. Of the first class he describes four types of cases—(1) mild cases, which, however, may lead to some permanent disability; (2) similar cases with more fever and more severe joint symptoms, some with glandular enlargement described as Stell's disease; (3) cases simulating rheumatism, with high fever and often endocardial and renal complications, leaving permanent joint disability; and (4) cases associated with other infectious diseases, such as typhoid and gonorrhœa. D.

The Rôle of Nuclein in the Animal Economy.—McCaskey (*Journal of the American Assoc.*, Dec., 1906) has determined the amounts of uric acid and of phosphoric acid in the urine of a large number of patients, in an attempt to measure roughly the amount of nucleins represented by these substances, which are their cleavage products. The nucleins of the body are widely distributed, but occur especially in the nuclei of the cells. They are of interest for their own properties, and as antecedents of the purin bodies, including uric acid. The nucleins have some germicidal power; they may be active in bacteriolysis and in production of phagocytosis; the toxins of diphtheria and tetanus are precipitated by nucleinic acid. Uric acid is not toxic, causing symptoms only as a mechanical irritant when precipitated. The results of the analyses are tabulated. The excretion of uric acid (and presumably of other purin bodies) was most strikingly increased in Bright's disease. D.

Cirrhosis of the Pancreas.—Schmieden (*Mun. Med. Woch.*, 1906) reports a case of cirrhosis of the pancreas causing puzzling symptoms and leading to great debility. An exploratory laparotomy cleared up the diagnosis and allowed appropriate treatment, which restored the patient to health. The patient was a woman, æt. 24, with healthy children. A painful knobby tumour corresponding to the head of the pancreas was accompanied by typical pancreas colic and pronounced delay in the glutoid test. Three weeks after the birth of the last child the first attack of colic came on; the pain was more in the median line than in case of gallstone colic, and radiated in the back to the shoulder, especially on the right side, with paroxysmal sweating. The patient could not bear to have her clothes buttoned, and frequently was obliged to stay in bed for a day or so, and was unable to stoop. The pains had no connection with the taking of food, but vomiting occurred two or three times a day, free from blood. The response to Sahli's glutoid capsules did not appear for 21 hours, showing abnormal delay. There was no fever; neither was there albumen or sugar in the urine. The pancreas was found knobby and enlarged, and embedded in old leathery adhesions. A wedge-shaped piece was cut out of the head of the pancreas and abdomen closed. No evidence of fat necrosis was disclosed. The patient was treated with a pancreatic preparation and potassium iodide, and recovered completely. The microscope revealed typical severe cirrhosis of the pancreas, free from any tendency to tumour formation. Another woman presented absolutely the same clinical picture, only the cachexia was less marked, but the microscope revealed alveolar carcinoma. D.

The Paravertebral Triangle of Dulness in Pleural Effusion.—Thayer and Fabyan (*Amer. Journ. Med. Scien.*, January, 1907) discuss the value of this sign in the diagnosis of pleural effusion. The sign was originally described by Grocco in 1902, and has been since accepted by the majority of writers on the subject as one of considerable value. The writers of the present paper have made a special examination of it in thirty-two cases of pleural effusion, and find the sign practically constant in cases where there is free fluid in the pleural cavity. This triangle is an area of relative dulness, the vertical side of which is represented by the line of the spines of the vertebræ, the apex reaching a point somewhat above the level of flatness of the effusion; the base is formed by the lower limit of pulmonary resonance on the healthy side for a distance of from 2 to 7 cm. from the spine; the hypothenuse by a line connecting these points. The last line shows sometimes a slight outward convexity, and the dulness is more marked as one approaches the spine. The dulness disappears, or becomes markedly less, if the patient lies on the affected side, but returns again when the erect posture is assumed, or when the patient lies on the other side. The triangle is usually larger on the left side—that is, in the case of right-sided effusions—than on the right. The authors are inclined to accept the explanation given of the phenomenon by Baduel and Siciliano, namely, "that the fluid lying against and passing anteriorly over the bodies of the vertebræ acts as a mute in suppressing the sonorous vibrations of the spine." Very rarely has anything in the nature of a paravertebral triangle of dulness been demonstrated in cases of consolidation of the lung, and in the rare instances in which it was found little or no change could be demonstrated in it on change in position of the patient. K.

Treatment of Scabies with Balsam of Peru.—Robinson (*R.A.M.C. Journal*, January, 1907) reports the results of the treatment of thirty-seven patients as recommended by the "Third Report of the Advisory Board for Army Medical Services." Colonel Robinson has made some alterations in the method of treatment suggested by the report. The patient on admission to hospital is given a hot bath and thoroughly scrubbed with soap and water. He is then quickly dried, and at once rubbed over with the following preparation:—Balsam of Peru, three parts, and glycerine, one part. The balsam is applied to the whole body "with an old nail-brush, soft from long usage, and well rubbed into the flexures and crevices of the skin. He dresses in clean clothes, and remains in hospital till his bedding and clothing are disinfected (usually three days); he is then discharged, to attend once a week for a month at the hospital for observation." "The patient should not be allowed to bathe till four weeks have elapsed, *i.e.*, until he is free from all danger of relapse. Should there be any subsequent return of the itching, which is unusual, the man is detained for a day, bathed, and has a further application of the balsam to the itchy parts." The three most important points in the treatment are thorough scrubbing in the bath, thorough application of the preparation immediately after the patient is dried, and complete abstinence from baths for four weeks after the first application. It was through neglect of the last of these rules that many of the earlier cases treated proved unsatisfactory, and since it has been rigidly enforced the results have been uniformly good. In no case was any subsequent dermatitis met with. K.

Adams-Stokes Disease.—Ashton, Norris, and Lavenson (*Amer. Journ. Med. Scien.*, January, 1907) report the case of a patient who died in hospital from this disease, and in whose heart on *post-mortem* examination a gumma was found in the interventricular septum. The patient was a man, æt. 30 years, who gave no history, and showed no signs of syphilis. His cardiac symptoms dated from four days before admission to hospital, when he became unconscious in a tramcar, and during the next few days he had similar attacks. On admission to hospital his heart was found to be enlarged, his apex beat diffuse, first sound feeble and accompanied by a systolic murmur. The pulse rate was 48 per minute. While in hospital he had numerous attacks of syncope, during which his pulse rate was generally about eighteen per minute, increasing at frequent intervals to thirty. During one of these attacks, which occurred about three weeks after the onset of the disease, he died. On *post-mortem* examination some thickening of the mitral valve was found, and on histological investigation a gumma was found in the interventricular septum, which in one part completely interrupted the auriculoventricular bundle of His. K.

Aristochin.—Giordani (*Gaz. Internat. di Med.*, Bd. viii., April, 1906) has made use of Aristochin in an epidemic of whooping-cough, and also in malaria and other febrile diseases, with the object of determining its value as an anti-pyretic. Altogether he employed it in about 60 cases. He finds that, on account of its absence of taste, it is well and easily taken, and that it possesses the specific action of quinine on the plasmodium malariæ. It also acts well as an anti-pyretic and anti-neuralgic, while in pertussis the results were very encouraging, and in many cases a favourable influence in the course of the disease was plainly marked. The drug, which is a carbonic acid ester of quinine, was given in powder, or else suspended in milk, the dose being from .2 to .1 gramme in the 24 hours, according to the age of the patient and the severity of the case. M.

Phillippovich's Phenomenon in Typhoid Fever.—The symptom which has been described by Phillipovich as pathognomonic of typhoid fever consists of a peculiar yellow colouring of the palms of the hands and soles of the feet, such as would be produced by rubbing them with potassium nitrate and picric acid. The symptom has been observed also by French writers as being frequently present in typhoid, and some regard it as being produced by some alteration of tissue metabolism brought about by a specific toxin. Other authors, however, deny its importance as a diagnostic sign, and maintain that it may be observed in many other acute infections. They regard it as being merely the result of an excessive destruction of blood-pigment. Minuotti (*Gazz. degli ospedali*, 1906, No. 36) has lately observed the phenomenon in a typhoid patient in whom it appeared, along with severe pains in the hands and feet. Both pain and discoloration disappeared at the same time, from which fact the suggestion is made that possibly both were the result of a toxin acting both on the ordinary tissues and on the sensory nerves. M.

Myositis in Typhoid Fever.—Michalke (*Med. Klinik*, 1906, No. 34) observed during the convalescence of a typhoid fever case a rise of temperature with rigors on three distinct occasions. The first time there was great swelling and pain in the left leg; the second time there was pain and cramp in the right thigh, and on the third occasion the right leg was similarly affected. On each occasion the neighbouring chains of lymph glands became swollen and tender, and the leucocytes, which are normally lessened in typhoid fever, became increased in number. All this appeared to the writer to point to inflammatory processes in the muscles, and of a non-purulent nature, inasmuch as recovery took place in a few days. Such a non-purulent myositis must be rare, as a sequel to enteric fever, since no records of such can be found in the literature. M.

Heart Massage in Cases of Apparent Sudden Death.—Dr. T. A. Green (*Lancet*, Dec. 22nd, 1906) contributes an interesting paper on this subject, and gives an analysis of 40 cases in which heart massage was attempted, as well as describing in detail two cases of his own. The method had principally been employed for cardiac syncope under anæsthetics, especially in chloroform cases, but has also been occasionally tried in hanging cases, syncope in diphtheria, death from electric shock, and in brain injuries. In his own first case a trivial operation was being performed on a child aged 9, chloroform being administered. Syncope suddenly took place, and as other means failed to restore the heart action, the abdomen was opened 25 minutes after the accident, and direct massage of the heart was carried out through the diaphragm. Soon both cardiac and respiratory action became re-established, and the patient was brought back to bed in an unconscious condition, but with strongly-acting heart. Toxic spasms set in a little later, and returned in spite of treatment, the patient finally dying 20 hours after the restoration of heart-beat. Dr. Green's second case was one of sudden post-diphtheric syncope. Heart action was restored by the massage, but the respiratory rhythm did not become re-established, and so the effort to revive the patient failed. Out of the 40 cases analysed, a partial success was gained in eight, the longest time of survival being 24 hours, and the longest period of cessation of heart-beat prior to massage being 45 minutes. The writer, though not very enthusiastic, thinks that there is a future for this treatment in desperate cases, and gives the outline of a definite method of procedure which he intends in future to adopt. M.

Epigastric Pain in Emphysema and in Heart Disease.—De Brun writes (*Rev. de Méd.*, 1905, p. 981), on the occurrence of epigastric pain in pulmonary emphysema. He points out that it is very frequently present in a more or less severe form, and out of fifty cases it was so bad in five as to simulate gastric ulcer, biliary colic, and other severe abdominal conditions. It is usually situated in the middle line at the tip of the ensiform cartilage, sometimes a little higher, and more frequently at a lower level and to the left. As a rule, it is definitely circumscribed, is nearly always continuous, and tends to be worse at night. It is increased by movement, and pressure may cause it to become almost unbearable. The pain may be present quite early, and indeed is not uncommonly the earliest subjective sign of emphysema. It in no way depends on the condition of the stomach or its blood supply, and can be distinguished from colic due to arteriosclerosis by the fact that this last-named pain is not made worse by pressure. A similar pain is present when the right ventricle is over-distended, and is thus often seen in mitral disease with failing compensation. M.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber." "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

L. N.—Poisoning symptoms have been noted from the use of sesame oil as an enema, but further investigation seems to point to the oil from French sources being at fault. The German oil is said to be harmless.

PREVENT.—In America the matter has attracted more notice than here, and the Vermont State Board of Health last year issued to each medical practitioner in the State a packet of leaflets containing directions for the avoidance of the spread of syphilitic infection. They asked that these might be given by the doctors to all their syphilitic patients.

WHY DOCTORS STARVE.

A TIVERTON Guardian on one occasion expressed a public hope that the doctors "will write more plainly this year, whereupon the *Daily News* published the following verses:—

Dear Doctor,—If it's not too late
To frame a New Year's vow,
Accept this copy book and slate,
And bring your pot-hooks up to date
Deliberately now.

Poor Tom is raving with the pain
Your last prescription gave;
The lotion mixed for Teddy's blain
Has brought his earache on again;
The pills have crippled Dave.

How small your yearly total sounds!
I send remittance due.
Please say when next upon your rounds
If it is two or twenty pounds—
I've made it out for two.—A. W.

MERROW.—"Barlow's Disease" is the same as "infantile scorbutus." It is disputed as to whether there is any necessary connection between Barlow's disease and rickets, the change it is said being in the lymphoid marrow, which is atrophied.

DR. P. N.—The operation has been described several times in the last few years in our "Operating Theatres," and you will glean most of the information you require if you run your eye over the cases described therein. The question as to whether a patient is a fit subject for removal of the prostate involves many considerations, for apart from his general health it is well to be assured as to the character of the prostatic enlargement. If on bimanual examination a moderately large growth projecting towards the interior of the bladder and freely movable is felt, the operation is generally indicated.

"MORE LIGHT."—Red light has been tried in scarlet fever as well as in small-pox. It is said that by excluding all light except red from the patient's room night and day the fever and rash are averted, but complications are not affected. The results as reported, however, do not carry much conviction to our mind.

SESTOS.—We do not know the brand of whisky named, nor can we trace any reference to it. The distillers will probably reply if you write to them and say whether it is a pot-still whisky or a blend.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 30th.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5.30 p.m.: Discussion on the Influence of Climate upon Gout, Rheumatism, and Rheumatoid Arthritis (introduced by Dr. C. W. Buckley (Buxton). Dr. J. Groves (Isle of Wight), Dr. H. Cumming (Torquay), Dr. P. Lewis (Folkestone) and others hope to take part in the discussion.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. P. L. Daniel: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. H. L. Jones: Cervical Ribs and Muscular Atrophy of the Hands (with lantern slides).

NORTH EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Dermatological (Dr. Meachen), Ophthalmological (Mr. Brooks), Medical Out-patient (Dr. Whipham). Lecture:—Mr. R. P. Brooks: Ocular Headaches.

THURSDAY, JANUARY 31st.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m.: Card Specimens. 8.30 p.m.: Papers:—Mr. S. Snell: (1) A Case of Tubercle of the Eyeball in which the Opsonic Index was regularly taken; (2) A Family Tree of Nyctalopia. Mr. A. Lawson: Two Cases of Streptococcic Infection of the Conjunctiva. Mr. G. B. James: Some Notes on Stereoscopic Vision.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Mr. L. Mummery: Rectal Hæmorrhage, its Causation and Treatment.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles), Cliniques:—Medical (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Clinique:—Medical In-patient (Dr. Chappel). 4.30 p.m.: Lecture:—Dr. Macdonald: The Pathology of the Pneumonias.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Treatment (Constitutional and Local in all its Forms).

FRIDAY, FEBUARY 1st.

SOCIETY OF ANÆSTHETISTS (20 Hanover Square, W.).—8.30 p.m.: Paper: Dr. L. Guthrie: Poisonous After-effects of Chloroform and of Ether.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. D. Grant: Clinique. (Ear).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m. Surgical Operations (Mr. Edmunds). Clinique. Medical Out-patient (Dr. Auld), Ophthalmological (Mr. Brooks), 3 p.m. Clinique. Medical In-patient (Dr. Leslie).

Vacancies.

West Riding Asylum, Menston, near Leeds.—Second Assistant Medical Officer. Salary £200 per annum, with board and apartments. Applications to the Medical Superintendent.

West Riding Asylum, Menston, near Leeds.—Fourth Assistant Medical Officer. Salary £150 per annum, with board and apartments. Applications to the Medical Superintendent.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Resident Medical Officer. Salary £100 per annum, with board, residence, and laundry. Applications to W. M. Wilcox, Secretary.

Stroud General Hospital.—House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the Hon. Secretary.

Newcastle-upon-Tyne and Northumberland Sanatorium for Consumption, Barrasford-on-Tyne.—Resident Medical Officer. Salary £180 per annum, with board and laundry. Applications to Secretary, 13 Grey Street, Newcastle-upon-Tyne.

North Lonsdale Hospital, Barrow-in-Furness.—House Surgeon. Salary £100 per annum, with board and lodgings. Applications to Secretary. North Lonsdale Hospital, Barrow-in-Furness.

King Edward VII. Sanatorium, Midhurst, Sussex.—Junior Assistant Medical Officer. Salary £100 per annum, with board, lodging, and attendance. Applications to the Hon. Secretary, 19 Devonshire Street, Portland Place, London, W.

The Royal Hospital for Diseases of the Chest, City Road, E.C.—Resident Medical Officer. Salary £120 per annum, with furnished apartments, board, and washing, Applications to the Secretary.

Newport Borough Asylum, Caerleon, Mon.—Assistant Medical Officer. Salary £170 per annum, with board, apartments, and attendance. Applications to the Medical Superintendent.

Royal Cornwall Infirmary, Truro.—House Surgeon. Salary £100 per annum, with board and apartments. Applications to J. C. R. Crewes, 4 Parkvedras Terrace, Truro.

Monaghan Asylum.—Resident Medical Superintendent. Salary £500 per annum, with house, fuel, &c. Applications to R. L. Donaldson, Acting R.M.S.

Appointments.

HOSFORD, J. STROUD, F.R.C.S.Edin., Honorary Assistant Surgeon to the Royal Eye Hospital, Southwark.

MARKS, URBAN, M.R.C.S., L.R.C.P.Lond., House Physician at the Worcester Infirmary.

POLLARD, G. S., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Midsomer Norton District of the county of Somerset.

ROSS, S. J., M.D.Vict., Certifying Surgeon under the Factory and Workshop Act for the Bedford District of the county of Bedford.

WATKIN, ARTHUR CHRISTOPHER, L.R.C.P.Lond., M.R.C.S., House Surgeon at the Aberystwyth Infirmary.

YOUNG, J. STIRLING, M.B., Ch.B.Vict., Fourth House Surgeon at St. Mary's Hospitals, Manchester.

Births.

COOKE.—On Jan. 26th, at 69 Bridge Street, Cambridge, the wife of Arthur Cooke, F.R.C.S., of a son.

ELLIS.—On Jan. 23rd, at 208 London Road, Leicester, the wife of L. Erasmus Ellis, M.D., of a son.

GILBERTSON.—On Jan. 25th, at Southbourne Lodge, Southampton, Hants, the wife of William Gibertson, M.A., M.D., of a son.

ROGERS.—On Jan. 24th, at 28 Sutherland Avenue, London, the wife of David de Sola Cohen Rogers, L.D.S., R.C.S.Eng., of Buenos Ayres, of a son.

Marriages.

AVELING—SHIMWELL.—On Jan. 23rd, at St. Wilfrid's Church, Northenden, Leslie Baldwin Aveling, B.A., M.B., B.C., of Royton, son of the Rev. F. W. Aveling, M.A., B.Sc., of Blackheath, London, to Dorothy, second daughter of W. J. Shimwell, of Gatley, Cheshire.

CARBERY—HUTTON.—On Jan. 23rd, at Bath, Staff-Surgeon E. O. B. Carbery, R.N., son of the late Edward Spencer Carbery, to Amy Muriel, elder daugher of Thomas Hutton.

JEANS—BARRY.—On Jan. 24th, at St. Luke's Church, Liverpool, Frank A. Gallon Jeans, M.A., M.B.Cantab., son of A. G. Jeans, of Birkenhead, to Eveline, second daughter of the late Garrett J. Barry, of Liverpool, and of Mrs. Barry, Rockferry.

Deaths.

OLDHAM.—On Jan. 24th, at 38 Brunswick Square, Brighton, Charles James Oldham, F.R.C.S., eldest son of the late James Oldham, of Brighton, aged 62.

SPENCE.—On Jan. 25th, John Utley Spence, 50 Rosendale Road, West Dulwich, eldest son of the late John Spence, M.R.C.S., L.R.C.P., Bedale, Yorks.

PURLEY, SURREY.

A road has now been made through that little piece of the old forest lands of Surrey known as THE FURZES, which offers the unusual opportunity of erecting a new house in an old garden; the land is about 400ft. above sea level, with a gentle South slope: and only ten minutes from the station; detached houses of approved design to be erected on not less than one acre each: the road has kerb, channel, sewer, S.W. drain, gas and water mains, and is considered to be not only the prettiest but the best made in the neighbourhood.—Plan and particulars may be obtained of Mr. Winborn. Furze Lane, Purley.

TO YOUNG MEDICAL MEN.—Splendid opening for Dispensary Practice. Populous suburb S.E. Double-fronted detached house, corner of two roads, everyconvenience, for sale £75 cash, balance could remain at 5 per cent. 71 years lease, low ground rent. (Sold by order of administrator.)—Apply Hatch and Hatch, 62 Rushey Green, Catford.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, FEBRUARY 6, 1907. No. 6

NOTES AND COMMENTS.

Non-Professional Attendance.

JUDGE O'CONNOR, of the Sunderland County Court, has ideas about professional attendance on the sick which suggest the conundrum : When is medical attendance not medical attendance ? The answer would seem to be : When the doctor expects a fee. The other day, in Sunderland, Dr. Cunningham was summoned by the foreman of Messrs. Greenwell and Co., ship repairers, to attend to a workman who had a fit. The summons was duly observed, and Dr. Cunningham did all there was to do for the patient, eventually putting him on a stretcher and conveying him from the ship's hold to a cab. When the question of a fee was raised in due course, the firm, with that despicable meanness which characterises the relations of many large trading concerns towards medical men, refused to recognise the obligation. Dr. Cunningham stood by his rights so far as to sue Messrs. Greenwell and Co. in the County Court for a guinea for the services he had rendered. The judge, however, would not hear of the claim. What Dr. Cunningham had done, he said, was the sort of thing that nurses, policemen, and ordinary pedestrians did ; it was not professional attendance. He would give judgment for the defendants with costs. Are we to conclude, then, that the law of the land does not recognise a doctor's services in an emergency as "professional," because doctors have taught lay people how to render first aid ? Would the learned judge decline to receive his salary because medical men, journalists, and other non-legal folk also consider themselves capable of forming a rational judgment ? Whether he would or not, we may be allowed to state that in our judgment his decision is a preposterous one, and that the country pay handsome salaries to County Court judges in order to get good judicial work from them, and not pettifogging quibbles of the Stareleigh order.

One Stroke, One Orange.

THE stand which the MEDICAL PRESS AND CIRCULAR always takes against stupid punishments and other relics of barbarism in the treatment of prisoners, has brought us some notes from a correspondent about the flogging of boys by magistrates' orders. It may well be that, in time to come, when humanitarianism and discretion have permeated our modes of punishment, flogging may be altogether abolished, but it would require more boldness than we possess to say that whipping young boys can be entirely done away with. Indeed, as a means of correction we greatly prefer a few strokes of the birch, especially applied by the offender's father, to the stupidity of imprisonment or the ineffectiveness of a fine. In one of the cases brought to our notice a lad, aged ten, was charged before the magistrate with stealing oranges, and he was ordered a stroke of the birch for each orange stolen. That seems a fair compromise, especially as the prosecutor allowed the oranges to be retained to efface the smarting of the rod. The point that we would make ourselves is the positive wickedness of bringing a child of such tender years into contact with the police-court and its associations for an offence so puerile. Indeed, if the prosecutor could have been ordered three strokes for each given to the boy, justice would have vindicated its character for evenhandedness more completely.

Bipolar Version.

The solicitude of the State for the protection of the midwife is almost as marked a feature of its policy as its airy neglect of the public interest in every other medical and quasi-medical respect. At Mansfield, the other day, a woman who had practised as a midwife for twenty years, and was known to the authorities as a clean and respectable person, was prosecuted by the County Council for calling herself a midwife when she was not on the roll, and in the end a conviction, with a fine, was obtained. The woman seems to have been a very favourable specimen of her class ; she had attended some four or five thousand cases of midwifery in her time, had testimonials and certificates from medical men in the town, and had applied not only for admission to the register, but also for leave to attend midwifery lectures in the town. She was refused registration twice, although she was entitled to it under the Act, because, owing to a misunderstanding on her part, she applied too late, and she was refused admission to the qualifying county lectures for the paradoxical reason that she was not qualified. To ring down a successful curtain on this delightfully Gilbertian situation, she was prosecuted by the county authorities. So the unfortunate woman was had every way. The principle of "Heads I win, tails you lose" should now be clear to her unsophisticated brain, and doubtless if she is sufficiently educated to read a text-book on midwifery, bipolar version will acquire new meanings for her.

Aerated Milk. The problem of keeping milk for infant use at once fresh and sterile has racked many brains of late, but a Mr. Randolph Hemming has, it is claimed, solved it at last. By a process of his own devising he can so introduce carbonic acid gas into milk that bacteria are destroyed, and the milk is preserved in all its pristine and nutritious vigour. Milk, like champagne and soda-water, can be ordered in by the dozen, and the joys of aërated beverages are no longer to be reserved till puberty, when lemonade is acceptable, or manhood, when nothing with a sparkle comes amiss, is reached. From the moment of entering the world, the young human will be accustomed to the joys that accompany the stimulation of the gastric mucosa with bubbles of gas, and the popping of the cork will cheer him in the nursery even more frequently than it does his sire in the dining-room. To every advance in science there are corresponding drawbacks, and we fear there are selfish persons who will be inclined to resent even this boon if their sleep is to be disturbed on warm nights by the violence of starting corks and the domestic catastrophes that accompany them. The present troubles from "wind in the stomach" are likely, we should judge, to be nothing to what this vista opens out before us.

"Slink" Meat. Our contemporary, the *Manchester Evening Chronicle*, deserves much congratulation for the success that has attended its revelations on the "slink" meat trade. One of the results of its *expose* is that two Gorton butchers have been detected in their operations and sent to gaol. The method employed by these scoundrels seems to have been to convey into Gorton by night meat from diseased animals killed in the country. Saturday was the chief day for its sale, when in the working-class districts the pestilential stuff was sold by mock auction, at ridiculously low prices. The police and sanitary authorities, becoming aware of the dodge, laid a trap, as the result of which they seized a quantity of meat described as showing signs of tuberculosis and giving off a "fever smell" when cut into. It is very encouraging that although the meat had not actually been sold, the magistrate should have visited the offence with such a severe penalty—imprisonment without option of a fine—because in such cases prevention is of the essence of protection for the public. Yet in a case at Battersea last week a butcher who was summoned for having in his slaughter-house an ox suffering from extensive tuberculosis, signs of which, according to medical and veterinary evidence, must have been present during life, was let off by the magistrate because there was no evidence that the meat was intended for sale. "The Council's officers were too premature," he said. If stopping diseased meat from being sold to the public is considered acting prematurely, we can only hope that all councils will encourage the breed of similar hasty officials.

The Hair and the Dog. In these cosmetic days, when the causes of baldness are debated annually throughout the dermatological societies of Europe, it is something of a relief to be able to fix on at least one very concrete cause—to wit, dog-bite. It is not, it seems, necessary that the bite should be applied *in situ*—in fact, any convenient part, such as the calf, may be chosen for the purpose, and yet the hair will fall out from the scalp in due time. In the Marylebone County Court last week a young lady who had been bitten by a dog sought and obtained damages against its owner, one of the special features which entitled her to remuneration being that as a consequence of her fright and shock, her hair fell out in patches. Being still young, the lady may look forward to a replenishment of her locks, said the medical witness, though had she been over forty the prognosis would have been gloomy. Without committing ourselves to these views *in toto*, we can imagine that this specific instance will come as a shock to the advocates of the bacterial origin of alopecia areata, but we can also see a fine opportunity for the vendors of hair-restorers, for in this case, where the hair is bound to grow again, what a safe cure would be wrought by any nostrum applied! Probably the lady in question will be inundated with advertisements; the most sagacious firm would be that which would supply "free samples." Its testimonial would be assured.

LEADING ARTICLES.

"PROFESSIONAL MISCONDUCT" IN THE LAW COURTS.

The chaotic state of the laws that regulate and govern the medical world has long been an object of ridicule, satire, and ineffectual remonstrance. Unwritten rules of Draconian severity are administered with iron hand either by the sheer force of professional opinion or by the action of medical associations and corporate bodies. The difficulty of enforcing rules that have never been properly defined by bodies whose *locus standi* often rests upon no firmer ground naturally ends now and then in more or less of a deadlock. Take, for instance, the constantly recurring question of professional advertising. It would be impossible to draw up any satisfactory statement of what does and does not constitute "advertising" as it is commonly regarded by the General Medical Council. In extreme cases there would be little or no difficulty in deciding one way or the other, but in a vast number of instances there would be a great deal to be said on both sides. An illustration of these remarks may occur to readers in the case of a North Country medical man who some years ago was taken to book by the British Medical Association for putting his name on the gates of an institution devoted to some quite legitimate method of treatment. In subsequent lawsuits the fact transpired that a prominent London consultant, a Fellow of the Royal College of Physicians, who came to testify to the unprofessional character of the plate, had his own name and address distributed broadcast to the public at the foot of calendars issued by a large insurance company. The whole world of medicine was roused to Gargantuan laughter at this unexpected turning of the tables, and the case against the humbler practitioner not unnaturally collapsed. The jurisdiction of the General Medical Council, however, armed with its penal clauses, has hitherto been regarded with due respect as an all-powerful tribunal, whose decisions were final in the matter of ethical offences. But this belief has been utterly destroyed by a recent decision of Mr. Justice Warrington, delivered in the case of Clifford *v.* Timms on January 29. Both parties to the suit were dentists, and as such came under the disciplinary control of the General Medical Council. Mr. Clifford had a private practice in Grosvenor Street, and took Mr. Timms into partnership. Later, on account of an interview published in the *Review of Reviews* with the American Dental Institute, of which Clifford was a director, he was adjudged by the General Medical Council to have been "guilty of infamous and disgraceful conduct in a professional respect," and his name was removed from the *Dentist's Register*. The defendant, Timms, acting upon a clause in the partnership agreement, attempted to sever his connection with plaintiff, who thereupon brought an action to insist upon the continuance of the partnership. The point upon which the plaintiff relied was the denial of unprofessional conduct. This argument practically brought the decision of the General Medical Council before the Law Courts for review. Upon that clearly defined issue the case hinged, and assuming that right of review, Mr. Justice Warrington delivered a judgment that is momentous, not only to members of the dental profession, but also to every medical practitioner in the British Empire. The General Medical Council, after due enquiry, find Mr. Clifford guilty of professional misconduct and remove his name from the *Register*. His partner attempts to dissolve partnership with the disqualified man. The latter appeals to the Law Courts, with the result that a judge declares him not to have been guilty of unprofessional conduct, therefore the partnership cannot be dissolved on that score. This overriding of the Council's action sets up a situation that is simply untenable. Mr. Timms is now tied for life to an unqualified practitioner. The only logical course open to the General Medical Council is to prosecute Timms for "covering" an unqualified dentist. If the ruling in this case be upheld every man in medical partnership throughout the kingdom may at any moment find himself in a precisely similar predicament. Moreover, every decree of the General Medical Council disregistering a qualified practitioner will be open to an appeal in the law courts. What is to happen now in the case of Clifford. A high court of law has declared him not guilty of unprofessional conduct. How, then, can the Council refuse to reinstate him in the possession of his right to legitimate practice? If Mr. Justice Warrington be right, then we must bid farewell to the future effectual control of the Council over wrongdoers. But the matter is not likely to end here. The principle involved is one of such supreme importance to the authority of the Council that it is certain to be raised in some form or other for further trial. The high-handed attitude of Mr. Justice Warrington may be gathered from his demand, on subpœna, of confidential documents in the possession of the General Medical Council. By some more or less subtle legal hair-splitting, one of the documents was produced in court, but the point as to the legality of the demand was left undecided. In conclusion we submit that there should be no loss of time in testing the assumption of an English judge to override the powers conferred on the General Medical Council by the Medical Acts. In any case the profession is sadly in want of an amending Act, whereby the whole guidance, control, and defence of the profession should be placed on a basis more in accordance with modern views as to the proper constitution, powers, and administrative methods of a great judicial and controlling authority like the General Medical Council.

THE REPORT OF THE ROYAL TUBERCULOSIS COMMISSION.

The second interim report of the Royal Commission appointed some six months ago to inquire into the subject of tuberculosis has just been published. Its importance is obviously great, although it is hardly possible to estimate at the present moment its precise significance in the prevention of the disease. There can be little doubt, however, that this report of the British Royal Commission will form one of the great landmarks in the history of the scientific study of tuberculosis. The ball was set first rolling effectually by Koch's discovery of the specific micro-organism in 1882. Great strides were subsequently made in the treatment of the disease by bettering the environment of infected individuals. But the broad general questions of prevention have never been hitherto seriously attacked. The crucial points of the identity of tuberculosis in man and in the lower animals, for instance, was in dispute, with the consequent and correlated questions of the infectivity of the flesh and milk of lower animals used as the food of man. The terms of the reference, it may be well to remind readers, were to ascertain whether the disease in the lower animals was identical with that in man, whether infection might be reciprocal, and, if transmissible, under what conditions it was conveyed. These points were raised in consequence of the sensational announcement by Koch at the International Medical Congress, held in London in 1900, to the effect that human tuberculosis in man and in the lower mammalia were distinct maladies not communicable from one to the other. If accepted, that theory would have swept away the whole of the proposals for a vast machinery of prevention by the extermination of tuberculosis in all animals utilised for human food, whether by way of flesh or of milk supply. It was at once keenly disputed at the Congress, and that denial has now received the formal endorsement of the highest scientific authorities in the United Kingdom. In this place we do not propose to discuss the conclusions of their second interim report.

It may be briefly stated that the Commissioners have come to the unanimous conclusion that tuberculosis may be communicated to human beings by cow's milk. The direct practical application arising therefrom is inevitable, namely, that stringent measures must be taken to prevent the sale of milk from cows suffering from tuberculosis. This will mean a revolution in the vast interests, both in town and country, involved in the national milk supply. The excessive infantile death-rate that constitutes a standing reproach to our modern science and humanity is closely wrapped up in the prevention of tuberculosis. Parliament will doubtless proceed to act with little delay upon the findings of this report in the direction of the inspection of dairy farms and town byres with a view to the rigid exclusion of tuberculous cows. Similarly, steps will have to be taken to test and exclude contaminated milk. An enormous impetus will probably be given to the municipalisation of milk supplies, while the duties as well as the powers of medical officers of health will be greatly multiplied. One much-needed reform that will probably be forced upon the attention of legislators at an early date is the centralisation of county sanitary districts, and the co-operation of town and county areas, as well as the necessity of making the office of medical officer stable and permanent, in order to relieve him from the pressure of local influences. The present report is a model of clear and precise statement. "The milk coming from such a tuberculous cow," runs one sentence, "ought not to form part of human food, and indeed ought not to be used as food at all. . . . Our results clearly point to the necessity of measures more stringent than those at present enforced being taken to prevent the sale or the consumption of such milk." In many ways this bids fair to become one of the most important public health documents ever yet presented to the world.

CURRENT TOPICS.

Proposed Charter of King Edward's Hospital Fund.

The extraordinary nature of the proposals contained in the Bill to confer a charter upon King Edward VII. Hospital Fund was recently commented upon in our leading columns. The reactionary spirit shown by its promoters was freely criticised, and we stated our conviction that no satisfactory administration of the funds of the medical charities could be hoped for except on the basis of democratic, or, at least, of representative—government. A great trust fund of this kind should be controlled by elected representatives of all interests concerned. The public, the medical profession, the medical charities, great and small, and the working classes should be adequately represented as well as large hospitals, the higher consultant ranks, professional philanthropists and other prominent public men. Can it be possible that King Edward's executive will ignore the recommendation of the Lords' Committee for a Central Hospital Board to be purely representative, that is, elected by various bodies. Thence is a far cry from the proposal to vest absolutely autocratic powers in the hands of a president. As a hint of the way in which such an action is likely to be viewed by the profession, we append a quotation sent us by an eminent London surgeon as illustrative of the injustice attached to civil autocracy:

> "The career of Amurath is a memorable proof of how perilously the possession of unlimited power tempts, first, to excessive severity for real wrongs—next, to ruthless haste in punishing for imaginary offences—and, finally, to the practise of inhuman cruelty on the slightest suspicion or vexation. The earliest executions which Amurath ordered, when he assumed independent power, were those of traitors and mutineers, whose guilt was as heinous as it was unquestionable. His slaughters grew more sweeping; but still for a long time his cruelty was seldom or never awakened out of mere wantonness or caprice. It was against real or suspected state offenders that the Imperial manslayer exercised his terrible prerogative during the first two years of his actual sovereignty. But by degrees his temper grew more moody, and human life became as nothing in his eyes. When he rode forth, any unfortunate wretch who displeased him by crossing or impeding the road, was instantly put to death, and frequently fell pierced by an arrow from the gloomy despot's own bow. . . . He beheaded his chief musician for singing a Persian air, which he said was doing honour to the enemies of the empire. Many other acts of equal atrocity are recorded of him, and the number of those who died by his command is reckoned at 100,000." (*a*)

Medical Man or Matron.

An excellent example of the ignorance of hospital authorities with regard to the proper relative positions of medical men and nurses was revealed at a Liverpool Vestry meeting last week. The Vestry recently opened an infirmary in the neighbouring country for old and ailing people, among whom are a number of senile dements. This institution is known as Highfield Infirmary, and is under the supervision of a matron, with a resident medical officer on whom devolves none but purely medical duties. To everyone with knowledge of institution work, and to most people with common-sense, such a paradoxical arrangement conveys the knowledge of certain trouble. Nor has it been long in coming. The nurses, being under no obligation to the medical officer, have apparently been banding themselves together to defy him, after discovering that he had sufficient self-respect and strength of character not to fall in with their ideas of the "discipline" of the patients. On one occasion, it seems, the nurses wanted to reduce the diet of certain of the patients who had given them some offence, and in another to put one of these poor old creatures into a cold bath during the recent icy weather. Offended with Dr. Hastings' refusal to comply with these humane proposals, it is asserted they got up an agitation which, reaching the ears of the committee, produced the impression that Dr. Hastings was "not an

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(*a*) "History of the Ottoman Turks." By Sir Edward Creasy, M.A.—Extract from Chapter XIII.

unqualified success." Consequently when a question of an increase in Dr. Hastings' salary came up, members opposed, it and fortunately a debate was thereby produced which revealed the state of affairs at the infirmary. We are glad to see that the increase was eventually granted, and that the committee are taking steps seriously to inquire into the nurses' conduct, which seems to have been unbecoming in the extreme, and it may be hoped that in the course of their inquiries they will find the necessity of radically altering the system of government of the infirmary. As one of the members appropriately remarked, "If they opened a school they would put a schoolmaster in charge, if they opened a church they would put a parson in charge, but they opened an infirmary and put a matron in charge." To put a man to serve under a woman is bad, to put a medical man to serve under a matron is not only folly, it is an insult.

A Curative Institute.

Our attention has been drawn to a newspaper advertisement of a "New Health Cure," which is stated to be "under medical specialist supervision," and "approved by the leaders of the English medical profession." Extracts are given of notices from various London newspapers. The treatment is said to be "highly beneficial" in cases of constipation, chest complaints, liver troubles, heart affections, locomotor ataxy, and spinal curvature." This conglomeration of complaints, which may obviously include many conditions of an extremely grave and incurable kind, lends the affair an air of quackery that no amount of mere specious protest can dissipate. We are told that "the Consulting Physician may be seen from 11 to 1, and 2 to 5, or at any time by appointment. There is no fee for consultation." Recently, we believe, a circular was issued by this trading association in the name of a duly qualified practitioner. Under these circumstances we think his anomalous position claims the immediate attention of the medical defence societies and of the General Medical Council. If a qualified man is paid a fixed salary in a business venture, he is surely committing much the same offence as the much reprobated officer to the medical aid association, only that in the institute case quoted the offence is aggravated by the advertisement.

Cardiff Surgeon's Case.

It is announced that notice has been served on the solicitor for the plaintiff to the effect that in the case, "Southern v. Lynn Thomas and Skyrme," the appeal which had been entered with a view to setting aside the verdict returned when the case was tried in London before Mr. Justice Bigham and a special jury will not be proceeded with. The judgment, therefore, stands. It will be remembered that the verdict was for £100 damages and costs. The amount of the latter was said at the time to be about £8,000.

PERSONAL.

Dr. T. Blair has been presented by the Wigan Medical Society with a silver sugar-basin shaped like a cradle to commemorate the fact of a son being born to him during his presidency of the Society.

Dr. H. H. Williams on retiring from practice at Wick, Gloucestershire, has been entertained to dinner and presented with a piece of plate by his friends and patients.

Dr. Fletcher Little has been appointed a Justice of the Peace for Marylebone.

Dr. A. H. Carter, senior honorary physician to the Queen's Hospital, has been compelled to resign that position on account of increasing professional work. Dr. Carter will continue to hold his position as Professor of Medicine in the University.

Dr. J. O'Dowd, Government Medical Officer, British Guiana, at present on leave of absence, has been granted an extension of three months from March 18th next.

Dr. J. E. Godfrey, Surgeon-General of British Guiana, has returned to the Colony and resumed duty.

Dr. C. E. Maguire, who has been acting as Senior Medical Officer of Fiji, has severed his connection with that Colony on accepting the appointment of Government Medical Officer for the Tongan Protectorate.

Mr. Priestley Smith had the honour of the Honorary Fellowship of the Royal College of Surgeons of Ireland conferred upon him on January 26th.

Dr. Josiah Court, who stood in the Unionist interest for North-East Derbyshire last week, was beaten by 729 votes only. At the General Election last year he failed by 1,762.

Dr. Charles E. Beevor is the Lettsomian Lecturer for this year at the Medical Society of London. His subject is the "Diagnosis and Localisation of Cerebral Tumours."

Mr. H. O. Pilkington, Medical Officer of Health for Preston, will read a paper on "The Reduction of Infantile Mortality without Municipal Milk Depôts," at the Society of Medical Officers of Health on February 8th.

Mr. E. Parker Young, the Master of the Society of Apothecaries, presided at the annual meeting of the After-Care Association yesterday afternoon.

Dr. Oliver Avison has received permission from the King to wear the insignia of the Fourth Class of the Order of the Tai-Keuk conferred on him by the Emperor of Korea.

Dr. R. M. Simon has been appointed an examiner in Medicine at the University of Cambridge.

Last week a handsome testimonial was presented to Mr. William Bunn on the occasion of his resignation from the post of Secretary of the Metropolitan Hospital Saturday Fund, after many years of faithful and successful service.

At the Manchester Royal Infirmary, Dr. G. E. Loveday, M.B., B.C. (Cantab.), M.R.C.S., etc., has been appointed director of the Clinical Laboratory; Mr. E. H. Cox, M.B., Ch.B. (Vict.) re-appointed Assistant Surgical Officer; Mr. W. E Rothwell, M.B., Ch.B. (Vict.) re-appointed Junior Anæsthetist; and Mr. A. E. Johnson, F.R.C.S., re-appointed Surgical Registrar.

A Clinical Lecture
ON
CHRONIC NON-SUPPURATIVE DISEASES OF THE MIDDLE EAR. (a)

By MACLEOD YEARSLEY, F.R.C.S.Eng.,

Senior Surgeon to the Royal Ear Hospital.

LECTURE II.

Gentlemen,—In our last lecture we considered the subject of hypertrophic catarrhal deafness in its clinical and pathological aspects. To-day we must turn our attention to its treatment. We may conveniently consider this under the heads of internal remedies, the restoration of the permeability of the Eustachian tubes, and the correction of abnormal conditions of the nose and post-nasal space.

One of the most valuable *Internal Remedies* is Strychnine. This must, however, be given in fairly large doses. It is useless to give it in the form of Easton's syrup or any similar preparation; it should be administered either as the B.P. Liquor or in tabloid form. Personally, I prefer to employ the latter, commencing with one tabloid of $^1/_{30}$ gr. three times daily, and increasing the dose by one tabloid *per diem* until the limit of tolerance is reached. If the Liquor is used, one can start with $^1/_{20}$ gr. or $^1/_{30}$ gr. thrice daily, and augment this dose by $^1/_{100}$ gr. to toleration, or until $^1/_{10}$ gr. or $^3/_{25}$ gr. is taken thrice daily. In many cases this treatment will add to the improvement in the hearing and diminish the tinnitus. Another valuable remedy for tinnitus is Dilute Hydrobromic Acid. It is especially useful when the noises are of a pulsating character, and may succeed when Strychnine fails. It requires to be given in doses of from dr. ss. to dr. j., or even dr. jss., and may be prescribed alone or in conjunction with Strychnine. Other useful remedies for noises are Valerian (in full doses of the Ammoniated tincture), Iron and Arsenic (in anæmic cases), and Carlsbad Salts (in gouty persons).

As regards the restoration of the permeability of the Eustachian tubes, inflation is one of the most valuable methods we possess in the treatment of deafness. For the reasons pointed out in my last lecture, I prefer to use the Eustachian catheter in nearly every case. Another method of inflation that I wish to speak of and to warn you against is *Auto-inflation*. Never teach your patients to inflate themselves, either by the Politzer bag, by Valsalva's method, or by means of any of the so-called Self-inflators. Patients invariably overdo it, and, finding that inflation improves them, they practise it continually until they have so overstretched their membranes that their hearing is made much worse by the lax membrane resting upon the inner tympanic wall and ossicles.

The frequency of the inflation is to some extent dependent upon the case and the progress of improvement. I wish, however, to impress upon you the fact that if you inflate a chronic case and then wait a week before you repeat the inflation you give the ear an opportunity to revert to its former condition, and your labour is Sisyphus-like in its having to start afresh at every application of the catheter. To get anything like a result, you must inflate daily, or, at any rate, every other day. By that means, you are able to get a little more improvement each day before the previous result has quite passed off. It is my practice to inflate daily for a fortnight, then every other day for a week, then twice a week, and so on until the fortnightly or monthly application of the catheter is sufficient to maintain the improvement obtained. In doubtful cases, do not give up hope until you have tried for at least a fortnight.

With inflation, the injection of various medicaments is often very useful. Of these, Parolein, with Iodine (½ per cent.), Menthol (1 per cent.), or Iodide of Potassium (gr. v. to the ounce), are the most valuable. They are used by putting one or two minims into the wide end of the catheter, and then inflating, when the effect of a fine spray is produced. These methods often act best when combined with massage.

When there is much stenosis of the Eustachian tube, the passage of the Eustachian bougie, already described, is very valuable.

In cases with much tinnitus, it is sometimes of advantage to administer, through the catheter, such vapours as ethyl chloride, ethyl iodide, acetic ether, or nascent chloride of ammonium.

A method of treatment which has been used recently, and with some success, is massage of the drum and ossicles. This may be done by means of the Pneumo-masseur of Delstanche, the Siegle speculum, the Pressure probe, or the Oto-masseur of Lake. Of all methods I prefer the latter as giving the best results in my own hands. In using it, it is necessary to bear in mind that rapidity of vibrations and shortness of stroke are the essentials.

Of operative treatment, mobilisation of the malleus, in fixation of that ossicle, is the most useful. It must be performed under gas and by means of a modified pressure probe.

Of other operations, such as incision of the posterior fold, exploratory tympanotomy, &c., I shall not speak. They are mostly disappointing, certainly still *sub judice*. It is probable that, in a certain number of cases (those in which there are definite adhesions binding down the ossicles, and the stapes in particular) exploratory tympanotomy might be attended with good results.

Upon the question of the correction of nasal and naso-pharyngeal conditions I shall not touch, as they will be adequately dealt with by a colleague in a future lecture.

(a) Being the second of two Post-Graduate Lectures delivered at the Royal Ear Hospital on December 13th, 1906, and January 3rd, 1907.

I now pass on to the consideration of the disease which has been termed

OTOSCLEROSIS.

This name is a misleading one, both pathologically and because it has resulted in a confusion between the disease under consideration and the post-catarrhal changes in chronic hypertrophic catarrh. The pathology of this malady, which is responsible for a number of cases of chronic incurable deafness, is not yet fully made out, but it is, apparently, a rarefying osteitis of the labyrinthine capsule, characterised by the fixation of the stapes by bone, the throwing out of osteophytes both extra- and intra-labyrinthine, and the occurrence of spots of osteoporosis in the labyrinthine capsule.

Its onset is usually very insidious. It affects women twice as often as men, and makes its appearance usually between the ages of twenty and thirty, although it may start between ten and twenty, or as late as between thirty and forty. In a certain number of cases it appears to be hereditary, and has been ascribed by some writers to hereditary syphilis. As might be expected in a disease so prominently affecting young women, anæmia plays a part in its origin. Pregnacy and parturition have a decided adverse influence upon the disease, although I myself am inclined to believe that it is the after-strain of lactation that is most to blame in the advance which occurs in this form of deafness at this period.

Owing to the fact that patients suffering from otosclerosis, or, as I prefer to call it, rarefying labyrinthitis, do not usually die of their disorder, the *pathology* of its earlier stages has not yet been worked out, owing to the scarcity of material. What work has been done on the subject has been on cases already far advanced in the condition. These show two distinct changes, the occurrence of patches of osteoporosis in the bony labyrinthine capsule, especially in the promontory, the modiolus, and the neighbourhood of the fenestræ; and the formation of intra- and extra-labyrinthine osteophytes, with bony anchylosis of the stapes. There is in the ligamentous attachment between the footplate of the stapes and the edge of the fenestra ovalis a tongue of cartilage, and in this disease it is this structure which ossifies and so anchors down the stapes. In advanced stages of the condition the intra-labyrinthine fluids become diminished, and may disappear.

You will see by what I have said how hopeless is the outlook as regards treatment.

The disease usually progresses steadily to an advanced degree of deafness, but this progress may intermit, so that the patient remains for some time stationary. Again, it may suddenly progress rapidly, a condition to which Politzer gave the name of "malignant sclerosis." It is impossible, in the present state of our knowledge, to say what cause influences its progress. A certain number of cases occur in childhood, usually associated with adenoids. These are the children who disappoint us after the removal of their post-nasal growths by not recovering their hearing.

The chief *symptoms* in rarefying labyrinthitis are deafness, tinnitus, and Paracusis Willisii. The deafness comes on very gradually, increases to a marked degree, and is uninfluenced by inflation (unless there is an admixture of hypertrophic catarrhal deafness). The tinnitus generally precedes the deafness, is usually of a hissing character, and becomes a matter of very great annoyance to the patient. It is, as a rule, referred to the head rather than the ears. Paracusis Willisii, which I told you was a comparatively late symptom in hypertrophic catarrh, coming on in the contracting and post-catarrhal stages, is a fairly early symptom in rarefying labyrinthitis.

As regards the *tuning fork tests*, the Rinne reaction is negative for both the C and C forks. In very early stages it may be negative for the lower fork only. Bone conduction is, in the early stages, increased. This is probably due to the irritation of the auditory nerve by the commencing process going on in the cochlea. Later, it becomes diminished. Gelle's test gives the negative reaction of a fixed stapes.

On examination, the menbrana tympani appears practically normal, and shows no signs of retraction. It may, however, be somewhat more transparent than usual. Over the region of the promontory (more rarely in the neighbourhood of the oval window) there appears, in the majority of cases, a very characteristic reddish blush, due to the osteitis going on in that region. The external meatus is usually dry and with a lack of ceruminous secretion. On inflation the Eustachian tubes, in uncomplicated cases, are either normally free or appear more than usually patulous. Further, the patient *hears* the inflation whilst he does not *feel* it.

The upper air passages do not as a rule show any specially typical changes. The nose has been described as abnormally patulous. Some observers have insisted that the disease is dependent upon Atrophic Rhinitis (Ozena), but I do not think this has been at all satisfactorily proved.

The *Prognosis* is extremely unfavourable. When we consider that the disease is as much intra-labyrinthine as middle-ear, it is very evident that no manipulations or applications directed to the tympanum can have very much effect. However, despite this somewhat hopeless prospect, a few words must be devoted to the question of *treatment*.

First and foremost, *do not* inflate these cases. Inflation does no good, often positive harm. The only instances in which inflation is permissible are those in which there are in addition chronic catarrhal changes. The catarrhal trouble may then be amenable to treatment without interference with the rarefying labyrinthitis. In pure, uncomplicated cases the only use that can be made of the catheter is for the injection of remedies into the middle ear. Occasionally, in early stages, the use in this way of gr. v. to the ounce of Iodide of Potassium in Parolein, or of a solution of Parolein with ½ per cent. of Iodine may be found of service. The only local treatment that seems to me to promise anything is otomassage. This should not, however, be used if the first application diminishes the hearing.

In a disease such as this, our best hope should lie in internal remedies. Of these Phosphorus has been stated to give good results. It is best given in a 10 per cent. solution, either in oil or in Mist. Amygdalæ, the dose being from 10m., increasing gradually to 45m., three times a day. This drug requires to be given cautiously, as it may cause gastric disturbances. Strychnine (in full doses), Iodide of Potassium (in doses of gr. iij. to v. thrice daily in plenty of water), and the Syrup of the Iodide of Iron have all had their advocates. From what I have already said, a special look-out should be kept for hereditary syphilis.

Various operations have been suggested, but if the pathology of rarefying osteitis of the labyrinth be considered, the futility of the radical mastoid (advocated by Malherbe) or of trephining the promontory will be only too obvious. Personally, I look upon this malady as something akin to a tropho-neurosis, and, until the true pathology of the disease be elucidated in its early stages, we cannot expect to find a treatment adequate to deal with it. Probably the treatment of the future will lie mostly in prevention.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Sir Charles Ball, M.Ch., F.R.C.S.I. and Eng., Honorary Surgeon to His Majesty the King, Regius Professor of Surgery in the University of Dublin, &c., on "The Treatment of Malignant Gastric Ulcer."*

ORIGINAL PAPERS.

A POSSIBLE DANGER IN EXPLORATORY PUNCTURE OF THE CHEST.

By HUBERT ARMSTRONG, M.D. Vict., etc.,
Assistant Physician, Liverpool Infirmary for Children.

The operation of exploratory puncture of the chest is generally regarded as a very trivial one, and quite free from danger to the patient. Of course there is the obvious and easily avoidable danger of infecting the pleura with a dirty needle. Unskilfulness may lead to infection of the peritoneum from an empyema, by exploring too low or directing the needle obliquely downwards. Pneumothorax has resulted. Subcutaneous emphysema, also, has followed the withdrawal of the needle. But the particular danger of which I am speaking to-night is not one of faulty technique, nor is it one which can be absolutely avoided, except by the avoidance of the operation, because it cannot be entirely foreseen. Last session, in the discussion which followed Dr. Buchanan's paper on empyema, I remarked that when in doubt as to the diagnosis I never hesitated to make use of the exploring needle. During the recess I have encountered a case which has caused me to modify this view. Now while, if I were *certain*, I should have no hesitation and no fear in exploring to confirm the diagnosis, it is just in the doubtful case that I should take up the needle with some trepidation.

The relation of my case will explain the nature of the danger to which I refer.

On June 27th, 1905, Bertha M., æt. 2 years and 9 months, was sent to the Infirmary for Children by Dr. McCann for a diagnosis, and came under my notice. Dr. McCann gave the following history: "The child had measles three months ago, complicated by lobar pneumonia. I left town shortly after, and my *locum tenens* on my return stated that there was an empyema which necessitated operation. I could not satisfy myself on the point, and as the dulness had not cleared up I thought it better to have another opinion. I gave her drop doses of tincture of iodine, with five-drop doses of phosphoric acid and compound tincture of cinchona, which improved matters to a certain extent, but they have been at a standstill for some weeks." The girl was only seen by me in the out-patient department, and my notes are not very full, but I have the following:—

The child was thin and wasted, and rather fretful, with a hectic flush. Temperature 101°. The actual pulse and respiration rates were not recorded; both were accelerated, but maintained a normal ratio. No dyspnœa. On examination, the right side of the chest was dull posteriorly up to the spine of the scapula; there were bronchial breathing and increased vocal resonance all over this area, with loud inspiratory crepitations. Apex of the heart not displaced.

Upon these physical signs I was inclined to agree with Dr. McCann as to the absence of fluid; but the dulness being so absolute, bronchial breath sounds in empyema being so common in children, and empyema being the element it was desired to exclude, I felt justified in exploring. Consequently I made the usual exploratory puncture in the posterior axillary line just below the angle of the scapula. The result was exceedingly alarming. The child gave a gasp, and then began to cough, bringing up a quantity of frothy mucus freely stained with blood. At the same time she became pallid and broke into a profuse sweat; the pulse failed, the facial expression took that "far-away" look characteristic of impending dissolution, and for some minutes I could not disguise from myself that the condition was extremely critical. However, stimulants being administered, the cough stopped after a little, and the patient gradually revived, and later in the afternoon was able to be taken home. If the evidence of the hæmoptysis had been wanting, the needle was *felt* to have entered the lung, being moved through a considerable angle by the first gasp. The piston was drawn and the needle removed almost simultaneously and at once, and nothing but a little blood was obtained either in the syringe or the lumen of the needle. The diagnosis made was chronic interstitial pneumonia, possibly infected with tubercle. The after-history of the case has many points of interest, but I only make use of that portion which illustrates my subject.

I consider myself fortunate that the patient did not die on the spot, for such a catastrophe has since formed the subject of a paper and discussion at a meeting of the Society for the Study of Disease in Children, and several other fatalities have been recorded. Carpenter (1) reported the first in 1893, Russell (2) one in 1898, Oliver (3) one in 1904, another was published by Fortescue-Brickdale (4) in 1904, while two more are related in the current volume of the *British Journal of Children's Diseases* (5). In all these cases the amount of hæmorrhage varied, but the symptoms were similar to those I have described in my patient, only that death ensued within a few minutes instead of recovery. Other cases have been described in which death did not occur until some hours or days after the exploration, although the alarming symptoms dated from the moment of operation. Six out of nine collected fatalities occurred in children under eight.

In all cases the danger seems to lie in the puncture of chronically inflamed lung-tissue, and to be non-existent when fluid is present provided the needle does not pass through this and strike diseased lung beyond.

In 1900 Dr. McAlister read a paper here in which he advocated puncture of the lung in chronic pneumonic conditions as a therapeutic measure "which" (I quote the report in the *Liverpool Medico-Chirurgical Journal* (6)) "can certainly do *no* harm, and may be followed by beneficial results." I do not know whether he still advocates this practice, but in view of these reported fatalities it would appear that the benefits, which I confess I think I have seen myself in some cases, are purchased at what must now be considered a by no means negligible risk.

As to the cause of the syncope. In some of the recorded cases it has been attributable to hæmorrhage, both directly—a large quantity of swallowed blood having been found in the stomach—and indirectly, from asphixiation by the bleeding into the lung and air-passages. In others it is ascribed to irritation of the terminal filaments of the pulmonary vagus, leading to reflex inhibition of the vital centres in the medulla, and vaso-motor disturbances producing œdema of the lungs, with the expectoration of the frothy mucus. Into others both these elements may enter. Obviously there is something more here than mere faintness at the momentary pain of the prick, or fright at the sight of the blood. My patient was not coughing before the operation, and certainly the quantity of watery mucus she brought up was not what one would have expected from the signs in the chest, while she was collapsed before the blood had reached the mouth and become visible. The symptoms resemble those described as the result of a sword-thrust into the lung; but an exploring needle is not to be compared with a rapier, and as it is used over and over again without bad results in such cases as I have described, there must be some personal element involved, in addition to a hyper-excitability of the pneumogastric which may be presumed to originate in the pneumonic condition.

Treatment.—It would be as well, when about to explore a doubtful case, to fortify the patient by the previous administration of such stimulants --alcoholic or otherwise—as you pin your faith to, to perform the operation in the recumbent position, and not to plunge the needle too far in. If, after that, syncope threatens, artificial breathing should be tried, unless there is hæmorrhage as well. In the latter case it is hard to see what can be done with advantage.

No doubt this is a rare accident, but there can also be no doubt now that puncture of a lung in a state of chronic inflammation involves a danger deserving of recognition, and that we should learn not to depend too much on the results of exploration, but rather to cultivate the safer and sounder method of the correct interpretation of physical signs.

REFERENCES.

(1) *American Journal of the Medical Sciences*, 1893, p. 422.
(2) *St. Thomas's Hospital Reports*, vol. xxviii.
(3) *Lancet*, 2, i., 1904.
(4) *Reports of the Society for the Study of Disease in Children*, vol. v., No. 36.
(5) Pp. 339 and 462
(6) 1901, vol. xxi., p. 20.

ON TUBERCULOSIS DISPENSARIES AND THE CO-ORDINATION OF MEASURES AGAINST TUBERCULOSIS. (a)

By R. W. PHILIP, M.A., M.D., F.R.S.E., F.R.C.P.
Physician to the Royal Infirmary, Edinburgh, and to the Royal Victoria Hospital for Consumption.

THE tuberculosis dispensary as a factor in the campaign against tuberculosis is no longer on its trial. In any complete organisation against tuberculosis the dispensary will be found to play a most important part. This has been my belief for the past 20 years. It was this that led to the foundation by me in 1887 of the Victoria Dispensary for Consumption in Edinburgh. The practical value of what was then an *a priori* conception has been firmly established during the development of operations. Increasing familiarity with the idea has led to a widespread recognition of the significance of the dispensary. More recently the rapid and apparently independent erection of similar institutions in Belgium, France, and Germany has been remarkable.

CONCEPTION OF THE TUBERCULOSIS DISPENSARY.

The *motif* for the establishment of the Victoria Dispensary in 1887 was the query: What practical value had accrued to the community, as a community, by Koch's discovery of the tubercle bacillus? If the community, as such, was to benefit practically by the discovery, there appeared to be need of centralised effort in order to ascertain the extent of tuberculosis in a district, and to devise means for its limitation and prevention.

To meet this indication, the method of treatment which was then in vogue in hospitals was useless. The amelioration, or even cure, of a certain number of cases of tuberculosis could do little to affect the wider issue. The formation of a central institution or dispensary, to which persons of the poorer classes affected by tuberculosis should be invited or directed, seemed to offer the basis of a completer solution. Thereby access would be readily obtained to the foci of disease, not merely in the affected individual under examination, but also in other members of the same household and in affected dwellings.

FUNCTIONS OF A TUBERCULOSIS DISPENSARY.

The tuberculosis dispensary should be, for every city or district, the uniting point of all other agencies. It should not be an isolated institution, but form an integral part, indeed the centre, of a great network of operations. To the dispensary tuberculous patients of the poorer classes, and hospital patients with chronic colds or phthisis or persistent ill-health, should be invited. Tuberculous patients presenting themselves at infirmaries, hospitals, and other charitable institutions should be directed to the tuberculosis dispensary. Employers of labour and heads of public works should be apprised of the existence of the dispensary, so that invalid employés may be directed thither. The public should be made aware that the dispensary is prepared to answer all inquiries regarding tuberculosis, and to advise, in a given case, what is best to be done. The dispensary should constitute a centre for the dissemination, in the widest fashion, of information regarding prevention and treatment.

THE ROYAL VICTORIA DISPENSARY FOR CONSUMPTION, EDINBURGH.

The programme of the Royal Victoria Dispensary was as follows:—1. The reception and examination of patients at the dispensary; the keeping a full record of every case, with an account of the patient's illness, history, surroundings and present condition and progress. 2. The bacteriological examination of sputum, etc. 3. The instruction of patients how to treat themselves and to minimise the risk of infection to others. 4. The dispensing of necessary medicines, sputum bottles, disinfectants, and—where the patient's condition seemed to warrant it—foodstuffs and the like.

(a) Being Introduction to a discussion on Tuberculosis Dispensaries at the International Conference on Tuberculosis held at the Hague, September 5-8 1906.

5. The visitation of patients at their own homes by (1) a qualified medical man, and (2) a specially trained nurse, for the double purpose of treatment and of investigation into the state of the dwellings, the general conditions of life and the risk of infection to others. 6. The selection of more likely patients for hospital treatment, either of early cases for sanatoria, or of late cases for incurable homes, and the supervision, when necessary, of patients after discharge from hospital. 7. The guidance generally of tuberculous patients and their friends on every question concerning tuberculosis.

The premises of the Victoria Dispensary as at present arranged contain:—Two consulting rooms, a laryngoscopic room, one large waiting room, two dressing rooms (male, female), a general office where names are entered, a laboratory for bacteriological examinations, a drug and food store. The dispensary is open thrice weekly for three or four hours, the staff consisting of—

(1) Four qualified physicians (three honorary) who attend for the purpose of examining and instructing patients. (2) One of the medical officers receives a salary of £60 a year and devotes a large amount of time to the work. In addition to examining patients at the institution, along with the honorary physicians, he pays domiciliary visits to the dwellings of patients, in co-operation with the trained nurse. He makes bacteriological examinations of expectoration and other discharges. By arrangement with the city authorities, he notifies all cases of tuberculosis which he meets. He advises regarding the disinfection of houses during illness, and after the removal or death of the patient. He supervises treatment of patients at their own home when this is desirable. He selects suitable patients for the sanatorium. In co-operation with the city authorities, he drafts the more advanced or dying patients to a hospital now dedicated to such cases in the neighbourhood of the city.

(3) A nurse who has been carefully trained in modern open-air methods at the Royal Victoria Hospital for Consumption, Edinburgh, the sanatorium in connection with the dispensary, visits the homes of the patients. She readily wins their confidence by her interest in their welfare. She instructs the patients or their friends (wives, mothers, etc.) both as to treatment and prevention. In co-operation with the visiting physician she reports regarding the patients' residence and other conditions according to the annexed schedule of inquiry. The reports, when completed, are vouched for by the signature of doctor and nurse.

SCHEDULE OF INQUIRY REGARDING DISPENSARY PATIENTS.

No. in ledger......... Date of report........... Name? Age? Address? Married or single? Occupation? Has patient changed occupation? Able to work full time? Or part time? If unable, confined to bed? How long ill? Situation of house (area, ground floor, first, etc.)? Number and ages of inmates? Number and description of rooms? General aspect of house (clean, damp, dusty, smelly)? Number of windows? Can they open? Are they kept open (a) by day? (b) by night? Have they always been kept open? Does patient sleep alone (a) in bed? (b) in room? How is washing of clothes done? How long in present house? If has moved within two years, previous addresses? Have there been illnesses or deaths in house (a) in own time? (b) in previous occupancy? Exposed to infection (a) at home? (b) at work? (c) among friends? Present health of other members of household? What precautions taken to disinfect? T. B. in sputum? T. B. in dust of room? General dietary? Teetotal? General condition (well-to-do, badly off)? Proximate income of household? Assisted by societies, church, friends, rates?

Signed .... Reporter.
.... Medical Officer.
(Signed by doctor and nurse.)

(4) A volunteer Samaritan committee of ladies, in conference with the doctors, take charge of more distressing cases, where through prolonged illness the financial conditions have been much reduced.

(5) An officer—a working man who gives his entire time to the dispensary—lives on the premises. The man receives and enters the names of the patients on the afternoons when the dispensary is open. When the dispensary is not formally open, he attends to requests from patients or other persons. The officer is conversant with the home and work conditions of many of the patients, and is a valuable lieutenant both to the doctors and nurses.

RESULTS OF DISPENSARY OPERATIONS.

The organisation of the dispensary is thorough. Each part of the system is closely related to the rest, so that a large amount of work is expeditiously and inexpensively overtaken. From first to last we have found no difficulty whatsoever in relation to the nurse's house-to-house visits. On the contrary, these have been most gladly welcomed by all types of patients, and her inquiries willingly answered. There can be no doubt that the system of domiciliary visitation by a specially trained nurse, in co-operation with the doctor, has been a sanitary agent of great importance to the city of Edinburgh.

From my experience of the satisfactory way in which the work of investigation and general guidance is effected by the nurse, who herself has been most carefully trained in methods for the prevention and treatment of tuberculosis. I should be unwilling to replace her services by those of the so-called working man *enquêteur* as recently recommended in France and Belgium.

The dispensary's programme has been successfully carried out by the staff during the past 19 years. During each year some 17,000 attendances have been registered. As many as 87 individual patients have been received in one day. About 1,000 reports are made annually regarding the home conditions of patients, and about as many notifications have been made to the city authorities.

By means of the systematic record of the home conditions according to the schedule referred to, there has been accumulated a great mass of valuable statistics and information regarding the incidence of the disease in the district. These are continually added to from day to day.

An analysis of these records has yielded facts of the greatest importance. Thus there has been illustrated the extreme frequency of tuberculous disease in children and in housewives. A map of the city has been made showing the frequency of the disease in certain houses and streets. Proof has been obtained of its occurrence, along with various insanitary conditions of dwellings (insufficient air, absence of sunlight, etc.), and the attention of the authorities has been drawn to the fact. The reports show the frequency with which one or more persons share a room, or even a bed, with the consumptive patient. Particular attention has been paid to such cases, either by removal of the affected patient (a) to a sanatorium, or (b) to a hospital for dying cases, or by removal of unaffected members of the household to healthier surroundings. One of the doctor's duties in such circumstances is to examine into the health of other members of the family. It is remarkable how frequently two, three, or even more persons, not previously suspected, have thus been shown to be tuberculous. Another important point has emerged—viz., the frequency with which the tuberculous patient, from one cause or another—often from financial reasons—changes his house. By this means infected areas become quickly multiplied. The records also show the absence—apart from the interference of the dispensary—of precautions with a view to disinfection. Now happily, by arrangement with the city authorities, the dwellings of such patients are thoroughly disinfected at the city expense.

It has been sometimes maintained that such a dispensary is impracticable, as running counter to the interests of, and therefore likely to be opposed by, the medical practitioners of the place. This has not been the experience of the Victoria Dispensary, either with medical men or medical charities.

It should be clearly understood that a dispensary such as this is a much more elaborate institution than exists in relation to the out-patient departments of consumption or other hospitals. The latter doubtless do excellent work, so far as their resources allow. Their effort is, however, primarily directed towards the treatment of the individual patient, and little attention is extended to the wider aspect of the tuberculosis problem.

MAINTENANCE AND DEVELOPMENT OF DISPENSARY.

This sketch of the operations of the Royal Victoria Dispensary during the 19 years of its existence and development may serve to illustrate the important part played by a well-organised dispensary in any complete movement against tuberculosis. It will be found desirable that operations should extend on all the lines I have indicated. The dispensary should be in closest relationship with sanatoria for early cases, and with hospitals for dying cases. Thus the Victoria Dispensary has established as sanatorium the Royal Victoria Hospital, with accommodation for 80 patients, and has relationship, through co-operation with the city authorities, with a hospital for dying cases, with accommodation for 50 persons.

As to maintenance, a further question presents itself. Having regard to the extent of the issue, we cannot afford to trust to individual effort, or even to wider benevolent enterprise.

On whom, then, should fall the responsibility for such an organisation? The answer seems to be clearly —on the local authorities, municipalities, parish councils, boards of guardians, and the corresponding bodies in different countries. In our cities the institution should be municipal. Experience in the foundation and development of the Royal Victoria Dispensary has satisfied me that the extensive ramifications of the disease demand that the central dispensary as a base of operations should be maintained by the local authorities. Local authorities ought to possess the information regarding tuberculosis which a well-planned dispensary is calculated to yield.

The dispensary should be placed under the direction of the Medical Officer of Health. It should, however, form a separate and well-defined department of his activity.

The actual cost of the Royal Victoria Dispensary is approximately £500 per annum. This is a small sum having regard to the extent of the operations. The advantages accruing to the community are incalculable, and should thoroughly justify the discharge of public money for the purpose. Seldom does expenditure by local authorities promise such certainty of satisfactory return.

So far as Scotland is concerned, a rapid advance has been made. Every year the extent of operations of the Victoria Dispensary has steadily increased. Several towns and districts of Scotland have awakened to the large sphere of work which is compassable only by such an institution as the tuberculosis dispensary. Still more recently the Local Government Board of Scotland has emphasised in the strongest way the significance of the dispensary as an element in the administrative control of pulmonary tuberculosis, and has strongly recommended local authorities to institute similar dispensaries.

ORGANISATION AND CO-ORDINATION OF MEASURES AGAINST TUBERCULOSIS.

Much is to be gained by uniformity of action in such a campaign. Deeply impressed with this, I venture to reiterate what I have frequently had occasion to propose as a scheme of organised and co-ordinated operations against tuberculosis which might be uniformly followed in our larger centres. The organisation, which implies notification in one or other form, should include:—

(1) A tuberculosis dispensary with the functions and relations I have attempted to outline.

(2) A hospital or asylum for dying patients, chiefly in the interest of other persons.

(3) A sanatorium or sanatoria for selected patients who, with a view to cure of the disease, require a special *régime* not procurable at their own homes.

(4) Colonies for the after-life and supervision of patients in whom the disease has been arrested, so as to make selected open-air employment feasible and desirable.

The various departments should be intimately connected and co-ordinated. They will each be more serviceable the more closely they are thus related. Each department is of value itself, and each has its own sphere of operations. The key to complete success in the campaign against tuberculosis lies in well-adjusted co-ordination of the several departments.

Every step in the gradual development of the Edinburgh scheme during 19 years has strengthened my belief in the efficacy of the tuberculosis dispensary as a base for further operations. In this belief I recommend to every considerable community the establishment of such an institution which will serve at once as a developmental centre and uniting point of other agencies.

It seems to me, indeed, difficult to over-estimate the value of the dispensary as an instrument of preventive medicine, whether as a bureau for receipt and distribution of information and assistance, or as a clearing-house in respect of the vast amount of tuberculous material with which every community will find itself called upon to deal.

CLINICAL RECORDS.

AN EARLY CASE OF LEONTIASIS OSSEA. (a)

By S. HORACE LAW, M.D.,
Surgeon to the Dublin Throat and Ear Hospital, and Throat Surgeon to the Adelaide Hospital, &c.

PATIENT, J. J., æt. 12, male. This condition was first described by Verchow, and named leontiasis ossea by him. The number of cases reported are few, the majority of which were found post-mortem in the dissecting-room, etc., and while the condition is mentioned in most text-books, little is said beyond referring back to the classical case of Verchow.

In looking at this case, one might almost think that it was the original one described, so great is the similarity. The chief points of interest are as follows:—When first seen, some four years ago, by me, the condition of swelling was much less marked, and I did not think that it was pathological, though I distinctly remember being struck by the bilateral enlargement on each side of the nasal processes of the superior maxillæ. He then complained of nasal obstruction, and the removal of adenoids gave him relief, though not for long. I saw him once or twice since then, but the peculiar enlargement did not strike me until this last occasion (November, 1906), when the growth had become marked.

The condition found is as follows:—

The patient is a small boy for his age, which is 12, but upright and sturdy. He seems strong and in good general health, and his only complaint is nasal obstruction, and that was what brought him to me.

On examination a hard, bilateral growth is seen in infra-orbital region, extending up in such a way as to cause the eyes to be pushed outwards, and also to bring about exophthalmos.

The lateral walls of the nose are pushed towards the middle line, so as to occlude the nostrils, though a probe can be passed up to the sphenoid, etc., and air can be blown through nose.

The naso-pharynx is not involved.

The pharynx and palate are normal.

The antra of Highmore are dark to transillumination, and when I passed an ordinary antrum drill in through the canine fossa on the right side, I failed to reach a cavity, though I went in about an inch in two directions.

The bone was soft and spongy. One may therefore conclude that there are two large osseous masses lying on either side in the infra-orbital regions, filling both antra, and extending in various directions, as mentioned above.

Incidentally, he has dacryo-cystitis on both sides.

X-ray photographs show dense shadows corresponding to the obvious growths, and especially I would mention the shadow of the growth lying between the orbits, and the fact that the cranial vault of this child is about the same thickness as one would expect to find in an adult.

(a) Read at the Surgical Section of the Royal Academy of Medicine in Ireland.

I have ventured to call my case by this classical name, leontiasis ossea, and if one compares it with the case originally described by Verchow, in his "Pathologie des Tumeurs," 1869, Vol. II., page 21, which was under the care of Forcard, one sees that it agrees very nearly with it. It commences in early life. My patient was 8 at the time I first saw him. Forcard's was 12. But, from the description of his case, undoubtedly the condition had existed for some little time previously.

My case has suppuration in the lachrymal sacs. as also, apparently, had the other; though this, of course, is merely a coincidence. The development has been very slow—so slow, in fact, that it would be almost impossible to measure it, though, after the lapse of a few years, the contrast is distinct and unmistakable.

Nearly all writers on surgery refer to this disease. Von Bergmann, in his "System of Surgery," Vol. I., gives an exact account, and two woodcuts, both of which show the advanced stage of the disease. He mentions the specimen (also mentioned by Verchow) in Dupuytren's Museum. I have not been able to form any idea as to how many cases have been described, as, though most books mention it, they rather take up the historic case, and do not describe actual cases seen. Looking back in the *British Medical Journal* for 10 years, I found three cases recorded. The first, in Vol. I., 1898, page 1,392, is described by Dr. Churton, and seems very similar to my own, except that the child showed more symptoms of rickets; and the second, in Vol. I., 1900, page 1,230, is recorded by Dr. Stephenson, and he describes the growth as beginning in the lower jaw. The third, in Vol. II., 1901, page 1,341, is described by Mr. Robinson as a fairly typical case. Unfortunately, some works do not seem to have differentiated between ostitis deformans and this condition. Suffice it to say that in ostitis deformans the long bones are first affected, and then the skull, and the disease is limited to the head, and, in the condition before us, the face is the first to be affected. Also, ostitis deformans commences in adult life; leontiasis ossea in childhood. Again, others have included it under tumours of the nasal processes. One picture, which I have found in two or three text-books, quoted as after Hutchinson, is called symmetrical osteomata of the nasal processes of maxillæ, and presents most clearly the same facial aspect as is seen in my case, the only difference being that, apparently, it was in a grown-up man. One other condition mentioned by Bland Sutton in his book on "Tumours," page 43, is worthy of comparison—namely, that many of the negroes on the West Coast of Africa present symmetrical exostosis of the infra-orbital region; but there the similarity ends, as the deeper enlargement is absent, nor is there any thickening of the cranium.

Syphilitic hyper-osteosis of the skull and face might occasion some difficulty in diagnosis, but they are never so uniform and so symmetrical, and the other symptoms of the disease would probably clear the matter up.

Again, acromegaly always begins at the epiphyses of the bones of the lower and upper extremities, and this would enable the differentiation to be easily made. The differential diagnosis between simple osteomata and this condition of hyper-osteosis should not, as a rule, present much difficulty. The age, the symmetry, the comparative painlessness, the cessation of growth in the earlier part affected, and the taking on of new growth in other parts of the face and skull, should render the differential diagnosis clear. It is quite clear that neither syphilis nor injury can be ascribed as a cause of this very typical disease, and no treatment seems to be of any avail. Surgical methods are obviously impossible, and the administration of mercury or iodide of potash does not seem to have influenced it one way or the other.

The prognosis is nothing short of lamentable. One can only expect slow advance in the portions now affected, then the cessation of growth there, and the commencement of thickening in the other parts of the skull, till finally, often at the age of 35 to 40, the gradual pressure on the brain gives rise to dementia and death.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Sinuses due to foreign bodies.

By PEYTON BEALE, F.R.C.S.

AMONGST the out-patients was a man, æt. about 21, complaining of a discharge of pus from a small sinus about half an inch to the left of the anus. The patient's history was rather vague, and at first sight not very much to the point, for about fourteen or fifteen years ago he had suffered from some very extensive suppuration apparently in the upper part of the abdomen. On examining his chest he was found to have a scar just below the angle of his right scapula; the scar looked a very old one, and the man could give no account of it, but from its position it was fairly obviously the result of an operation for empyæma, probably performed when the patient was four or five years old. He could give very little account of the abscess in the upper part of his abdomen, for he was treated at a provincial hospital, but he remembered that three or four incisions were made in the right loin, that drainage tubes were used for some weeks, and then that the incisions healed up. Ever since he had had more or less discomfort in the region of the right loin, never any really acute pain. About three weeks ago he had a severe pain on defæcation about the anus, and then noticed that he had a hard lump on one side of it; he poulticed this and it burst, discharging a good deal of pus, and it had continually discharged until the present time. On examining the sinus with a probe dipped in pure carbolic acid, a hard body was found about half an inch beneath the skin; it was movable and felt like hard bone. The skin over the sinus was painted with pure carbolic to render it anæsthetic, and was cut with a pair of scissors for about a quarter of an inch away from the anus; on introducing a pair of forceps, a piece of bone was easily removed; this bone was found to be about a quarter of an inch of rib, corresponding in size to that which one would expect in a child about four years of age. The history of the case, Mr. Beale said, was probably as follows: when about four years old the patient was operated upon for an empyæma; the surgeon no doubt excised a piece of rib, and finding he had not a sufficiently large opening, cut off another small piece about a quarter of an inch long; this no doubt fell to the bottom of the pleural cavity, where it must have remained for some years. By a slow process of ulceration it must then have penetrated the pleura and caused an abscess in connection with the diaphragm; this no doubt became a subphrenic abscess. The piece of rib must then have got down by one of the crura of the diaphragm and passed along the sheath of one of the posterior abdominal muscles, possibly the quadratus lumborum, then it must have made its way down into the pelvis behind the peritoneum until it reached the ischio-rectal fossa, where it formed an abscess which burst as described. Mr. Beale remarked that he had never come across a case similar to this, but he had removed from the pleural cavity a piece of rib which had slipped in and been lost, as the result of an operation for empyæma seven or eight years previously, but this had caused a sinus in the chest wall at the seat of operation to remain open continuously. In this case he was struck by the fact that the piece of rib had undergone no change except in colour, which was grey; in shape, and as regards its edges it looked exactly as if it had been recently cut with a pair of sharp bone forceps. He had come across several cases of ischio-rectal and perineal abscesses and persistent sinuses which, when opened up, were found to contain pieces of rubber drainage tube, and it was, he thought, a remarkable fact how these came to be left *in situ* for so long a time; he believed the explanation was that the patient went from one surgeon to another, and when an exploratory operation was advised it was again and again refused.

OPERATING THEATRES.

MIDDLESEX HOSPITAL.

Operation for Wiring Fractured Patella.—Mr. **John Murray** operated on a man, æt. 30, who had been admitted four days previously for a transverse fracture of right patella. The history was that the patient was carrying a sack of coals into a house, when he tripped against a piece of wood and fell heavily to the ground. On admission the right patella was found to be fractured transversely near the centre. There was three-quarters of an inch separation between the fragments, and a great deal of swelling of the joint, which was distended with fluid. There was also a good amount of ecchymosis of the soft parts. The limb was placed on a back splint, and an ice-bag applied. At the operation four days later an elliptical incision with the convexity outwards was made over the knee, and on reflecting the flap thus formed the fracture was exposed. A quantity of bloodclot filling the joint and extending between the fractured surfaces was removed, and the fibrous tissue, the remains of the torn quadriceps extensor tendon, which overlapped the edges of the fractured surfaces, was carefully separated so as to allow the surfaces to come into contact. Each fragment was drilled with a bradawl, and a silver wire passed with which the fragments were accurately approximated. A few silk sutures were inserted so as to bring the torn ends of quadriceps extensor together. The skin was sutured and dressings applied, the limb being placed on a back splint. Mr. Murray said that he preferred the open operation to any form of subcutaneous suture. He thought there was no doubt that failure to obtain bony union was due to the overlapping of the torn quadriceps extensor tendon, which invariably covered the fractured surfaces and effectually prevented the fragments from being brought into immediate apposition, and that it was only by the open method—that is, by an open operation—this fibrous tissue could be removed from between the fragments. The first essential for the success of the operation was, he considered, the thorough cleansing of the skin, and this he always gave instructions to be carefully carried out for at least two days previous to the operation. Another advantage of postponing the operation for a few days after the accident was, he said, that there was less tendency for subsequent effusion into the joint to occur. With regard to the incision, provided it was not made directly over the centre of the patella, he did not think the direction of the convexity was a matter of great importance. It was, of course, necessary to carefully remove all bloodclot, and more particularly to displace the fibrous tissue from between the fragments; the advantage of not removing this fibrous tissue was that it forms a covering for the wire. With reference to drilling the bone, he pointed out that the first fragment was drilled from without inwards, and the second from within outwards; by so doing the drill-holes could be made to correspond accurately. He thought that in cases of operation on the knee-joint, if strong antiseptic lotions were used there was much greater tendency for subsequent effusion to take place. Therefore he preferred to employ normal saline solution or boiled water for instruments and dabs, and also for the operation wound. With regard to the application of a splint, one was merely put on, he remarked, to restrain movement whilst the patient was recovering from the anæsthetic, and it would be removed on the following day.

A fortnight after operation the wound was healed, the patient could flex his knee through 45 deg., and was to get up in a few days.

TRANSACTIONS OF SOCIETIES.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Meeting held Thursday, January 3rd, 1907.

The President, Mr. Priestly Smith, F.R.C.S., in the Chair.

Mr. **Simeon Snell** (Sheffield) related a case of TUBERCLE FILLING THE EYEBALL, in which the opsonic index was regularly taken. The patient was a boy, æt. 12. Before coming under Mr. Snell's care in April, 1906, he had been under surgical treatment for tubercular abscesses in the arm and leg. At the time when he was seen the sight of the left eye had begun to fail four months before, and then the left eye was prominent and apparently slightly larger than normal; the conjunctiva was injected, but there was no pain. Vision was lost. The interior of the eye was occupied by a mass of yellowish-grey material, on which retinal vessels were seen. Tubercle of the choroid and vitreous was diagnosed. Immediate enucleation was decided against. A little later the eye became inflamed and painful, its tension was raised, and its size increased, and the interior became more filled up. Tuberculin injections were then tried, and the opsonic index was regularly taken. Tuberculin injections of 1/800 m.g. were twice given. The boy greatly benefited, the eye became smaller, and the mass in the interior was thought to be caseating. The eye was removed on September 17th, by which time it was no larger than normal. The boy did perfectly well after the operation. Examination of the globe showed it to be tubercular, but bacilli were not found. The choroid was the structure most affected.

Mr. **Snell** also related particulars of a family several of whom had suffered from "Nyctalopia." The earliest ancestor who suffered was the patient's grandmother. Information was obtained of 63 of her descendants, extending to the fourth generation. Out of 64, 12 were affected with nyctalopia, 9 being males and 3 females.

A peculiar feature was that the males had girls affected and boys healthy, and the females had boys affected and girls healthy.

Mr. **Arnold Lawson** related two cases of acute STREPTOCOCCIC INFECTION OF THE CONJUNCTIVA.

Case I. occurred in a child 16 days after birth. At first there was some swelling of the lids and a muco-purulent discharge. After 10 days the cornea became infiltrated, and the case ran a rapid and acute course. A tough conjunctival membrane developed, and within 36 hours of the first affection of the corneæ the sight was hopelessly destroyed. The general health was not affected. Swabs taken from the conjunctiva showed almost pure cultures of streptococcus pyogenes. Mr. Lawson did not see the case until the corneæ were infiltrated, and nothing seemed of any avail in allaying the course of the disease.

Case 2 occurred in a child convalescing from scarlet fever, who was then attacked with measles. Ten days later the temperature was high and fluctuating, as seen in pyæmia; at the same time brawny swelling of the lids commenced. After a few days the discharge increased rapidly, and the corneæ became suddenly infiltrated, and within 24 hours the condition was hopeless, and palpebral and ocular conjunctivæ of both eyes was covered with a dense yellow tenacious membrane. The child was exceedingly ill, and recovery was doubtful. The sloughs eventually separated, but the cicatricial contraction of the conjunctiva was very severe. The infection was a mixed one, due to staphylococcus pyogenes aureus and streptococcus pyogenes. The contraction in both cases was very severe, and in neither case did treatment seem of the slightest avail in arresting the course of the disease.

Mr. **Brooksbank James** read some notes on

STEREOSCOPIC VISION.

He remarked that most experiments which had been carried out had been conducted at comparatively short distances. He described an apparatus which he had introduced in order that the same may be estimated at the usual testing distance of, say, 6 metres. The apparatus was simple and at the same time most delicate in the estimation of the third dimension. It consisted of a box in which only the floor and end walls remained, the sides and roof having been removed. In the front wall was an oval aperture in its centre. At each side was an electric lamp which illuminated the interior; the front and back walls were covered with black velvet. The floor was pierced with numerous round holes, each separated by an interval of about an inch. The test objects were white painted sticks of different sizes, and they were long enough for each extremity to be hidden behind the margin of the aperture in the front wall of the instrument when placed upright in the holes. In this way it was found impossible for a person using one eye only to tell whether one stick was in front of the other; they always appeared to be in the same plane. The apparatus could, of course, be used at any distance, and it afforded a convenient way of ascertaining the quality of the stereoscopic vision in cases of partial amblyopia of one eye.

Mr. James alluded to the theories held with regard to the estimation of the sense of depth, and also to the importance of recognising the several grades into which binocular vision can be divided.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Surgery.

Meeting held Friday, January 11, 1907.

The President, Mr. H. R. Swanzy, in the Chair.

SOME POINTS IN THE TREATMENT OF ENLARGED PROSTATE.

Mr. L. G. **Gunn** made a communication on the above subject. He thought that too much attention was paid to the operative treatment of this affection. As many cases can be greatly benefited, though not cured, by non-operative treatment, it is well to remember this before advising a patient to have the gland removed. Mr. Gunn then gave a brief account of work he had seen at Paris, London and Berlin. At the first city prostatectomy was hardly ever performed, at London it was always advised, while in Berlin palliative measures were often used. The speaker then gave in detail the lines on which he tried to carry out the treatment of such cases, giving a short account of 41 cases of enlarged prostate which he had treated. Of these 11 had required operation, nine had made good recovery, two had died, 19 cases had been treated by palliative means with more or less relief. None of these had to use a catheter, as Mr. Gunn believed that the risks of catheter life must be always greater than the risk of an operation.

Mr. **Walton Browne** (Belfast), was pleased to hear Mr. Gunn advocating not being in a hurry in dealing with such cases. He believed a good deal could be done by washing out the bladder.

Mr. C. A. K. **Ball** expressed the view that a large number of cases had been operated on in the past which, no doubt, would have lived, and perhaps in a more comfortable state, had palliative measures been tried instead of operation. He thought that palliative measures ought to be employed unless there was absolute obstruction to the flow of urine.

Mr. D. **Kennedy** thought that before recommending either palliative or radical treatment the circumstances of the patient should be taken into consideration. A well-to-do patient could afford to avail himself of skilled surgical aid, and might well decide to undergo treatment of a palliative nature; but in the case of a man without means the proper employment of a catheter or other palliative measures might be attended with difficulty.

Mr. **Blayney** considered that there was a certain amount of danger attending the return to more conservative measures in the treatment of enlarged prostate. Many cases which had ended fatally after operation would probably have recovered had radical measures been carried out earlier.

AN EARLY CASE OF LEONTIASIS OSSEA.

Mr. S. **Horace Law** read a paper on a case of the above, which will be found under heading of "Clinical Records," on page 147.

In the discussion that followed the President regarded the dacryo-cystitis, not as a coincidence but rather as the direct result of the bony growth. He thought the best mode of treatment would be extirpation of the lachrymal sac on each side, as, under existing circumstances, ulceration of the cornea of a very intractable type would be likely to occur.

Mr. **Walton Browne** alluded to the symmetrical appearance of the two eyes. If the orbits were at all involved they must, he believed, be involved to an equal extent.

HARVEIAN SOCIETY OF LONDON.

Meeting held Thursday, January 24th, 1907.

The President, Dr Sidney Phillips, in the Chair.

Clinical Evening.

Dr. **Sidney Phillips** showed a case of "Congenital Heart Disease." The patient was a boy, æt. 9. There was a loud systolic murmur over the aortic cartilage; no cyanosis. The condition was probably one of congenital narrowing of the aorta.

Mr. **Clayton Greene** showed a case of "Bilateral Cystic Disease of the Kidneys" in a man, who had come under treatment for hæmaturia. The kidneys were greatly enlarged. The question of treatment was discussed, and in view of the hopelessness of these cases the possibility of kidney grafting was raised. It was suggested that a kidney might be grafted in the scrotum, the spermatic vessels and the vas deferens being used to take the place of the renal vessels and the ureter.

Mr. **Colebrook** showed, for Mr. Maynard Smith, a case of "dislocation" of the shoulder with a fracture through the lower half of the glenoid cavity. The patient was an elderly woman, and the injury had occurred four months previously. A skiagram was shown.

Dr. **Langmead** showed, for Dr. Caley, a case of "Aneurism of the Innominate Artery," and raised the question of surgical treatment.

Dr. **Phillips** considered the case unsuitable for operation. He pointed out the difficulties in exact diagnosis, and also the general degeneration of the patient's arteries, which were unsuitable for ligature.

Mr. **Crisp English** showed a man, æt. 62, with a large tumour of the left breast. This had existed for twelve years, had greatly increased during the last twelve months, and was mainly cystic. In its upper part was a small, very hard, and nodular area.

Mr. **Jaffrey** thought that the hard portion might prove to be sarcomatous.

Dr. **Spilsbury** considered that the tumour was probably an innocent cystic growth.

Mr. F. **Jaffrey** showed a woman with a fracture of the lower end of the radius and wasting of the muscles of the hand. In spite of continued massage, the condition had improved but slowly, and it was questioned whether any nerves had been injured.

Dr. **Sidney Phillips** thought that there was no actual paralysis, and that the muscles would ultimately recover.

Dr. **Sidney Phillips** showed a man suffering from general paralysis of the insane, with atypical symptoms.

Dr. **John Broadbent** showed a case of paralysis of the third cranial nerve of rapid onset in a woman, æt. 30. Improvement was occurring under treatment with potassium iodide. It was pointed out that some of these cases of nerve paralysis ultimately developed locomotor ataxia.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Feb. 3rd, 1907.

Tuberculous Laryngitis.

Tuberculous laryngitis is one of the most difficult affections to treat. The patients suffer and are impatient. The majority of medicinal agents give but temporary relief. However, besides the general tonic treatment of consumption, the laryngitis claims special remedies.

Two symptoms in particular distress the patients, dysphagia and hoarseness. For the latter, hot compresses on the front of the neck, changed frequently during the day, and cotton wool put on at night, together with hot drinks, will give some relief. The following mixture can be prescribed also :—

Dionine, 11 gr.
Tincture of aconite, 50 mm.
Cherry laurel water, 1 oz.
Canada balsam, 10 oz

A tablespoonful morning and evening in an infusion of eucalyptus leaves.

Pulverisations will act both on the hoarseness and the dysphagia :—

Menthol, 1 dr.
Proof spirit, 4 dr.
Water, 6 dr.

A tablespoonful in a glass of water for spraying the throat.

Or,

Hydrochl. of cocain, 15 gr.
Phenic acid, ½ dr.
Cherry laurel water, 1 oz.
Glycerine, 1 oz.
Water, 7 oz.

A tablespoonful in a glass of water.

For dysphagia itself the following application a short time before meals is beneficial :—

Phenic acid, 5 drm.
Cocain, 1 gr.
Glycerine, 2 oz.
Cherry laurel water, 2 oz.

Aspirations of certain powders is recommended by M. Leduc, for which he has invented a special glass tube. The powders he uses are composed of—

Iodoform, 2 dr.
Cocain, 2 gr.
Morphia, 1 gr.

Treatment of Chronic Diarrhœa.

Every practitioner has been consulted from time to time for obstinate diarrhœa, but which does not appear to compromise the general health. The patients suffer only from their diarrhœa; the alvine evacuations are often preceded by colic with abundant flatulency.

Examination of the abdomen or the different organs presents no important sign. Such a diarrhœa has neither a tuberculous nor a uræmic origin, nor is it due to ulcerations of the intestines. It seems rather to depend on insufficiency of gastric digestion. The stomach empties itself too quickly. M. Soupault, who read a paper on the subject before the Société Therapeutique, advises hydrochloric acid at the beginning of each meal, from 10 to 20 drops in a glass of sugared water.

Improvement is observed in from two to eight days, and finally a complete cure, and frequently without any change in the diet. However, M. Soupault prescribes a strict regimen, as well as enemas and antiseptic powders after meals. He treated thus 38 patients, of whom 21 were completely cured. The indications of the acid treatment are : Furred tongue gastric fermentation, and intolerance for milk diet.

The counter-indications are : Brilliant red tongue, the stomach painful to pressure, with a burning sensation, and when ulcer is suspected.

In such cases, astringents take the place of the acid treatment. At each repast a cup of infusion of wild strawberry root (20 gr. for each cup) and bismuth or ratanhia. M. Sinossier draws attention to a form of diarrhœa accompanying biliary lithiasis. It is produced exclusively at mealtimes. The patient sits down to table, feeling quite well. He has not gone far in his dinner before he experiences pain in the region of the gall-bladder, followed by an imperious desire of evacuation. He quits the table and passes a liquid biliary stool, after which he feels better.

It would be entirely wrong to treat this form by the classical means. Astringent and absorbent drugs are hurtful. A season at Vichy will give good results, or, if not possible, a drachm or two of sulphate of soda in a glass of Vichy water (warm) before each meal, and opium might be given from time to time.

M. Mathieu confirms the results obtained by M. Soupault. Hydrochloric acid succeeded with him, not only in chronic diarrhœa of neuro-arthritic patients but also in that of cancer and phthisis. He also prescribes :

Salicylate of bismuth, 6 gr.
Benzo-naphthol, 6 gr.
Resorcin, 10 gr.

For one wafer. To be taken before each meal.

Alopecia in Women.

Nothing distresses a woman more than to lose her hair, and it is the duty of the practitioner to be prepared to relieve her distress. If he succeeds in making the hair grow for his patient, she will be for ever grateful to him.

Alopecia in women might be put under two types —that accompanied by pityriasis, and that where no pityriasis is apparent. In any case, the treatment is simple, and consists mainly in stimulating lotions applied with a hard brush.

Dr. Sabourand recommends the following formulæ, which might alternate in their application, as variety in the remedies increases their actions :—

Hoffman's anodyne, 6 oz.
Spirits of camphor, 1 oz.
Spirits of lavender, 1 oz.
Nitrate of potash, 10 gr.
Formal, 15 mm.
Distilled water, 2 oz.

Acetone, 3 oz.
Proof spirit, 3 oz.
Liq. ammonia, 1 dr.
Caffein, 10 gr.
Tincture of capsicum, 4 dr.
Ess. of violets, 1 oz.
Water, 2 oz.

Hydrochlorate of pilocarpine, 10 gr.
Proof spirit, 6 oz.
Ether, 1 oz.
Spirit of lavender, 1 oz.
Rose water, 2 oz.

At the end of two or three months, new hair appears and continues to grow regularly. At the end of a year it attains three or four inches. Those patients who are not afraid of vigorous brushing are those who obtain the most satisfaction ; on the other hand, patients who fear to lose their hair by hard rubbing are certain to be disappointed as to the desired result.

Otherwise the constant success of the treatment demonstrated the difference between alopecia in women and alopecia in men. Nine times out of ten, M. Sabourand observed that in man it is a question of commencing baldness, which progresses more or less rapidly as years go by, in spite of every treatment; whilst in the same proportion in women, if the patient has not entirely recovered her hair, which is the rule, very satisfactory results are obtained.

Naturally, if some general trouble accompanies the alopecia (anæmia, hepatic colic, neurasthenia, constipation), it must be treated by the usual means. It would seem that in women, more than in men, the hair follicles are particularly sensitive to slight disorders of the organism.

GERMANY.

Berlin, Feb. 3rd, 1907.

At the Verein für Innere Medizin, Dr. Lewandowski showed a youth, æt. 15, who was suffering from

Hæmatomyelia.

He had been admitted into the Friedrichschain Hospital in August last. Before the present illness he had been perfectly healthy. He was a worker in tobacco, and had had to work in drawing the tobacco leaf out of a bag when in a bent position. Whilst at work he felt a violent pain between his shoulders, so severe that he had to give up. On dressing to go home, he suddenly collapsed and was unable to travel. The urine had to be drawn off. On admission into hospital there was complete paralysis of the right leg, less complete of the left. There was complete paralysis of the sympathetic of the right side. The second and third dorsal vertebræ were painful on pressure, but there was no spontaneous pain over them. In regard to diagnosis, it must be one of three things—(1) acute myelitis, but the sudden onset of the symptoms was against this; (2) spondylitis, but with that there would be great pain over the spine, and there was not, and an X-ray examination did not support this; (3) hæmatomyelia, hæmorrhage into the spinal column; and all the symptoms were in favour of this hypothesis. There he had now come to a standstill. The trouble was almost limited to the right side. Nothing definite could be said as to where the bleeding came from. The patient's occupation included lifting heavy bales of 80 to 90 kgm., and he had been doing this an hour before the attack. This for a youth of 15 was a good deal, and it might have caused the hæmorrhage. He would therefore have a claim to compensation for accident. In reply to a question from Dr. Cohn, he said the abdominal muscles were also paralysed.

At the Hufeland Society, Dr. Neumann spoke on a diagnostic point in connection with

Diseases of the Chest in Children.

He said that in children loud bronchial breathing was often heard between the shoulder-blades, and in front and behind on the right side an equally bronchial or prolonged expiratory sound.

This was important from a diagnostic point of view, as these symptoms had been very widely but erroneously held to be signs of phthisis. He pointed out that they were really a part of the symptoms due to enlarged bronchial glands, and he then pointed out what the other symptoms were.

At the Ophthalmological Society, Dr. Steindorff showed a patient with

Swelling of the Left Side of the Face.

It was at first taken to be a rheumatic affection, and antipyrin was given, but without effect. An examination of the adjoining cavities was then made, and both the frontal sinus and antrum were found to be dark, but no pus was found in the nose. The case was then taken to be one of mucocœle In the meantime the symptoms were getting worse; there was protrusion of the eyeball, paralysis of the oculomotor nerve, and great pain in the region of the frontal sinus, and it was decided to open the cavity. On this the striking result was obtained that there was no frontal sinus at all, that the antrum and the other sinuses were healthy. As the frontal nerve was cut through at the operation, the pain ceased, and a dull, tender spot remained. On October 10th the patient remarked that he had suddenly gone blind on that side, but the ophthalmoscope revealed nothing. Notwithstanding denial on the part of the patient that he had ever had syphilis, Hg. treatment was at once begun. Under this all the symptoms improved with the exception of the amaurosis, which showed itself to be due to gradually advancing atrophy of the optic nerve. He concluded that a periostitis that caused pressure on the nerve was the cause of the symptoms.

At the Medizinische Gesellschaft Dr. Baginsky showed a child who had become

Blind, Deaf, and Weak in Intellect through Whooping-Cough.

It had had convulsions, and the symptoms above-named had made their appearance after them. The pupillary reflex had remained, and this he took as a good omen—in fact, now there appeared to be some slight sense of sight, but the prognosis was very doubtful.

Probably the symptoms should be looked upon as of a toxic nature, but there was a possibility that they were due to multiple cerebral hæmorrhages.

The discussion on Heubner's paper on

Orthostatic Albuminuria.

was resumed by Dr. Langstein, who had made an examination of the tissue changes in Heubner's case. He found an albuminous body that could be precipitated in cold with acetic acid. No importance could be placed on increased excretion of oxalic acid. Urea and uric acid showed no changes. The disease was much more frequent than it had been thought to be. It had been found to be so especially in the polyclinics. A connection with a previous illness was very doubtful; orthostatic albuminuria had scarcely anything to do with nephritis; vasomotor disturbances probably lay at the bottom of it. Dr. Baginsky thought the affection had been considered in too "doctrinaire" a manner, and its clinical importance overestimated. He laid stress on the extraordinarily varying course, and noted its resemblance to purpura, in which, after the cessation of all hæmorrhages, they might come on again in the lower parts on the patient getting up. The kidneys as well as the vessels were probably at fault.

Hr. Fürbringer did not consider the kidneys shown sound, but did not consider the slight changes explanatory of the considerable amount of albumen passed. In his view kidney disease was not the basis of orthostatic albuminuria. He was supported in this by a case in which he gave a dietary that would have made a real kidney disease worse; he gave alcohol, large quantities of meat, meat extracts and spices, and, last of all, cold baths, and they had not the least effect on the disease.

For insurance it would not be right to reject every case of orthostatic albuminuria; the great majority of the cases, as was shown by the fact that Heubner was only now in a position to record the post-mortem condition of one.

Dr. V. Hausemann considered the cicatrices to be entirely without significance. Even fat in the kidneys was without any pathological significance so long as no cells were destroyed, and it was very frequently met with both in the human subject and in animals. He believed, however, that the cell nuclei in the glomeruli were increased for the age of the child. and from this there arose a possibility that there has been a previous glomerulonephritis.

AUSTRIA.

Vienna, Feb. 3rd, 1907.

High Tension Dyspnœa.

At the Gesellschaft, Pal communicated his experiments on paroxysmal dyspnœa produced by tension in the vessels. He divided these into two forms—cardiac asthma, which was identical with the second form, cerebral asthma—both of which could be relieved by reducing the blood pressure in the arteries. In both cases the asthma disappeared, while the cerebral symptoms were greatly improved in that form.

He further elaborated the connection between cardial asthma and angina pectoris, which, he contended, was due to stenocardia.

Lead Poisoning.

Pollek reported on a case of chronic lead poisoning, which he had exhibited to the members of the Gesellschaft two months ago. At that time he remarked that the symptoms were severe for such a short time since the onset of the injurious effect of the metal, which was estimated at three years. Since then the patient had died from lead intoxication, which was far below the usual time of exposure, recognised in these cases as thirteen and fourteen years.

Serum Diagnosis of Carcinoma.

Salomon presented a report of his investigations and experiments on the reputed ferments of cancer. His efforts were directed towards discovery whether carcinomatous tissue when injected into the body of an animal possessed any particular property on the serum of the blood. It was taken for granted that carcinomatous serum had an anti-ferment which prevented the autolysis of carcinomatous tissue. The inhibition of hæmolysis by carcinomatous serum is no more than what takes place in those cases where normal serum is used, as both are powerful inhibitors of hæmolysis. He found in one guinea-pig that when the carcinomatous substance was dried and rubbed into fine powder with common salt, and again dissolved, the solution formed a serum void of carcinomatous results. This reaction appeared in several other cases, but he would not as yet give it as a general rule, as the experiments were not sufficient to justify a final judgment.

Ranzi said that he had undertaken several experiments with serum in order to diagnose carcinoma, but his results were woefully disappointing. Neither the "precipitin," nor the "complemental deviation" methods were successful in the diagnosis. Hofbauer thought these experimental results had cleared up a point that seemed at one time very obscure, viz., carcinomatous asthma.

The etiology of the difficulty in breathing has hitherto been dissociated with serum, but recent experiments show that it is similar to the diseased thyroid which is connected with the serum elaboration that affects the breathing. Pibram informed the members that the sero-therapeutic Institute of Vienna had been working for some time with the various sera to discover a series of similarities in normal and pathological sera, but, unfortunately, up to the present time their efforts have been in vain. No classifications can be established. Klein thought that the best methods yet devised for the elucidation of this subject was the complemental deviation which fully explained the Gengou-Moresch phenomenon. Kraus remarked that Gengou, in 1902, showed that the presence of antidotes and their antigenes checked hæmolysis, but, strange to say, that Moresch three years later, without any knowledge of Gengou's results, rediscovered the same phenomenon, which gives importance to this anti-complemental system.

HUNGARY.

Budapest, Feb. 3, 1907.

At the recent meeting of the Interhospital Association, Dr. Förök read a paper on

The Treatment of Acne.

He maintained that acne is even commoner than eczema, and that while it is true that the disease is often stubborn, the majority of cases can be greatly benefited in a short time, and very many of them cured promptly. The indications for treatment are as follows:—(1) Improve the condition of the skin, so that it will no longer be a suitable culture ground for the bacillus. (2) Empty the follicles of the skin of the colonies of bacilli. (3) Keep the skin constantly aseptic, so that any bacilli that escape on it will be killed, and no new infection of the skin will be possible. The first indication is met by attention to the patient's general health, by means of baths, exercise, diet, attention to hygiene, and lastly, drugs. The follicles are emptied by the use of the curette, the acne lances, and the comedo-expresser. The best local application is sulphur, preferably in the form of the old lac sulphuris, which is mixed with carbonate of potash. Resorcin is also useful, as well as sulphur soap. The use of the X-rays should be limited to intractable cases, and requires great caution to prevent injury.

Treatment of Night Sweats.

Dr. Tauszk, writing on the above subject, says that one of the most disagreeable symptoms of early pulmonary tuberculosis is nocturnal perspiration, since it robs the patients of sleep and weakens them considerably. The cause of these night sweats is not known, but they are probably a result of the action of the toxins of the tubercle bacillus on the central nervous system. According to him, the treatment is very unsatisfactory, and hence the number of drugs recommended is legion. Antipyretics and atropine have been warmly recommended, but the former very often aggravate the condition, while a tolerance is very soon established for the latter. Agaricin is very uncertain in its action, and may cause diarrhœa, and the same applies to camphoric acid and its compounds. The author has invariably seen the best results after the use of veronal in doses of 0.3 grammes, rarely increased to 0.6 grammes. In conjunction with this, the patient should sleep in a cool room with open window, and use one of the many dusting powders recommended.

At the last meeting of the Medical Society, Dr. Levai referred to the

Therapeutical Value of Nitroglycerin.

He has tested the effect of this drug on arterial pressure in patients by means of the sphygmomanometer, and also in animals, and finds that high arterial pressure in man is not perceptibly affected by it, nor is dilatation of the blood-vessels apparent. Some of the conclusions reached are as follows:—The usual dose of nitroglycerin of 0.005 (half a milligramme) is too small to produce an effect in pathological conditions; one milligramme is a minimum dose. It is a perfectly safe drug to use. Even in large and repeated doses the speaker has never seen any ill effects. Its effects are very transient, as shown by the experiments on the dogs, and the ordinary dose of half milligram every four hours could not possibly have any effect on the arteries. Nitroglycerin is said to increase the quantity of urine (first observed by H. P. Loomis, of New York) in chronic Bright's disease; but after keeping accurate records of the daily amount of urine passed, the speaker was never able to satisfy himself that any increase seen was due to this drug. In conditions due to arterial spasms, so-called, such as angina pectoris, migraine, asthma, nitroglycerin may be of benefit, in full doses often repeated, but not in arterial sclerosis, where the arteries themselves are more or less changed.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Cerebro-spinal Meningitis.—During the past few weeks there has been a considerable incidence of cerebro-spinal meningitis in Glasgow, and the latest reports show that the cases are numerous enough at present to warrant the term epidemic. Up to the first of February the total number of deaths from the disease is given at 52. On the same date there were 50 cases, as compared with 35 on the corresponding day of the preceding week. Dr. Wright, chief assistant to the medical officer of health, states that 113 cases have been notified during the month; 6 of which, however, proved to be some other disease. In a large proportion of cases the disease has been very acute, death taking place in from 24 to 48 hours. Fifty per cent. of the cases have been children under 5, and 30 per cent. between the ages of 5 and 10. In Leith also several cases have occurred, and the medical officer for health has issued a circular to the pactitioners in the burgh requesting them to report any suspicious cases. It is officially stated by Sir Henry Littlejohn that no cases have occurred in Edinburgh. Special accommodation has, however, been prepared in the fever hospital for the reception of any cases that may crop up.

EDINBURGH SCHOOL BOARD MEDICAL OFFICER.—The following form the short list from which the medical officer will be chosen :—R. C. V. Ash, M.B., D.P.H., medical officer to the Carnegie Dunfermline Institution ; Katherine S. Clark, M.B., D.P.H., resident medical officer Claigleith Poorhouse ; J. D. McCrindle, M.B., D.P.H., assistant medical officer of health, Birmingham ; J. H. Merkle, M.D., D.P.H., Bacteriologist, Edinburgh City Hospital ; Robert Thornton, M.D., D.P.H., assistant lecturer on medical jurisprudence and public health, Dundee.

BANGOUR ASYLUM.—Dr. Fraser, Commissioner in Lunacy, has issued his report on the subject of Bangour village, and it was submitted to the Lunacy Board a few days since. While generally commenting favourably on the discipline and organisation of the asylum, the Commissioner draws attention to the absence of any provision for isolation or separate treatment of tuberculous patients. There are in the asylum 15 such cases, the malady being acute in 7 of them. The margin of spare accommodation for male patients is ample, but it is found that that for women may not prove enough, as, even by re adjusting the proportion of males and females in some of the buildings in favour of the latter sex, there will be, when all the presently existing cases are transferred to Bangour, only 16 vacant beds.

MORISON LECTURES ON INSANITY.—These lectures were this year delivered by Dr. Urquhart, Murray's Royal Asylum, Perth, on January 28th, 30th and February 1st, the subject selected being the prognosis of insanity. In the first lecture a retrospect of the literature of insanity was given, showing how the ancient dictum of Hippocrates, that insanity is caused by disease, had been lost sight of amid the superstitions of the middle ages, and how it had been restored by such thinkers as Van der Kolk, and established by Stras. He then referred to various researches on the pathology of insanity by ordinary clinical methods, referring in particular to Dr. Lewis Bruce's recent work on the law of insane persons. In his argument for the unity of the disease, as a result of morbid somatic conditions, he referred to Sankey's generalisation that insanity is but the process, and that the varieties are differentiated by non-essential phenomena—apart, that is, from cases of a definite pathological nature, such as general paralysis, alcoholism, epilepsy etc. In discussing the hereditary nature of the neuropathic diathesis, Dr. Urquhart adhered to Dr. Macpherson's opinion that it was a natural variation which tended to occur, just as any other variation did ; it seemed, therefore, that any rough-and-ready nostrum for eliminating the unfit was not likely to succeed. He appealed for collective evidence as to the heredity of families taken at random, until sufficient data were obtained to yield reliable results when treated by statistical and biometric methods. Proceeding (in the second lecture) to distinguish between insanity due to gross pathological changes and those whose nature was obscure, he set aside cases due to syphilis, epilepsy, alcoholism and congenital defect. In ordinary insanity of obscure cause, which he classified as melancholia, mania, and delusional insanity, he showed that mental stress was inoperative as a cause except in connection with a neuropathic heredity ; further, that the hereditary cases recover in fair proportion, though more subject to relapse than the acquired. In a study of environment it was found that middle-class patients, drawn from rural and urban surroundings, had a practically similar heredity. Town life, therefore, had no markedly evil effects, but the kind of insanity was more severe in patients from urban than in those from rural districts. In the final lecture of the series Dr. Urquhart discussed the relation of psychology to medicine, and alluded particularly to Kraepelin's work on fatigue and the revolution it had caused in the educational methods in Germany. Insanity could not be communicated from one person to another without pre existent bodily disorder, nor could hypnotism cause insanity unless the patient were neuropathic. The lecture concluded with a reference to the importance of individualised treatment, and of clinical investigation in all departments, for all have an immediate bearing on the problem of insanity.

BELFAST.

CEREBRO-SPINAL MENINGITIS.—The epidemic of cerebro-spinal meningitis has increased considerably during the past week. Up to Friday, February 1st, there had been 45 cases reported, and 20 deaths. About 20 cases are under treatment at Purdysburn Fever Hospital.

THE IRISH UNIVERSITY QUESTION.—Where professional men have met during the past week, the one topic of conversation has been the proposed legislation on University affairs, as foreshadowed by Mr. Bryce. On a subject on which opinions differ so greatly, it is hard to generalise, but among local medical men, the vast majority of whom are graduates of the Queen's or Royal Universities, the commonest feeling seems to be one of sympathy with the Trinity graduates in their strong objection to seeing their old University destroyed, as all agree it would be under the proposed scheme. As regards the local conditions, no one cares to express a definite opinion till the details of the scheme are published ; but if the changes proposed are to be made, the more autonomy they give to Queen's College, Belfast, the better most men will be pleased. A certain amount of distrust is caused by Mr. Bryce's rather cryptic remarks on University teaching in higher subjects and college teaching in lower. If he means that Belfast students are to be sent to Dublin to finish their education, the plan will be most strongly resented. As regards the probability of the scheme being passed by Parliament, it is felt that it would hardly have been made public unless the Government had obtained the agreement of the Roman Catholic authorities and the Irish National party to its principles, and also that Mr. Birrell would not take charge of it unless he were assured it was sure to meet with a kinder fate than befell his last educational effort. On the other hand, it is thought by many that the Government may not have realised the intense feeling that will be stirred up on behalf of Trinity, in which so many educated Englishmen will share ; a feeling in opposition to the proposed changes far stronger than any that is likely to be evoked in its favour, for at best it can only be looked on as a compromise. In short, if the scheme becomes law, the Act will be a congenitally deformed infant, which its parents alone love, and even they cannot be proud of.

FORSTER GREEN HOSPITAL.—The annual meeting of this hospital was held on the 31st ult., the Lord Mayor, the Earl of Shaftesbury, presiding. The medical report was read by Dr. Howard Sinclair. It stated that 1,477 patients attended the extern department during the year, and 164 were treated in hospital, the average number of beds occupied being 35. The medical staff continues to impress on the committee and on the public the desirability of treating early cases in hospital. The natural tendency of the uninformed layman is still to send to hospital the most advanced and hopeless cases.

BELFAST HOSPITAL FOR SICK CHILDREN.—The annual meeting of this hospital was also held on the 31st ult., and was presided over by Sir William Crawford. Dr. McCaw read the medical report, which showed that 837 cases had been treated in the wards, and 330 operations performed. In the extern department, 5,551 cases were treated, and the total attendances were 16,667.

LETTERS TO THE EDITOR.

INFECTIVE BRONCHITIS AND ITS RELATION TO CONSUMPTION

To the Editor of The Medical Press and Circular.

Sir,—I read with great interest Dr. Prosser White's paper in The Medical Press and Circular this week, and I find much in it which the experience of the humble general practitioner, who lives far from the madding laboratory, and who uses his own experience and common-sense as his chief guides, can confirm. But is not the chief cause of all our bronchial and nasal troubles a combination of external and internal conditions? And is infection—that is, direct infection—always necessary? It seems to me that we ordinarily and constantly carry about in our nasal and bronchial mucous membranes the germs of many diseases, but that the "chill"—the lowering of vital energy by external cause—is the effective condition That is to say, that if we sit in a draught, or get our feet wet, or sleep in a damp bed, the vitality is lowered, and the most vigorous microbe in the nose or bronchus get his chance to infect us—and frequently does so. If this is very bad nonsense, please destroy.

Yours truly,

Bacillarius.

Leicester, February 1st, 1907.

THE SCIENCE OF THE TEMPERANCE QUESTION.

To the Editor of The Medical Press and Circular.

Sir,—The views entertained and expressed by Mr. Haldane on the value of science in almost every kind of work are likely to have great influence, and it would be well if the temperance question could be carefully considered from a strictly scientific point of view.

The question is this: What is alcohol, and how is it produced? That is the first question. What is the value of alcohol in health or disease? is another question. Alcohol is the product of fermentation, a process of a very singular character. There is one thing quite certain, and that is, we may use ordinary fermented liquids without injury to digestion or health if not used in excess; but if we separate the alcohol and use that, it is a very different matter. When we have to consider how to legislate on this temperance question, we must draw the line strongly and markedly between a fermented liquid and alcohol. There would be no difficulty in working on this simple basis, and there is no doubt but that the assistance of the medical profession in settling this matter would be great.

I am, Sir, yours truly,

Temperance.

DIRTY AND INSANITARY RAILWAY CARRIAGES.

To the Editor of The Medical Press and Circular.

Sir,—The time has long passed when the better cleansing of railway carriages should have taken place. If anyone only watches the *modus operandi* at any of our stations, you cannot but be struck at the perfunctory manner in which the work is done. With a brush and dustpan the porter simply walks in one side, flings the brush about, and walks out of the other side; does not even remove the loose dust, leave alone what is trodden into the wooden floor. Soap and water is an unknown quantity with the carriages from their birth to the scrap-yard. What should be done is the removal of the seat cushions at the end of each journey, and well brushed, if the material will not allow of it being washed with some disinfecting fluid. The back cushions should be made to be removed also, and treated in like manner. The woodwork of the seats should then be washed with soap and water; also the floor, doors, racks, roofs, and sides. The seats, if made to turn up on hinges, would greatly facilitate the process of proper cleaning. But it will never be done while the work is left to such a class of men as railway porters, or carriage cleaners, as they are incorrectly called. Each railway company should have a properly qualified medical officer of health, whose duty it should be to travel up and down the line and see that the station waiting-rooms, lavatories, and all places connected with the company are kept clean and sanitary. At present some of the provincial stations are a disgrace to the company and country in which we live. How often does one see the hose turned on the platforms of a station which are in use for about eighteen hours a day, people spitting and animals running about, live stock deposited on the station to await removal, milk cans left for hours sometimes, and other articles for food consumption? The dirt and offensive matter is allowed to dry in at night. The porter runs a long brush over it, and that is sufficient until the next morning. I have known and traced infectious diseases to railway stations and carriages, but, of course, it is impossible to say which compartment or train very often. Those who cater for the public, whether carriers, or food producers or sellers, are not sufficiently under control.

Yours truly,

Edward Carnell, D.P.H

OBITUARY.

SIR MICHAEL FOSTER, K.C.B., M.A., M.D., D.Sc., D.C.L., LL.D., F.R.S.

We regret to announce the death of Sir Michael Foster, which occurred suddenly on January 29th. Born in 1836, at Huntingdon, Michael Foster was educated at University College School, and at University College, London. After taking his degree of M.B. at London in 1859, he practised for a few years as a surgeon at Huntingdon; but in 1867 he became Teacher, and two years later Professor, of Practical Physiology at University College, London. In 1869 also he was appointed to the Fullerian Professorship of Physiology at the Royal Institution in succession to Huxley. In 1870 Foster went to Cambridge to teach physiology as Prælector of Physiology at Trinity College. In 1883, by the new statutes, Cambridge was able to confer a degree upon him, and to recognise the success which had attended his efforts by endowing a chair of physiology for him to fill. He took by far the larger share in the development of the Cambridge Biological School, and his influence was not confined to the department of physiology alone. In 1900 the duties of his chair were entrusted to a deputy, and in 1903 he handed in his resignation. In 1872 Foster was elected into the Royal Society, and in 1881 he succeeded Huxley as one of its secretaries. He held this post till 1903, taking a very active part in the work of the Society, and he also found time to serve on the Royal Commission on Sewage Disposal and to act as chairman of that on tuberculosis. In 1900, when Sir John Lubbock was raised to a peerage, he was elected in his place as member of Parliament for the University of London. At first he was a Liberal Unionist, but later his opinions changed and he sat on the Liberal benches. Sir Michael Foster's own contributions to the work of original research were not very numerous, but as a teacher he exercised a profound influence. Sir Michael Foster was the author of a "Text-Book of Physiology," which was first published in 1876, and has gone through seven editions. In addition he wrote a life of Claude Bernard, "Elements of Physiology," in conjunction with Dr. J. N. Langley, and "Elements of Embryology" with F. M. Balfour; and with Dr. Ray Lankester he was joint editor of the "Scientific Memoirs of T. H. Huxley." The "Journal of Physiology" was founded and edited by him. He was created K.C.B. in 1899, and acted as President of the British Association at its Dover meeting in the same year. Many other scientific and academic distinctions also fell to his lot, including honorary degrees from Oxford, Dublin, Glasgow, St. Andrews, and the McGill University, together with membership of various foreign learned societies. He was twice married, first to Georgina, daughter of Mr. C. Edmunds, and secondly to Margaret Sarah, daughter of Mr. G. Rust.

WILLIAM M. PREES, M.R.C.S.ENG., L.R.C.P.ED.

WE regret to announce the death of Mr. W. M. Prees, of Liverpool, which occurred suddenly at the West Derby Union Offices on January 22nd. Mr. Prees had been officially connected with the West Derby Guardians for nearly thirty years, his first position in the service of the Union being that of medical officer at Mill Road Infirmary, which was then used as an infectious hospital. He held his present appointment for many years, and by all the officials in the union and amongst the poor he was held in the highest respect and esteem, and his sudden death will be deeply regretted by all who knew him. When he first came to Liverpool he started as an assistant to Dr. Sheldon, in Boundary Street, whom he left to take up the position of medical superintendent at Mill Road.

SAMUEL PARTRIDGE, M.R.C.S., L.S.A.

WE are sorry to have to record the death of Mr. Samuel Partridge, of Great Barr, formerly of Darlaston. The deceased gentleman was the first medical officer of health for Darlaston, and continued in that position for forty years. He was also district medical officer, and for 35 years was certifying surgeon under the Factory Act for Wednesbury and Darlaston. He married the younger daughter of Dr. Henry Garman, of London, sister of Dr. William Garman, of Lapley Hall, near Stafford, and leaves three sons, one of whom, Dr. Sydney Partridge, is the present medical officer of health for Darlaston.

JAMES LITTLE, M.D.ED., M.R.C.S.

WE regret to record the death of Dr. James Little, which occurred at his residence, Fleming Square, Maryport, on January 29th. The deceased, who suffered from phthisis, was in the Threlkeld Sanatorium on the slope of Blencathra for a time, and derived considerable benefit from the treatment. On getting back to work again he speedily relapsed, and in the end died from pleurisy. He qualified as M.R.C.S. (England) in 1874, and took the M.D. at Edinburgh in 1877. He was appointed a Justice of the Peace for Cumberland in 1900, was formerly surgeon-major of the 1st C.R.G.V.A., a Fellow of the Royal Institute of Public Health, and medical officer of health for Maryport. Dr. Little was a man of many parts—a successful physician, a skilful vocalist and musician, an entertaining conversationalist; in his youth he was a good all-round sportsman.

SPECIAL ARTICLE.

ROYAL COMMISSION ON TRINITY COLLEGE, DUBLIN, AND THE UNIVERSITY OF DUBLIN.

With reference to the provision made for post-graduate study and the encouragement of research, the Commission report as follows:—

"The only special provision in the College for the endowment of post-graduate study or for the encouragement of research is afforded by the FitzGerald Memorial scholarship and medal. A fund of £1,600 was collected and invested, a part being allocated to an endowment of a scholarship for the encouragement of research in Physical Science by students who have obtained the B.A. degree of the University, and who during the term of the scholarship are to carry on research in the Physical Laboratory of the College, and to take part in the practical instruction of students therein, and the residue to found a medal to be awarded to students for research work carried out in the Physical Laboratory of the College. We learn with much satisfaction that, as a result of a public effort, a new laboratory for the School of Experimental Physics has just been completed; that the accommodation for the School of Botany will be largely increased, and that the School of Geology and allied sciences will shortly receive some extension of room.

"We are of opinion that some more definite encouragement of post-graduate study and of research is essential to the full life of such an academic body as Trinity College, and without attempting to go into details we *recommend* that opportunity shall be given to some of the Probationary Fellows and to graduates of Dublin and other Universities under proper conditions as to residence or supervision, to pursue courses of independent research, whether in literary or scientific subjects, and that by way of further encouragement degrees shall be awarded for research in the University, following, so far as may seem desirable, the arrangements in that respect of the Universities of Oxford, Cambridge, Edinburgh, and London. If these suggestions should be adopted it will evidently be necessary to establish a special fund in aid of research, and, though external help may be necessary, we *recommend* that attention shall be given to the point when the whole financial position of the College is considered.

"We feel bound to add that, in spite of the absence of special endowment for original research, the publications made from time to time by both the elder and younger members of the College show that much admirable and original work, and some of the very highest character, owes its inspiration to the College."

The Commission report as follows with reference to the opinion they have formed of the character of the University, its work in the past, and the manner in which the Board has discharged its duties to the Institution:—"The University and College have not been unmindful of the advancement of learning and the widening of science; and the Board of the College has been enabled within the last fifty years, from funds partly of the College and partly contributed by friends of the College to make important additions to the teaching staff and to the equipment of the institution. From the statement in the Appendix it will be seen that within that period there have been established within the College twelve new professorships, and ten new lectureships, and that the following buildings have been either constructed and equipped or greatly enlarged and improved—viz., the Museum Building, the Medical School Buildings, the Laboratories for Mechanical and for Electrical Engineering and the new Buildings of the School of Experimental Physics. The foundations of a new building for the Botanical School are at present being laid. . . . We believe that Trinity College is capable of improvement, as we shall indicate in the course of this Report, and that it will in the future increase in strength and usefulness; but as it stands to-day it is a noble institution for the maintenance of sound learning not unworthy of its great traditions and of the affection and veneration with which it is regarded by its children. . . . We desire to express very strongly the high opinion which we have formed of the work done by the Board as the supreme power in the College, and of the liberality with which, during the last half century, it has striven to extend the area of instruction within its walls. But, nevertheless, we are of opinion that certain changes in the government of the University and College would increase their usefulness to the country."

The foregoing conclusions and remarks are signed by the whole body of Commissioners, and constitute the Report proper. To this Report is added a number of notes signed by different members. The first of these is signed by Sir Edward Fry, Sir Arthur Rücker, and Mr. S. H. Butcher, and details the reasons why they consider that any second College should be affiliated, not with Trinity College in Dublin University, but with the Royal University. The second note is signed by the Lord Chief Baron, Sir T. Raleigh, Professor Jackson, Dr. Douglas Hyde, and Dr. Coffey, and details the reasons why they think any new College or Colleges should be affiliated, not with the Royal University, but with Trinity College. The third note is signed by the Lord Chief Baron, Dr. Douglas Hyde, and Dr. Coffey, and gives with more detail some of the reasons which lead them to the conclusions stated in the previous note, and with which reasons presumably Professor Jackson does not agree. The fourth note is signed by the Lord Chief Baron, and refers to the relation between Trinity College and Dublin University. The fifth note is signed by Professor Jackson, and gives the reasons why he considers the present time an unsuitable one for forcing an affiliation between Trinity College and any newly constituted Colleges within the University of Dublin, although he approves the principles of such a scheme. The sixth note is signed by Dr. Douglas Hyde and Dr. Coffey, in which they state that they have no objection to two teaching Universities in Dublin, and express the belief that two such Universities will be necessary if the recommendations which they have made in the previous note are not carried into effect. The seventh note is signed by Mr. S. B. Kelleher, and states that he considers the demand for a College for Catholics in Dublin is unreasonable, and could not be conceded without "grave injury to the interest of Irish lay Catholics, and grave danger, at no distant date, to the peace of the country." The final article in the Report is a memorandum on the relation between the College and the University which has been added as additional information on this important point.

We think that all those who study the Report in its entirety will agree as to the painstaking and careful manner in which the Commission has discharged its duties.

Rapidly following the publication of the Report of the University Commission came a speech from Mr. Bryce, the departing Chief Secretary for Ireland, to a specially summoned deputation of representatives of the Presbyterian Church and of Roman Catholic laymen. In the course of a lengthy speech Mr. Bryce laid before his audience the principal point in the scheme which the Government intended to adopt. He repeated the four courses which were open, and to which we have already referred, and, like the Commission, reduced them to two, that of a College engrafted upon either the Royal University or upon Dublin University. He then proceeded to give the reasons which lead the Government to favour the latter scheme, and to unfold their proposals. These are briefly as follows:—The Government propose to create a new College in Dublin University such as is contemplated by the Majority Report of the University Commission. They propose to furnish it with adequate buildings and laboratories, and they hope that as regards the scientific aspect, use may be made of the Royal College of Science, and that its laboratories and apparatus may serve to avert the necessity of having to spend a great deal more money in crediting a complete set of things for the purposes of the new College. They propose to start the new College with a grant sufficient for buildings, and with an annual sum which will be enough to put it on a proper footing as a place for imparting education suitable to modern requirements. They will be able to draw for that purpose upon the funds of the Royal University. They propose that this new College shall be entirely free from any kind of theological tests, or any test to be imposed either upon governors, teachers, students, or upon persons who hold any emoluments. The governors of this new College ought to be appointed in the first instance by the Crown, and thereafter be appointed partly by the Crown and partly elected by the teaching staff and by the graduates—that is to say, the graduates belonging or attached to this new College. And when that system was in full operation the Crown nominees would be in a minority. The Royal University will be dissolved, and the graduates of the Royal University will be transferred to the new enlarged University of Dublin, which would give a national University for Ireland. The University of Dublin shall be enlarged to become a National University for Ireland, and to include as constituent colleges —(1) Trinity College, (2) the new College in Dublin, and (3) the Queen's Colleges in Cork and Belfast. Mr. Bryce agreed with the Commissioners in thinking that Cork and Belfast are not yet ripe to be created into separate Universities. This enlarged University of Dublin would be administered by a governing body or senate, partly nominated by the Crown and partly created by election, chosen by University teachers and by the whole body of graduates. The graduate representatives could be increased later on.

The University will be absolutely unsectarian, and there will be no tests for governors, fellows, if any, teachers, students or examiners. The University governing body will control and direct examinations, appoint University professors, subject to the approval of the Crown. The teaching in the Colleges would be supervised by the College bodies. The University would provide teaching in advanced subjects which are non-controversial subjects.

Whatever can be said for or against this projected scheme, one thing is obvious—that, apart from the question of names, the effect of Mr. Bryce's proposal is not to abolish the Royal University, and to enlarge Dublin University, but to abolish Dublin University and to add Trinity College to a reformed Royal University.

It may be well to repeat here the extract from the "Notes" appended to the Report of the University Commission by Sir Edward Fry, Sir Arthur Rücker, and Professor Butcher. Referring to the proposal to add the new College to an enlarged Dublin University, they say:—

"Trinity College rejects it. Lord Justice FitzGibbon, in refusing to accept it, speaks probably the general voice of his Protestant brethren. Mr. O'Reilly, expressing, as he believes, the opinion of the great mass of the Roman Catholic laymen of Ireland, considers it the worst of all proposals and intrinsically impracticable. The Rev. Dr. Delany, who may be taken to represent the higher Roman Catholic teachers in Dublin, reprobates it. The Rev. Dr. Hamilton, speaking for Belfast, Dr. Windle for Cork, and Dr. Anderson for Galway, are unanimous in their disapproval; and if possible still more important is the condemnation unanimously passed upon the scheme by the Senate of the Royal University at a large meeting of that body, which probably more thoroughly represents the higher education in Ireland outside Trinity College than any other body in Ireland."

On Friday last the evidence given before the Commission was published in a large Blue-book which possesses great interest for those who would understand the relation between Mr. Bryce's proposal and the opinions of those examined before the Commission. The principal medical witnesses were Dr. A. C. O'Sullivan, F.T.C.D., Professor of Pathology in the School of Physic, Trinity College; Dr. A. F. Dixon, Professor of Anatomy; Dr. W. H. Thompson, Professor of Physiology; and Dr. McWeeney, Professor of Pathology in the School of Medicine, Cecilia Street, Dublin. Two other events of importance have also occurred during the past week. On Thursday last a meeting, composed of about 50 members of the Staff of Trinity College and the College Council, was held, under the presidency of the Provost, for the purpose of further considering the Government scheme, as outlined by Mr. Bryce, for settling the Irish University question. It was unanimously resolved:—"That this meeting, consisting of the Provost, Fellows, ex-Fellows, Professors, Lecturers, and members of the Council, summoned for the purpose of considering Mr. Bryce's speech of January 25th, is unanimously of opinion that the scheme which he outlined would be fatal to the best interests of liberal University education in Ireland, as well as unjust to Trinity College." A Committee to be called the Dublin University Defence Committee was also appointed. On Friday a meeting of the Bishops of the Church of Ireland was held, at which resolutions opposing Mr. Bryce's scheme were adopted. Further, a most emphatic protest has appeared in the pages of the *Cork Examiner*, in which the scheme is described as a "deliberate insult on the country and on its most eminent and most competent spokesmen of every creed, class, and province."

REVIEWS OF BOOKS.

NUNNELEY ON ANEURYSM OF THE AORTA. (*a*)

The disease described in this monograph is, as the author remarks, one which escapes diagnosis very frequently. The symptoms are very often obscure, and, moreover, the very rarity of the disease causes it to be diagnosed with reluctance. The author takes a very modest estimate of his book, which is admirably written. The etiology of the disease is carefully considered, and in this connection it is noteworthy that in sixteen out of thirty-two cases death occurred before the age of 35. Nearly 50 per cent. of the cases are found to occur between the ages of 30 and 40. The majority of patients are women, while sudden violent effort generally produces the aneurysmal dilatation rather than continuous heavy work. Rupture of the aneurysm is by far the commonest mode of termination. The symptoms observed are pain, gastro-intestinal phenomena, cough and dyspnœa, spasm and twitching of the leg muscles, œdema of the right leg (in one case), retention of urine, and insomnia. The diagnosis is very carefully considered, and reference is made to the statement of Prof. Osler that in old men with thin abdominal walls a very sclerotic aorta may suggest aneurysm. The question of treatment is fully and fairly discussed. Reference made to the gelatin mode of treatment is to be noted, because the author considers it no more satisfactory as regards results than the Tufnell treatment. Röntgen-ray examination is only of service as a means of confirming a positive diagnosis.

The second part of the volume is taken up with records of cases, numbering thirty-two in all, and drawn from St. George's Hospital. Short histories are given as well as an account of the *post-mortem* findings in each case. These records are of great interest and permanent value to clinicians. The author supplies a table giving the more important data regarding these cases under separate headings. The volume contains a great deal of practical information, and adds not a little to our knowledge of this fortunately rare disease. The author was well advised in publishing this dissertation in book form, as it fills up a vacant corner in medical literature in a way which must at once commend itself to the profession. We cordially commend this monograph as a very valuable supplement to the ordinary text-books on medicine.

CARTER ON PRACTICAL MEDICINE. (*b*)

There are probably few medical men who do not remember using this text-book in their student days or as a work of reference in the early years of practice. We have now before us the ninth edition of this standard and well-approved manual. It has stood the test of time, and forms one of the best elementary introductions to the study of medicine that have been published. In this edition the chapters on Pathology and nervous diseases have been revised by Dr. Stanley Barnes, while the section on skin diseases has been revised by Dr. Douglas Heath, Otherwise there are but few changes to note in this edition. The nomenclature adopted is sensible. Thus pulmonary tuberculosis is used as synonymous with the older term, phthisis, and pulmonary fibrosis as equivalent to interstitial pneumonia. In speaking of the operative treatment of appendicitis, Dr. Carter mentions that this should not be undertaken hastily, and that apart from sudden perforation and general peritonitis, it is rarely justifiable earlier than the fourth day. A valuable feature of the book is the collection of typical prescriptions appended. They will serve as models for the student to follow in writing his own prescriptions in any particular case.

As a handy introduction to the study of the Practice of Medicine, Dr. Carter's book would be hard to beat. It has several rivals, but it bids fair to hold its own against all newcomers. Its teaching is sound and practical, and the student who masters its pages will have his mind stored with valuable facts which will serve him in good stead not only in his final examination, but in the actual practice of his profession. We congratulate the author on the success of his efforts to produce an introductory manual of practical medicine, unburdened by needless details and theoretical discussions.

DISEASES OF THE EAR, NOSE, AND PHARYNX. (*a*)

The authors of this text-book have designed it primarily as a treatise on diseases of the ear and their treatment; affections of the nose and pharynx are only dealt with as subsidiary though essential causes of many aural troubles. The first chapter is devoted to a description of the various special methods of conducting examinations of the ear and nose, and we note that the writers, in contradistinction to most British rhinologists, use the palatal hook for posterior rhinoscopy. Next comes an outline of the anatomy of the external ear and auditory canal, followed by an account of the diseases of those structures. We are not prepared to accept in its entirety the authors' view of the pathology of hæmatoma auris in the insane, especially the statement that when it occurs it is a symptom "which points to an incurable form of brain disease." This, perhaps, is not so astonishing as to learn (page 112) that "very small fish have been known to enter the auditory canal while the victim was bathing. . . . Cases have been seen by the authors." In face of this assertion, we do not doubt that the fish did enter the auditory canal, but we must stipulate for their being "very small"—if we are to swallow them. Next comes the anatomy of the middle ear, which is sufficiently entered upon, as is also the physiology of hearing. The rest of the book consists of a satisfactory, straightforward account of the diseases of ear and nose, and the methods by which they are best treated. In the causes of deflection of the nasal septum, it is noticeable that early adenoid hypertrophy causing malformation of the palate and nose is not given the prominence to which we ourselves think it entitled, and in the operations for rectification of deflection, submucous resection, which gives such good results over here, is not favoured by the authors. In the operation for adenoids, it is recommended that the tissue to be removed should be painted or injected with 1-1,000 solution of adrenalin chloride immediately before operation, in order to lessen hæmorrhage. This is new to us, and seems difficult to accomplish, while we can hardly admit that the danger from hæmorrhage is "considerable," at any rate within our own experience. A "distinguished surgeon of New York" is taken to task for saying that while writers on aural surgery say much about the neglect of diseases of the ear occurring in the course of the exanthemata, he has found no means of doing anything to prevent the breaking out of such disease while measles and scarlet fever are going on, and he does not know, after all the warnings, that there is anything really to be done. We not only find ourselves in agreement with this surgeon, but also confess to finding no reason in what the authors tell us for altering our opinion. The rapid and insidious advent of middle-ear implication in these maladies baffles any prophylactic measures that we are acquainted

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(*a*) "Aneurysm of the Abdominal Aorta: Being a Dissertation for the Degree of Doctor of Medicine in the University of Oxford." By Frederick Pitcairn Nunneley, D.M., M.A., Brasenose College. Crown 8vo. Pp. vii., 121. 3s. 6d. net. London: Baillière, Tindall and Cox. 1906.

(*b*) "Elements of Practical Medicine." By Alfred H. Carter, M.D., M.Sc., F.R.C.P., Professor of Medicine, University of Birmingham, Senior Physician to the Queen's Hospital, Birmingham, &c. Ninth Edition. Pp. xvi., 614. Crown 8vo. 10s. 6d. London: H. K. Lewis. 1906.

(*a*) "A Text-Boox of the Diseases of the Ear, Nose and Pharynx." By D. B. St. John Roosa, M.D., LL.D., Professor of Diseases of the Eye and Ear in the New York Post-Graduate Medical School and Hospital, and Bearman Douglas, M.D., Professor of Diseases of the Nose and Throat in the New York Post-Graduate Medical School and Hospital. London: Macmillan and Co., Ltd. 1905. 12s. 6d. net.

with. The very small fish is nearly equalled by another incident related by the authors towards the end of the book, in which deafness from "affection" of the labyrinth resulted (apparently) from a kiss upon the ear. Finally, we may say we are cordially in agreement with the view that the medical treatment of deaf-mutes should go hand in hand with their education. Taken all round, this is an interesting book; it shows independent thought and opinion, and is not without a certain attractiveness of its own.

STEWART ON NERVOUS DISEASES. (a)

It is with considerable pleasure that we welcome the appearance of this volume. Such a book has long been wanted, and the present writer has judiciously supplied the demand. If we may judge from his style, he is accustomed to teach, and reflects his methods in clearness and directness of exposition, in attention to system, and in an apt discrimination between essentials and non-essentials. As he points out in his preface, it is seldom that diseases are met with in their typical forms, and hence the importance of being able to properly co-relate symptoms and physical signs in making a diagnosis. His aim is to put the student and practitioner in the position to do so as far as disease of the nervous system is concerned, and, in fact, to obviate the necessity of wading through long and often theoretical descriptions of many morbid states before coming to a definite conclusion about a doubtful case. The book commences with a short description of the clinical anatomy and physiology of the central nervous system, and in it we notice that he adopts, without comment, the view that most of the many fibres for touch, temperature and pain cross in the spinal cord soon after entering it, and proceed upwards in the contralateral region. The table on page 22, summing up the symptoms found in upper and lower motor neuroses respectively, will be found useful, but might have been supplemented by a similar state of "sensory neurosis" symptoms. The following chapter contains a very complete case-taking scheme, and then follow chapters on such symptom groups as coma, postures and gaits, tropho-neuroses, disorders of articulation, &c. It is unnecessary to criticise the facts in these, as they contain nothing that is specially new, and owe their value to the method in which they are treated. We may, however, express surprise at one point, namely, that Downs' view concerning the course of the taste fibres through the root of the fifth nerve is the one adopted, in spite of the large amount of clinical and pathological evidence which now exists against it. A chapter also is given on "reflexes," and on electro-diagnosis, both of which are admirable practical summaries of the subject dealt with. The book is profusely and well illustrated, and in particular we would draw attention to the well-selected series of photographs from clinical cases which are used to illustrate different points.

SCHOOL HYGIENE. (b)

There is no doubt a call for a book of the type before us in these days of carrying sanitary war into the elementary school, and we have not come across any short work on the subject which embodies as much information of a modern sort as does this little work by Dr. Porter. But we are not sure that, admirable as it is in many ways, it is quite the ideal text-book. To begin with, the descriptions of the structures and functions of the body seem to us to take up a disproportionate amount of space, and considering that the persons for whom the book is intended are supposed at the outset to have no anatomical or physiological knowledge, we think a lighter and more elementary style would be more helpful to them. Then, too, when teachers read a book by a medical man, they want something more than they can get from health lecturers and people of that sort, and it seems to us a matter for regret that Dr. Porter did not dwell more fully on the medical aspect of children's departures from health, especially the early and insidious manifestations. What he does say is good, sound, and sensible, and perhaps in the next edition he may see his way to expand this portion, even if he does so at the expense of the anatomical detail. But the book is one which can be safely recommended, for it is carefully and conscientiously written, and is quite straightforward and free from bias.

FOOD PRESERVATIVES. (a)

A medical man, although he may not often be brought into touch with the subject of this book from the scientific point of view, should be conversant with the broad facts of the subject. Unfortunately, this branch of science has not yet reached the stage when dogmatic assertions can be made, and in order to gain even a superficial knowledge, it is necessary to consider many experiments (often of an apparently contradictory character), and to make one's own deductions therefrom. The authors have, however, done their best to condense and elucidate the subject in its different aspects, and the reader is put to a minimum of trouble in connection with the acquirements of a knowledge of the subject.

Briefly put, the views of the authors may be stated to be that although of opinion that milk should be free from preservatives, yet other comestibles are not to be condemned on this ground, except the preservative be present in obviously injurious amounts. "It is impossible to say definitely that a single case of illness has ever been conclusively traced to the preservative," and "the old preservatives are permitted without question, although some of them are more deleterious if taken in immoderate quantities than their more modern substitutes."

There is one important point on which we find the book deficient: there are no figures given of the nature and amount of preservatives in well-known proprietary articles of food, with the exception of one or two instances mentioned under "Legal Cases."

HEATH'S MINOR SURGERY AND BANDAGING. (b)

We have before us the thirteenth edition of this well-known work. The fact that it is the thirteenth renders it unnecessary, and indeed impossible, to say much about the book. A careful examination has, however, led us to feel assured that it has been thoroughly brought up to date, and that it is fully entitled to retain the position it has held for so many years as a trustworthy guide to the house-surgeon and senior student in the performance of their duties. Owing to the death of the author, the present edition is produced under the able editorship of Mr. Bilton Pollard. Its original character, however, is maintained, and the alterations and additions, whilst only slightly increasing the size of the volume, have, if possible, enhanced its usefulness for the purposes already mentioned. We confidently expect that the reception of this new edition will be as favourable as that which has been given to the earlier ones.

(a) "The Diagnosis of Nervous Diseases." By Purves Stewart, M.D., Physician to Out-Patients at the Westminster Hospital. London: Edward Arnold. 1906.

(b) "School Hygiene and the Laws of Health." By Charles Porter, M.D., B.Sc., M.R.C.P.Edin., Barrister-at-law. 119 illustrations. London, New York, and Bombay: Longmans, Green and Co. 1906.

( ) "Preservatives in Food and Food Examination," by J. C. Thresh M.D., D.Sc., F.I.C., Lecturer on Public Health, London Hospital Medical College, Medical Officer of Health, Essex County Council, and A. E. Porter, M D., M.A., Assistant Medical Officer of Health and Chief Sanitary Inspector, Leeds, Demonstrator of Public Health, Leeds University, 1906. London: J. and A. Churchill. Pp. 484 and xv. Price 14s. net.

(b) "Manual of Minor Surgery and Bandaging," by the late Christopher Heath, F.R.C.S. Thirteenth edition, revised by Bilton Pollard, F.R.C.S., Surgeon to University College Hospital. London: J. and A. Churchill. 1906. Pp. 409.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL SUMMARY.

Ante-Partum Ophthalmia.—Stephenson and Ford (*The Ophthalmoscope*, April, 1906) analyse 31 published cases and 17 observed personally to show the occurrence of ante-partum ophthalmia. The paper is long, but the summary of conclusions shows that they prove their point. They are: (1) Instances of ante-partum ophthalmia are not so uncommon as hitherto believed. (2) About one-half of the cases (44.5 per cent.) are satisfactorily accounted for by a premature rupture of the membranes, allowing access of micro-organisms to the baby's conjunctival sac. (3) In the remaining cases (55.5 per cent.), a slight injury to the membranes may determine access of micro-organisms, or infection through the uninjured membranes must be assumed to have taken place. (4) Increased temperature of the conjunctival sac in utero, enhanced virulence of the causative micro-organisms, feebleness of the babies, slight lateral tears of the membranes, position of the fœtus in the maternal passages, and the condition of the placenta cannot be shown to be connected with the causation of ante-partum ophthalmia. (5) Several so-called congenital anomalies of the eyes, as corneal opacities, staphyloma, micro-ophthalmos, cryptophthalmos, and lacrymal abscess, are probably to be explained on the theory of an intra-uterine infection. M.

Injection of Alcohol in Facial Spasm.—Abadie and Dupuy-Dutemps (*Arch. d'Ophthal.*, February, 1906) have treated a case of one-sided facial spasm by deep injection of stovaine and alcohol into the facial nerve trunk. The operation was followed by paralysis of the facial nerve, which disappeared slowly. After two and a half months the paralysis had disappeared. The authors recommend the procedure as being free from danger, painless, and as superior to division of the nerve, which is usually followed by permanent facial paralysis M.

The Treatment of Paralytic Talipes Valgus by Tendon Transplantation.—Kilvington (*Brit. Med. Journ.*, Jan. 19th, 1907) reports three cases in which this treatment was employed satisfactorily. Case 1.—Child, æt. 4½ years, had paralysis of both tibial muscle and the extensor longus hallucis of the right leg. The flexor longus hallucis and communis digitorum were weak. Operative treatment was as follows:—The peroneus longus was cut as long as possible, brought across the front of the joint, and fixed to the inner and under surface of the scaphoid by silk sutures. About one-third of the tendo Achillis was split off its inner side, the separation extending well up into the calf muscle. The muscle thus formed was placed behind the inner malleolus in the sheath of the tibialis posticus, and fixed to the under surface of the scaphoid. The sheath was accurately stitched over the new tendon. The displaced posterior tibial tendon was fixed to the os calcis. Marked improvement in walking resulted, but subsequently it was decided to ankylose the mediotarsal joint to give greater stability to the foot. Case 2.—Child, æt. 3½. The tibials of the right leg were paralysed, and there was weakening of the inner head of the gastrocnemius, inner part of the extensor communis digitorum, and the inner hamstrings and adductors of the thigh. Treatment consisted in fixing the divided tendon of the extensor longus hallucis into the under and inner surface of the scaphoid. The peroneus longus was brought across the ankle and fixed to the peripheral end of the divided extensor longus hallucis. Case 3 is similar to No. 2. The author considers that the peroneus longus would be more efficiently employed in supporting the ankle-joint behind by passing it underneath the tendo Achillis and fixing it to the navicular bone. As regards technique, the transplanted tendons were fixed directly to bone where possible by silk sutures. A periosteal flap is previously raised, and subsequently sutured over the fixed tendon. No doubt the immediate results are better if the transposed tendons are fixed to the peripheral ends of the paralysed ones. The denervated structures, however, subsequently stretch, and the operation is nullified. S.

Intraperitoneal Implantation of the Ureters into the Colon.—Barling (*Brit. Med. Journ.*, Jan. 19th, 1907) reports the case of a young man, æt. 20, who five years ago suffered from fracture of the pelvis with rupture of the urethra and laceration of the neck of the bladder. Suprapubic drainage was then employed. In June, 1906, the whole of the urine escaped above the pubes, and there was, in addition, a suppurating sinus leading to the fractured bones. As an attempt to secure the patency of the urethra was unsuccessful, the following operation was performed, first on the left and later on the right ureter. The ureter was secured as it crosses the bifurcation of the common iliac, and lifted out of its bed for about an inch and a half. It was divided, and the lower end ligatured. An incision about one-third of an inch long was made on the inner side of the piece of colon selected. The upper end of the ureter was threaded with a fine catgut suture, the needle attached to which was passed into the opening in the colon, across the bowel, and through its opposite wall. By means of this suture the ureter was drawn inside the bowel, and held in position, while a first row of sutures fixed the outer coats of the ureter to the margins of the incision in the intestine. A second row of sutures approximated the peritoneal covering of the bowel to the outer coat of the ureter. The suture through the wall of the colon to retain the ureter while suturing fixed it, was now cut short, and its point of exit secured by a single mattress suture. The colon was displaced somewhat inwards towards the middle line, and the inner edge of the divided posterior peritoneum was sutured to the inner margin of the colon as further security against leaking. Since the operations three months ago, the patient has improved greatly, and is now able to earn his living. His bowels act almost every four hours when he is up, and at longer intervals when he is in bed. His temperature is normal, there is no complaint of pain over the kidneys, and neither kidney can be palpated. S.

Practical Points in the Operation of Colostomy.—Kelsey (*Med. Record*, Jan. 12th, 1907) points out that in cancer of the rectum, which is inoperable, no palliative measure has ever been devised approaching colostomy in its benefits, where it is done, as it always should be, early. The author considers that the average duration of life in cancer of the rectum after colostomy is much longer than after extirpation, though, of course, there is never a cure. In most unsatisfactory and fatal cases, operation has been done after there were symptoms of obstruction. In the author's experience the patients on whom he has done colostomy for any cause have been cleaner, more comfortable, and have had better control of their passages than those upon whom, after extirpation, the gut has been brought as near the natural anus as the operation allowed. The other indications for colostomy are congenital malformities of the rectum and anus, extensive ulceration, recto-vesical fistula in either sex, unless very small, and in some cases of acute intestinal obstruction. As regards technique, it is important to decide whether the opening is to be permanent or only temporary. In the former, steps must be taken to ensure absolute efficiency with the greatest amount of control, and with the certainty that nothing can pass below the opening. If the opening is temporary, efficiency must be somewhat sacrificed in order that the gut be as little injured as possible. In temporary operations sutures should be passed through the edges of the abdominal incision, the parietal peritoneum, and the walls of the gut. In the permanent operation the parietal peritoneum should not be included in the suture. In severe and long-continued cases of chronic obstruction, operate on the right side instead of the left, and make the opening temporary, with the idea subsequently of enlarging it and allowing it to remain, or preferably closing it and substituting an opening on the left, if conditions admit. The reason for this is that in such cases the greatest accumulation is often in the cæcum, that the sigmoid is likely to be so distended with solid fæces as to make a proper colostomy opening impossible until it has emptied itself, and that an opening in the sigmoid, even though large and free, may fail entirely to give relief to the distended large bowel before fatal results are caused. Any of the operations for an artificial anus may as well be completed at the time as to wait two or three days before opening the gut. Until it is opened there is generallv complete obstruction at the site of the spur, both for gas and solid matter, and the condition of the patient must be carefully watched. Often in 48 hours all the symptoms of acute obstruction may be acutely marked. Sigmoid colostomy may be impossible for three reasons. The gut may have no mesentery; it may be so implicated in cancerous disease as to be either unrecognisable or absolutely fixed and immovable, or it may be over-distended with fæces so that a lateral incision without a spur is only possible. In all these cases the abdominal incision should be closed, and an artificial anus made elsewhere. In closing an artificial anus, where the bowel has been too much injured to allow of plastic procedure, the recent experiments of Cannon and Murphy would indicate that end-to-end anastomosis is always preferable to lateral, in that the circular fibres are not cut longitudinally, and peristalsis is not therefore rendered impossible. S.

Congenital Dislocation of the Patella.—MacLennan (*Glasgow Med. Journ.*, Jan., 1907) describes the case of a girl, æt. 14 years, in whom complete dislocation of the patella outwards took place on flexion. There was slight asymmetrical genu valgum, in this patient, rather a sequence than a cause of the dislocation. There was no deformity of the condyles. Atrophy of the vastus internus was markedly present, but whether the result, or as one of the causes of the slipping of the patella was impossible to say. Operative treatment was as follows:—The tendon of the semitendinosus was isolated above the condyles of the femur, freed from its attachment from the tibia below, and drawn through the upper wound. The skin was then tunnelled through to the inner side of the patella, part of the capsule and periosteum slit, and the semitendinosus drawn through and stitched in position. The wound healed by first intention, and now (four and a half months later) the knee can be fully flexed without dislocation of the patella, the genu valgum is diminishing, and no inconvenience is experienced by the girl from the tendon transplantation. S.

The Surgery of the Large Venous Trunks.—F. Lejars calls attention (*La Tribune Med.*, Oct.) to the fact that the trunks of large veins are no longer outside the domain of surgery, as the danger of septic thrombosis may now be reduced to a minimum. Lateral suture, when practised in suitable conditions, may be applied to all large veins, including the cranial sinuses; the union of a divided vein by end-to-end amastomosis is but rarely applicable. Lateral suture is indicated when the wound in the vessel is small and well-defined; it should not be attempted when it is contused, or ragged and situated among suppurating tissues. Longitudinal tears of whatever size are suitable for suture, the results being very favourable. When the wound is transverse, suture is inadvisable if it exceeds the semi-circumference of the vein. Circular suture of large veins has not often been performed, and should never be done unless all the surrounding circumstances are favourable for the operation. The wounded vein should be emptied by digital pressure, or, if necessary, by ligature or instrumental pressure. In either case this must be very gently applied. The rent in the vein can best be closed by a continuous suture of fine silk, threaded on a round needle, and passed as a through-and-through stitch. It is useless to attempt a Lembert suture; the walls are too thin; so that a perforating suture becomes inevitable. It is well to carry the line of sutures a little beyond each end of the actual rent in the vessel. At first, when the blood is allowed to flow through the mended vein, it oozes to some extent, but pressure with a tampon will in most cases completely check this bleeding. G.

Streptococcic Appendicitis.—Emil Hain (*Zentralblatt fur Chir.*, January 12th, 1907) has studied specially that form of appendicitis due to the presence of streptococci. This form is always a severe one, at times seems to be endemic, and undoubtedly occurs at certain times of the year, during March and April, and again in autumn during October and November. It is rare to meet with a case at other times during the year. In streptococcic appendicitis the symptoms, as a rule, are severe, and are often associated with herpes or icterus. The appendicitis caused by the coli bacilli is much milder in character, and occurs with equal frequency during the entire year. The actual cause of appendicitis seems to vary in different countries; in northern lands it is associated with pneumococcus and bacillus coli. In Germany, France, and America it is more often caused by streptococci or coli bacilli; in England and Italy coli are much the commonest cause of this disease. This difference in the etiology of the disease probably accounts for the differences often seen in the statistics of the disease in various countries, the mortality being much higher in some than in others. Streptococcic appendicitis shows a predilection for young people. It is rather rare among older patients, but when it does occur in a patient who has reached adolescence, the prognosis is very bad; cases occurring among children are fairly hopeful. The prognosis of this form of appendicitis will depend more on the time at which the operation is performed than on anything else; the earlier the organ is removed the better the patient's chances. The so-called "intermediate" stage cannot, as a rule, be recognised in these cases. As a general rule, unless the appendix is removed within three days from the commencement of the attack, the patient will hardly recover. G.

Errors in the Treatment of Cutaneous Cancers.—A. R. Robinson (*New York Med. Journ.*, Dec. 29th, 1906), in a paper on this subject, sums up his experience of 24 years as follows:—(1) Every case of cutaneous cancer demands special consideration, special study, and special selective treatment. (2) No one method of treatment of cancer is best or most efficient for all cases of operable carcinoma. (3) All cases of multiple cutaneous cancer, and all aged persons with cutaneous cancer, require internal treatment in the form of diet and drugs, in addition to local measures. A diet of milk and green vegetables, and the avoidance of meats in general, and of meats of such organs as liver and kidneys in particular, and the avoidance of alcohols, is advisable in all cancers, whether the disease be external or internal. Thyroid extract should be given in as large doses as can be borne by the patient in all cases where there is a senile condition of the skin, and in most superficial epitheliomata. (4) A knowledge of the kind of cancer present, the pathological anatomy, and the manner of extension of the disease in general, and of the special variety of the case to be treated, is necessary to a correct choice of method of treatment. (5) When possible, all cases should be under observation at least one year after commencing treatment of any kind in order to treat promptly any recurrence of the disease. (6) Early diagnosis and correct treatment place cutaneous cancers among that class of diseases which do not deserve the name of "incurable" diseases, as, almost without exception, they can be successfully treated if the method employed be the correct one. G.

MEDICAL NEWS IN BRIEF.

Dispute as to Site for a Consumptive Sanatorium.

An enquiry has just been concluded before a Local Government Board Inspector as to the safety or otherwise of placing a sanatorium for consumptives on the banks of a small tributary of the River Lee some sixteen miles above the City of Cork. The proposed site is known as Myshall, and is situated on the Tullig River. A newspaper correspondence having started as to the probability of contamination of the Lee, which provides the drinking water for Cork, the Corporation became alarmed and asked for an enquiry. The proceedings extended over four days. Dr. C. Theodore Williams, of London, gave evidence expressing general approval of the site. Mr. Fairley, engineer, of London, said that the effluent might be safely discharged into the Tullig River. Professor McWeeney, in his evidence, stated there was no danger to be apprehended from the sewage. In the course of cross-examination he stated that tubercle bacilli can live in river water, but not for an unlimited time, and that it would be highly dangerous to drink a tumbler of water into which a consumptive patient had expectorated. Dr. A. E. Moore, lecturer on bacteriology at the Queen's College, Cork, said he disapproved of the effluent being conveyed into the river, and pointed out how the arrangements for purifying the sewage might break down, with the result that intestinal tubercle bacilli could find their way into the river. He considered the fact of the patients expectorating into the river would be a distinct source of danger. Dr. A. R. Parsons, of Dublin, visiting physician to the Newscastle Sanatorium, and Mr. F. K. Etlinger, superintendent of Cotswold Sanatorium, considered the site unsuitable for a sanatorium. Among other witnesses examined were three Cork medical men and two of the Cork engineers. It is believed that if the decision of the Local Government Board should be in favour of the Myshall site, the Cork corporation will appeal to a higher tribunal.

Concert in Aid of Sir Patrick Dun's Hospital, Dublin.

A concert in aid of Sir Patrick Dun's Hospital, under the patronage of their Excellencies the Lord Lieutenant, K.T., and the Countess of Aberdeen, and the Right Hon. the Lord Chancellor and Lady Walker, will be given in the Examination Hall, Trinity College (by kind permission of the Provost and Fellows), Thursday afternoon, February 7th, at 3.30 p.m. The concert is being organised by Madame Coslette Heller, who took her "Irish Ladies' Choir" to America last year, and had a most successful tour. The vocal items on the programme will be supplied by members of the choir. Miss Madge Murphy is a particularly gifted violinist, and Miss Macdonald, the harpist, is a professor at the Guildhall School of Music, London. Mme. Power O'Donoghue is to recite. Mr. Twelvetrees is very generously also giving his services, and his name alone ought to ensure the concert being a success.

Prestwich Workhouse Case.

The following letter has been published by Dr. H. W. Boddy:—

Dear Sir,—In the report sent to you from the Local Government Board of the inquiry lately held about the lunatic, W. W. Cowan, there are criticisms of my conduct in these affairs, and I should be glad of your permission to defend myself, as far as I can, against these adverse statements, and will take them in the order of the report.

First of all, I visited Cowan in little more than an hour after hearing of his admission, so there was not much delay on my part.

Secondly, that as I am not a resident medical officer, I could not give personal supervision to a great extent to the bathing and feeding of lunatics. I have usually been consulted by the attendant as to placing patients in the padded rooms, and have ordered their removal from such rooms when fit for it. If Cowan was in the padded room for hours before I knew of it, no one ought to hold me responsible. I have only two books that relate to lunatics. The first entry in the examination book might not be accurate, as the light in the padded room at night is a very poor one, and I could not see the patient at all well. The second entry was a perfectly accurate one as far as I could make it. In the Restraint Book I stated that he was in the padded room eighty-two hours, a perfectly accurate statement, and all that was required. And yet the Inspectors say that these books were almost useless as records.

Thirdly, in the Pauper Lunatic Examination Book, as the result of examination on discharge of the man Cowan from the workhouse on July 26th, I had made an entry, "Fracture of rib (doubtful)," this being an addition made next day. The facts were these: While examining him for a moment I thought there might be a fractured rib, but did not find it on further examination, so I did not think it wise to enter a doubtful fact into the book and cause perhaps unnecessary trouble. On the next day, on receiving from the asylum the report of Dr. Clowes that Cowan had a "fractured rib or ribs," I thought myself justified in making this additional entry in the book. for I was reminded of the doubt that I had in my own mind for a short while at the time of examination, and as I could not then make a second examination of the man, I did not think it necessary to enter a second date.

All these facts were fully and quite voluntarily stated by me (without any questions being asked) on the morning of October 30th at the inquiry then being held, so the words "elicited from the medical officer" give quite an unfair idea of what took place. Had I not told them myself that "fractured rib (doubtful)" was an addition made next day, the inspectors might never have know of it at all, and, moreover, I made the statement before any questions were asked, as could be proved by the written reports of the inspectors and by the report of my solicitor, Mr. Humphreys. I do not think, therefore, that I at all deserve that the epithet "most reprehensible" should be applied to my very straightforward conduct, since I made no attempt to conceal any of this matter. I will only add that I, as well as others, have been treated very harshly and severely by the inspectors of the Local Government Board, no account having even been taken of my twenty-six years of honourable service at the Prestwich Union.—I remain, dear Sir, yours faithfully, H. W. BODDY, M.D.

Medical Sickness and Accident Society.

The usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society was held on the 25th ult. As is usual at their first meeting of the year, the Committee considered special reports on the condition of all those members who are considered to be permanently incapacitated. Thirty-five of such reports were submitted, and few gave any hope that the member would ever be able to resume professional work. The sickness pay allowed is usually one hundred and four guineas a year, and the annual disbursement of the society in respect of these chronic claims now amounts to about three thousand pounds. The records for 1906 show that the Society has saved a considerable portion of its income, and made a substantial addition to its already large reserves. Prospectuses and all further particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London.

Army Medical Corps.

Consequent on the amendment of the Royal Warrant for Pay in regard to the promotion of Officers of the Royal Army Medical Corps, the Surgeon-Generals and Colonels on the Active List will be shown as removed from the Army Medical Staff and Royal Army Medical Corps respectively, retaining the ranks of Surgeon-General (ranking as Major-General) and Colonel (substantive rank in Army) respectively.

PASS LIST.

Royal College of Physicians of London.

Diplomas in Public Health were granted by the Royal College of Physicians, conjointly with the Royal College of Surgeons, on January 31st to the following candidates:—

Alexander Gray Banks, M.D., Ch.B. Glasgow, Glasgow University and King's College; Harold Graves Bennetts, M.B., C.M. Sydney, Sydney University and King's College; Woodley Daniel Betenson, L.R.C.P., M.R.C.S., St. Bartholomew's Hospital; Breadalbane Blacklock, M.B., Ch.B. Edinburgh, Edinburgh University and St. George's Hospital.

Robert Bruce Ferguson, M.D., B.C. Cantab., L.R.C.P., M.R.C.S. Cambridge University, St. Mary's and University College Hospitals.

James Henry Hugo, D.S.O., captain I.M.S., M.B., B.S. London, L.R.C.P., M.R.C.S., St. Bartholomew's and University College Hospitals.

Sydney Price James, captain I.M.S., M.D. London, L.R.C.P., M.R.C.S., St. Mary's and University College Hospitals.

Alfred Ernest Conquer Keble, major R.A.M.C., L.R.C.P. and S.I., Dublin University and Royal Army Medical College.

Percy John Probyn, D.S.O., captain R.A.M.C., M.B., B.S. London. L.R.C.P., M.R.C.S., Charing Cross Hospital and Royal Army Medical College.

Oliver Long Robinson, major R.A.M.C., L.R.C.P., M.R.C.S., Dublin University and Royal Army Medical College.

Alfred George Patrick Thomson, M.B., C.M. Edinburgh, Edinburgh University and Manchester University.

Arthur Lisle Ambrose Webb, captain R.A.M.C., L.R.C.P., M.R.C.S., Royal Army Medical College and University College Hospital.

Royal Colleges of Physicians and Surgeons Edinburgh, and Faculty of Physicians and Surgeons, of Glasgow.

The quarterly examinations of the above Board, held in Edinburgh, were concluded on January 29th, with the following results:—

First Examination, Five Years' Course.—Of 33 candidates entered, the following 19 passed the examination:—David Laurance Brown, Glasgow (with distinction); Abdul Majid Shah, Patiala; William Tilden Lawrence, New York; Charles Langley Ievers, Co. Clare; Shankar Pandurang Gogte, India; Behram Shapoorji Photographer, Bombay; Madan Lal Puri, India; Edith Huffton, Madras; Hamilton Hoyland, Ipswich; Conrad James Arthur, West Indies; Shivnarain Rozdon, India; Shridhar Chintaman Jog, India; Surendra Kumar Sen, India; Henry Gilbert Lamberty, Mauritius; Rajanja Sivasubramanya Aiyar, Madras; Cuverji Ruttonji Vevai, Bombay; Hiralal Keshavlal Nanavati, Junagadh; Framroz Maneckji Vajifdar, Aden; and Shivshankar Ramchandra Soneji, Bombay; and 3 passed in physics, 1 in biology, and 4 in chemistry.

Second Examination, Four Years' Course.—David Dewar McNeill, Orkney, passed the examination.

Second Examination, Five Years' Course.—Of 25 candidates entered, the following 11 passed the examination:—Angus Cameron Livingston, Glasgow; Daniel Hickey, Co. Cork; Walter Crosse, Liverpool; Shivnarain Rozdon, India; Richard Fraser Lunn, Edinburgh; Abdul Majid Shah, Patiala; John Alexander Irwin, Co. Donegal; Thomas Brownlie McKendrick, Wishaw; Albert Robert Henry Harrison, Berehaven; Denis Cogan, Co. Cork; and James Noonan, Ireland; and 2 passed in physiology.

Third Examination, Five Years' Course.—Of 40 candidates entered, the following 22 passed the examination:—Maurice Fitzgerald Anderson, Rosewell (with distinction); Edward Roland Porter, Belfast (with distinction); James McTurk, South Wales; Charles James Faill, Edinburgh; William Cape Doughty, London; John McKelvey, Belfast; Bhairawnath Dinanath Khote, Bombay; John David Jones, North Wales; Cuverji Ruttonji Vevai, Bombay; Thomas Boston Johnstone, Edinburgh; Alfred Benjamin Bateman, Cork; George Lindsay Irwin, Co. Donegal; Shankar Pandurang Gogte, India; Lionel Wilson Bradshaw, Wakefield; Shivshankar Ramchandra Soneji, Bombay; Franklin Joseph de Souza, India; James Barlow Barnes, Bolton; Hiralal Keshavlal Nanavati, Junagadh; Thomas Walsh, Sheffield; Thomas McClure, Ireland; Edward Peake Maitland, India; and Crichton Raoul Merrillees, Victoria; and 3 passed in materia medica.

Final Examination.—Of 82 candidates entered, 33 passed the examination and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—William Rollin, England; George Edward Peckett Davis, British Guiana; William Linton Watson, Midlothian; Daniel Kennedy, Cork; Herbert Moncrieff Sturrock, Edinburgh; Herbert Charles Orrin, Colchester; John Phelan MacDonald, Canada; Robert Marmaduke Riggall, London; Tiruvarur Arunachala Ramaswami Aiyar, India; Patrick Martyn O'Dwyer, Cork; Herbert Hoyle Whaite, Yorkshire; Horace Weldon Coutts, Canada; Nathaniel Moxon, St. Helens; Charles Gisborne Hurrey, New Zealand; Morgan Howard Howard-Jones, Newport; William Church Mann, Derry; Rajanja Sivasubramanya Aiyar, Madras; William Sunner Carter, Co. Kildare; William Harvey Bennett, Chester-le-Street; William Roberts Ellis, Bala; Thomas Wrenn Faulkner, Cooma, N.S.W.; Louis Joseph Patterson-Clavier, St. Lucia, W.I.; William Henderson, Scotland; Walter Langmuir Watt, Ontario; George Coats, Paisley; Lionel Christopher Wijesinha, Ceylon; Byramji Shavakshah Tarapurvalla, Bombay; Ellis Thomas Evans, North Wales; Alexander Paul Dias, Bombay; William Henry Curtis, Hampshire; John Smith Peebles, Dundee; Angus Cameron Mackay, Argyll; and Charles Andrew Lawrence, Darlington; and 8 passed in medicine and therapeutics, 2 in surgery and surgical anatomy, 15 in midwifery, and 8 in medical jurisprudence.

The Royal University of Ireland.

The Senate met on Friday last, February 1st, when the following were appointed Examiners in Medicine, &c., for the year 1907:—

Medicine.—J. A. Lindsay, M.D., J. F. O'Carroll, M.D.

Surgery.—T. Sinclair, M.D., M.Ch.

Pathology.—E. J. McWeeney, M.A., M.D., A. E. Moore, M.B., W. St. C. Symmers, M.D.

Midwifery.—Sir J. W. Byers, M.D., M.A.O., A. J. Smith, M.Ch., M.A.O.

Medical Jurisprudence.—P. T. O'Sullivan, M.D., A. Roche, M.R.C.P.I.

Materia Medica.—M. Dempsey, M.D., Sir W. Whitla, M.D.

Ophthalmology.—A. W. Sandford, M.D., M.Ch., I. Werner, M.B.

Physiology.—T. H. Milroy, M.D.

Diploma in Public Health.—Sir C. Cameron, C.B., M.D.

The Vice-Chancellor called attention to the Report recently published of the Royal Commission on Trinity College, Dublin, and the University of Dublin. After discussion it was agreed that the Senate should meet again on Wednesday, February 20th, for the further consideration of this matter.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

DR. H. N.—The point is an awkward one to advise upon at this moment, as it happens to be *sub judice*. A case was tried in London in which the telephone-tenant refused to pay a further year's rent after quitting his house, and the judge held that the Postmaster-General's agreement was harsh and inequitable. He therefore gave judgment for the tenant, thus overruling the wording of the agreement. An appeal has been entered. On the other hand, in other cases the tenant has always been made to pay.

THE FALLACY OF THE MUSCLES.

REFERRING to the annotation on this subject in our issue of January 23rd, a correspondent sends us

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Big muscles are all very well in their way,
But they must be kept up to the mark;
A very short illness will rapidly tell.
And supply ample cause for remark.
The muscles get flabby or turn into fat,
And if the complaint should last long
You friends never tire to daily enquire,
Why take such a time to get strong?
Ah! Give me the clock with reliable works,
The case not so showy to see;
To *last* longer, than *look* so much stronger,
It's far more important for thee.

Yours, &c., A. D.

A SAD CASE.

WE are asked to insert the following appeal:—The widow of a medical man (M.R.C.P.Lond., and M.R.C.S.) formerly in excellent practice in the West-end of London, finds herself in her old age reduced to less than bare necessaries. All she has to depend upon is an annuity of £20 a year from a medical charity (which is sufficient to pay her rent), and 5s. a week given by her children, which is all they can possibly afford. The husband was compelled to relinquish his practice in consequence of a long and painful illness, unfortunate speculations completed his ruin, and he was unable to provide for his widow and family. The poor old lady, who is 81 years of age, is crippled with rheumatism in both knees and is only able to crawl about a very little. Her sight is very bad, and she is entirely unfit to do any sort of work. It is desired to raise a small fund out of which an allowance can be made to supplement her income. Communications should be addressed to Mr. Colin F. Campbell, Hon. Social Secretary of the Church Army, 55, Bryanston Street, London, W., who will gladly answer all inquiries.

THE DEATH-RATE *VERSUS* LIFE-RATE.

"**A REPORT** just issued shows that the death-rate for last year was the lowest on record. On the other hand, the rate at which we live is constantly increasing."—*Punch*.

S. W. G.—If it can be proved that the entries in the ledger of patients were fictitious, you could demand a return of your deposit and the cancelling of the agreement.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 6th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: Annual Meeting. Specimens will be shown by Mr. J. Bland-Sutton, Mrs. Boyd, Mr. Doran (for the late Dr. G. B. Ferguson), and Dr. Tate. Annual Address: The President (Dr. Dakin).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Pardoe: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. E. Cautley:—Constipation in Infancy and Childhood.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Dermatological (Dr. Meachen), Ophthalmological (Mr. Brooks), Medical Out-patient (Dr. Whipham). 4.30 pm.: Lecture:—Mr. R. P. Brooks: Ocular Headaches.

THURSDAY, FEBRUARY 7th.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m.: Discussion on the Sequelæ of Influenza (opened by Dr. M. Leslie).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical) 5.15 p.m.: Lecture:—Dr. F. J. Smith: Some New Ideas on the Old Subject of Indigestion.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles), Cliniques: Medical (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Clinique:—Medical In-patient (Dr. Chappel).

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Syphilis as it modifies other Eruptions of the Skin: Symptoms, Diagnosis, and Treatment.

FRIDAY, FEBRUARY 8th.

WIMBLEDON AND DISTRICT MEDICAL SOCIETY (Worple Hall, Worple Road, Wimbledon).—9 p.m.: Paper:—Mr. R. Johnson: Acute Bone Suppurations in Children.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m.: Papers:—Dr. F. Hawkins: A Case of Typhoid Fever, with Acute Pneumonia, Pericarditis, and Hæmorrhagic Pleural Effusion. Mr. J. R. Lunn and Dr. G. Holmes: Clinical and Post-mortem Notes of a Case of General Paralysis of the Insane in a Boy. Dr. M. Fletcher and Mr. B. Robinson: Further Report of a Case of Idiopathic Dilatation of the Colon.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. J. Horne: Clinique. (Throat).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Ophthalmological (Mr. Brooks). 3 p.m.: Clinique:—Medical In-patient (Dr. Leslie).

Vacancies.

The Royal National Hospital for Consumption and Diseases of the Chest, Ventnor, Isle of Wight.—Assistant Resident Medical Officer. Salary £100 per annum, with board and lodging in the Hospital. Applications to the Secretary, 34 Craven Street, Charing Cross, London.

Newcastle-upon-Tyne and Northumberland Sanatorium for Consumption, Barrasford-on-Tyne.—Resident Medical Officer. Salary £180 per annum, with board and laundry. Applications to Secretary, 13 Grey Street, Newcastle-upon-Tyne.

King Edward VII. Sanatorium, Midhurst, Sussex.—Junior Assistant Medical Officer. Salary £100 per annum, with board, lodging, and attendance Applications to the Hon. Secretary, 19 Devonshire Street, Portland Place, London, W.

Glasgow District Asylum, Gartloch, Gartcosh.—Resident Assistant Medical Officer. Salary £125 per annum, with board and lodging. Applications to the Medical Superintendent.

Bath Royal United Hospital.—Resident Medical Officer. Salary £100 per annum, with board, lodging and washing. Applications to J. M. Sheppard, F.C.I.S., Secretary.

The House of Recovery and Fever Hospital, Dublin.—Junior Assistant Resident Medical Officer. Applications to John Marshall Day, Medical Superintendent. (See advt.)

Appointments.

ARNELL, EDWARD, L.R.C.P.I., M.R.C.S.Eng., D.P.H., Medical Superintendent of the Newton Abbot Joint Hospital District, Devon.

BLUCKE, HENRY FREDERICK STOKES, L.R.C.P., M.R.C.S., Medical Officer of Health of Shaftesbury, Dorset.

CANN, FRANCIS JOHN HUGHTREDE, M.B.Lond., L.R.C.P., M.R.C.S., Honorary Medical Officer to the Dawlish Cottage Hospital.

CHEATLE, C. T., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Burford District of the county of Oxford.

COPLANS, MYER, M.D.Lond (State Medicine), D.P.H.Camb., Demonstrator of Bacteriology in the Faculty of Medicine of the University of Leeds.

ELDER, DOUGLAS, M.B., Ch.B.Liverp., Pathologist to the King Edward VII. Sanatorium, Midhurst, Sussex.

FENTON, W. J., M.D.Cantab., M.R.C.P.Lond., Assistant Physician to the Hospital for Consumption and Diseases of the Chest, Brompton.

HUDSON, ARTHUR, L.R.C.P., M.R.C.S., D.P.H.Camb., Honorary Medical Officer to the Dawlish Cottage Hospital.

LAWRENCE, C. J. MONTAGU, L.S.A., Junior House Surgeon at the Borough Hospital, Birkenhead.

LOVELY, CHARLES NEWTON, M.D., B.S.Durh., Honorary Medical Officer to the Dawlish Cottage Hospital.

RAWES, LESLIE, M.R.C.S.Eng., L.R.C.P.Lond., Junior Resident Medical Officer at the Royal Waterloo Hospital for Children and Women.

ROBINSON, H. BETHAM, M.S.Lond., F.R.C.S., Surgeon to St. Thomas's Hospital.

SAWARD, A. H. M., M.R C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Richmond District of the county of Surrey.

STEVENS, WILLIAM MITCHELL, M.D.Lond., M.R.C.P.Lond., M.R.C.S., Honorary Consulting Physician to the Royal Hamadryad Seaman's Hospital, Cardiff.

STUART, HACKWORTH, M.D.Lond., F.R.C.S.Eng., D.P.H.Cantab., Medical Officer to the Staffordshire County Industrial School, Werrington, Stoke-on-Trent.

Births.

ADDISON.—On Jan. 30th, at Pretty Corner, Northwood, the wife of Christopher Addison, M.D., F.R.C.S., of a daughter.

MATTHEWS.—On Jan. 31st. at Wheathouse Road, Huddersfield, the wife of Craufurd Tait Matthews, M.B., of a son.

SILVER.—On Dec 10th, at Bermuda, the wife of Major J. P. Silver R.A.M.C., of triplets (girls).

Marriage.

CLOVER—ALEXANDER.—On Jan. 31st, at the Parish Church, Watford, Harry, youngest son of the late Joseph Thomas Clover, F.R.C.S., and of Mrs. Clover, of 16, Devonshire Terrace, Hyde Park, W., to Elsie Margaret, younger daughter of John Alexander, of Glendale Cassio Road, Watford.

Deaths.

MURPHY.—On Jan. 22rd, at Cork, Harriet Normand, widow of the late Surgeon-General M. W. Murphy, A.M.S., and third daughter of the late Henry Normand, Dysart.

COCKEY.—On Feb. 3rd, at 20, Somerset Road, Frome, Selwood Edmund Cockey, M.R.C.S.E., in his 90th year

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, FEBRUARY 13, 1907. No. 7

NOTES AND COMMENTS.

A Nervous Practitioner.

THE Thaw trial in America presents very little that is remarkable except the power of wealth, and the vulgarity of certain sections of society in that country and this. There is no mystery to be unravelled, and no legal difficulty to be solved. The murder was of the most prosaic and commonplace description, and if the persons concerned had not been both in affluent circumstances and connected with showy society, the mere fact would not have been worth chronicling in the British press. As it is, the only possible defence is one of insanity, and that only could be regarded as valid on the assumption that crimes of jealousy are all expressions of mental derangement. Surely no medical witness ever cut a more pitiable figure in the box than Dr. Wiley, the family doctor of the Thaw family. Mr. Jerome, the counsel for the prosecution, is credited with great ability for the way he riddled his evidence, but for ourselves we can only say that he had an uncommonly easy victim. In answer to Thaw's counsel, Dr. Wiley said he had devoted much of his life to the study of insanity, that he had acted as expert in a large number of cases, and that he was connected with the Dixmont Insane Asylum. As an expert, and from personal observation, he believed that Thaw was insane. Of Dr. Wiley's claim to be an expert, Mr. Jerome had little difficulty in disposing. The "expert" confessed he did not exactly know what Romberg's sign was; he did know the Argyll-Robertson pupil, but was not sure where he had heard of it, and he thought Argyll and Robertson were two different men! When asked what line of practice he followed, he described himself as a "nervous practitioner"—a statement that would lead us to the conclusion that neurology must be at a remarkably low ebb in Pittsburg. Indeed, since the days of Arthur Orton and the *pons asinorum*, we have heard nothing comparable to the ignorance of elementary facts displayed by this nervous practitioner.

Not Wily.

CONSIDERING that the defence has unlimited funds on which to draw, and that it commands the highest legal talent in America, it is almost incredible that such an "expert" should have been called as the principal witness, and moreover that it was never arranged for him even to examine the prisoner. It is not to be wondered at that Dr. Wiley's departure from the box was the signal for a breeze among Thaw's counsel, and that the plea of insanity was dropped like a hot copper. We know that there is little enough comprehension on the part of lawyers in this country as to what lunacy really is, but if the incident under notice is at all typical of what passes for expert evidence of insanity in America, the respect of lay people for medical knowledge of morbid psychology may justifiably be exceedingly slight. The "nervous practitioner"—a term which we take it was meant to signify a medical man practising as a specialist in nervous diseases—admitted that he had not extensively studied pyschology, but said he did know what was meant by the word. For the credit of American medicine, which has a justifiably high reputation, it is charitable to assume that Dr. Wiley was more nervous as a witness than as a practitioner, and that he really did not know what he was saying in reply to Mr. Jerome. A well-known surgeon in London confessed in Court the other day that the opposing barrister could make him say anything he (the barrister) wished, and perhaps Dr. Wiley was similarly artless. But the incident is inexpressibly humiliating to those who have the credit of the profession at heart.

Tonic Eggs.

WE have it on the authority of no less an expert than the late Dan Leno that eggs are divisible into three classes—fresh eggs, eggs, and eggs for electioneering purposes. To these must now be added a fourth, namely, medicinal eggs, that is, eggs which combine curative virtues with the usual nutritious qualities. The inventor, or breeder—it is difficult to know quite which is the correct term—of these pharmacopœial novelties is one Austin Goodyear Brown, a poultry farmer, of Lakewood. U.S.A. This gentleman conceived the idea that certain medicines might be made more palatable and eggs rendered of higher dietetic value if his hens were fed on tincture of iron, arsenious oxide, phosphate of lime, and similar medicaments. His early experiments—or "provings," as the homœopathics would say—were of an interesting, but rather disastrous character. In the drinking-pans of his hens he inserted small quantities of arsenic, and the intelligent birds, realising that great things were expected of them, exhibited great mental and bodily activity; they became very bright and active, ate ravenously, and laid eggs with extraordinary vigour. But, alas, the limits of avian physiology are not indefinitely extensible, and at the end of the week the hens were all dead. Undaunted by failure, Mr. Goodyear Brown started feeding twenty promising pullets on smaller doses of arsenic, and soon had the satisfaction of raising a brood of beautiful birds, who not only laid eggs, but laid arsenicated ones.

Fowler's Solution. SEEING that in Great Britain the difficulty is to keep arsenic out of beer, wall-papers, and other articles of domestic use, it seems rather gratuitous to attempt to introduce that metal into eggs, but Mr. Goodyear Brown finds these delicacies in request for ladies with sallow complexions and for sufferers from chorea and malaria. Indeed, jaded society belles are journeying to Lakewood to undergo the egg cure, and phosphatised eggs are reputed to be doing great things in the way of replenishing neurasthenic tissue and hysterical nerves. Far be it from us to condemn therapeutic enterprise, but the thought suggests itself that the dosage *per ovum* must be more than a little empirical, and though this may be a small matter in regard to phosphate of lime, or even tincture of iron, there seems to be some danger lest the patients who take this arsenic in the vitellised form may share the fate of the first batch of hens. Still, we may contain our souls in patience, for the magic egg is not likely to find its way to this country till the conditions of administration have been determined by experiment on our fair cousins, and if in the meantime we lay ourselves open to the reproach of being prejudiced and "behind the times," we may be on safer ground in adhering to the old and tried methods till such time as the term, "Fowler's solution" acquires another and more pregnant signification.

Legitimate Commissions. IT is unhappily our lot frequently to have to call attention to the puerile ignorance of County Court judges in relation to medical matters; indeed, it would be almost correct to say that that type of functionary seems endowed with an abnormal capacity for making itself ridiculous when called on to make a decision in questions affecting medical men. Our attention has been directed to a glaring case illustrating this principle of British law by the letter of a correspondent, which will be found in our correspondence columns this week. Last month, Dr. G. E. J. Crallan, the honorary secretary of the Association of Medical Men Receiving Resident Patients, had occasion to summon a member of the Association for failure to pay commission on a patient received into his house. Of the member's liability in law we have not sufficient evidence to speak decisively, but if we accept the judge's decision that the medical man in question was not shown by the evidence to be liable, we are utterly at a loss to understand his remarks in giving judgment. He said: "An association of professional gentlemen which, by its rules, stipulated for the payment of commission on sums received in respect of the patients was somewhat of a novelty. It was not his duty to act as censor, but he was by no means convinced that such associations or such stipulations as these deserved encouragement."

Self-Help or Agents. Now the Association referred to is composed of medical men who either do not practise in the ordinary way, or who seek to help to pay their way in the early years of practice by receiving resident patients into their houses, and in order to save the expense of individual advertisement and mutually to aid each other, they form a straightforward association free to anyone seeking the particular class of work dealt with, and staffed by honorary officers, to organise the placing of patients, and to give invalids wishing to reside with doctors information as to medical men who can offer accommodation likely to meet their requirements. Till the formation of the Association the work was done by lay agents who made a good profit out of the medical men who subscribed to their businesses and paid commission on fees from patients received. In a word, this Association is a defensive agency in which any profits arising from subscriptions and commissions is used for the common benefit, and as long as it is honestly managed and well conducted, as has always been the case, such a combination is perfectly honourable and legitimate. By means of it medical men are able advantageously to place patients with their colleagues in different parts of the country, and the members of the Association are assured of impartial treatment. So that for Judge Philbrick to offer comments such as those quoted displays a degree of ignorance, if he did not acquaint himself with the facts, or of impertinence if he did, which is equally blameworthy in a person holding his position of authority.

LEADING ARTICLES.

THE CEREBROSPINAL FEVER EPIDEMICS.

PUBLIC attention has been of late markedly drawn to the somewhat rare disease known popularly as "spotted fever," and scientifically as "cerebrospinal meningitis." The Belfast epidemic appears to be recurring as well as that in Glasgow, while the malady has recently invaded Edinburgh. At this juncture the medical officer of Glasgow, Dr. Chalmers, has published a valuable and timely report on the deaths attributed to meningitis in that city during the past six years. The most salient feature of his report is the fact that during the year 1906 the fatal cases referable to diseases of the central nervous system exceeded the six years' average by 136. This result was due to an increase of 63 under tubercular meningitis, and 147 ascribed to cerebrospinal fever, as against a reduction of 74 from simple meningitis. Dr. Chalmers has done well in insisting upon the need of great care in investigating cases before attributing them to the epidemic form of the disease. Compulsory notification is not provided for under the Act of 1889, but there is little difficulty in obtaining information from medical practitioners when they are aware of the incidence of cerebrospinal meningitis in their neighbourhood. The spread of the disease is rapid. On the first day of the present month no less than 63 cases, with three deaths, were intimated to Dr. Chalmers. He found the mortality, roughly speaking, about 70 or 80 per cent. of cases, but the case mortality is usually given as varying from 30 to 60 or 70 per cent. During the second week of January of the present year a considerable increase began in the number of cases registered. The exact figures for the three weeks ending February 2nd were 32, 32, 28 and 28 respectively. The age incidence of epidemic cerebrospinal meningitis is a striking feature. About 50 per cent. of cases occur under five years of age, and another 30 per cent. under ten years, while the rest may appear at any age up to forty-five or fifty. The name "spotted' which is so widely used by the laity, is curiously inappropriate, as it points to a by no means common characteristic of the attack. The origin of the malady is now generally recognised in the *diplococcus intracellularis meningitidis*, but it is not always to be found, especially in the later stages. This specific organism sets up inflammation in the membranes of brain and cord, and gives rise to a train of severe symptoms that present a well-marked clinical picture—the sudden onset with severe vomiting, headache, restlessness, retraction of head, squint, twisting of the face, pain all over body, fever, rash, and general and local disturbances. The specific pathogenic organism may usually be obtained by drawing off some of the cerebrospinal fluid by means of a lumbar puncture. It appears to be commonly conveyed through the milk of the nursing mother. A great deal, however, remains to be learnt with regard to the exact habitat and transmission of this specific microbe. Dr. Chalmers gives an interesting warning with regard to one possible channel of distribution as follows :—" In households where cases occur it should be remembered that discharges from the mouth, nose and ears have been associated with the occurrence of the disease in former outbreaks elsewhere." His advice generally as regards infection shows plainly enough that our scientific knowledge is not yet adequate in that direction. After warning parents against exposing children against sudden variations of temperature, he insists upon the necessity of a " rigid observance of absolute cleanliness of everything which may be placed in the mouths of young children, whether for food or other reasons." We are happy to be able to refer our readers to two articles on the subject published elsewhere in our columns. One is from the pen of Dr. William Elder, who has had several cases under his care at Leith Hospital during the past few months. The other is an interesting account of two fatal cases by Drs. John Thomson and Stuart McDonald, of Edinburgh. In conclusion, it may be remarked that Government would do well to spend any amount of money that might be required to investigate fully the facts concerned with epidemic cerebrospinal meningitis. The cost of such an enquiry would be trifling compared with the vast sums continually sunk in unproductive expenditure, and should be regarded in the light of a national investment.

SIR EDWARD BRABROOK presided on Monday afternoon at a special meeting of the Council of the Charity Organisation Society held at Denison House, Vauxhall Bridge Road, where a discussion on "Health Visiting in Relation to Infant Mortality" took place.

CURRENT TOPICS.

Servants' Insurance and Medical Examination.

HOUSEHOLDERS throughout the Kingdom are becoming anxious at the near approach of the day of full responsibility for accidents and illness arising from employment among their domestics. Hardly one of them has not anxiously scanned the terms offered by the various insurance companies who are bidding for the coming harvest of servants' insurance. One aspect of the new situation, however, appears to have hitherto escaped the keen scrutiny alike of employers and employed as regards insurance in this particular form of service. Obviously, the halt and the maimed, the sick and the feeble, will run infinitely greater chance of sustaining injury in the course of their occupation. It will be absolutely necessary, therefore, for the protection not less of the insurance companies than of the employers, to have a certificate of the bodily health of domestic servants before insurance. This duty must fall upon the medical profession, who will do well to adopt at once and decisively a uniform fee, say, of five shillings for each certificate. Unless the medical profession take a firm stand in the matter it is likely to find itself saddled with yet another medical certificate granted to the public free, gratis, and for nothing.

The First Garden City.

The annual meeting of the First Garden City (Limited) was held last week, and the report presented to it was of a most encouraging character. The boldness of the experiment is being slowly but surely justified by the success of its practical working, and as it is an experiment of first-class importance from the point of view of the public health, medical men generally will be delighted to hear that it is making excellent progress. In the last year the population has almost doubled, and there are now some three thousand inhabitants dwelling on the estate. The value of buildings erected has risen from £90,000 to £237,000 ; the Howard Memorial Hall has been opened, and other public buildings are under construction. A number of important firms, including Messrs. J. M. Dent and Co., the publishers, Messrs. W. H. Smith and Son, the Arden Press, Ltd., and the Garden City Embroidery Co., have taken sites for works, and the Heatly-Gresham Engineering Co., Ltd., have doubled the size of their buildings and increased their staff from eighty to two hundred persons. Moreover, the Great Northern Railway has taken fourteen acres for a goods yard—a sure sign of progress—and the Garden City Gas Company have been able to show a profit on the year's work. Unfortunately, as regards profit to the promoters of the Garden City Company itself, it is yet too early to speak, but though the working expenses exceed the income, the increased value of the land will soon now turn the concern into a really valuable asset, and when a valuation is made, as is about to be the case, it will probably be found that the Company is in a financially sound position. But the chief feature is that ultimate success is now assured; the population, the capital, and business enterprises are being attracted, and it will not be long before the Garden City is a self-contained community in which the condition of the poorest and weakest will be secured against encroachment and the best known modern conditions of healthiness assured to all. In so far as example is better than precept, so are the founders of the Garden City superior to those social reformers who talk much and do nothing.

Hospital Saturday Fund.

OF all the Metropolitan funds, the Saturday deserves the hearty support of the medical profession, inasmuch as its executive is representative of hospital charities, great and small, as well as of the class from which hospital patients are drawn. The result is that the Saturday distribution grants are often opposed in policy to those of the Sunday and the King Edward Funds. It may be fairly assumed that the support of any given institution by representatives of its *proteges* is a fairly good test of its usefulness and popularity. Certainly patients are more likely to be judges upon such a point than wealthy benefactors and professional philanthropists, who know little or nothing of what goes on behind the scenes in hospital life. The only suggestion we can offer the Saturday Fund is that the ranks of the medical profession be represented, as apart from the members of the honorary medical staffs of a few favoured large London hospitals who sit on the executive boards of the other two funds mentioned. Broadly speaking, at present the smaller hospitals get scant justice at the hands of any but the Saturday Fund. Both the Sunday and the King Edward Funds, by withholding a grant, may cast an absolutely undeserved stigma upon any institution, simply because it is small and struggling. Nor need they give any hint or explanation as to their action. They are essentially autocratic, irresponsible, and non-representative bodies, and as such lag hopelessly behind the times.

Mr. Bryce's Irish University Scheme.

A PERUSAL of the volume of evidence taken by the recent Commission on Dublin University, which appeared last week as a Blue Book, cannot fail to be interesting to everyone concerned with higher education in Ireland. Careful study of it, however, still leaves undiscovered any cogent arguments in favour of Mr. Bryce's scheme now before the country. The great weight of the evidence was against any tampering with Dublin University as at present constituted, beyond making certain important domestic reforms. All the witnesses representing the existing institutions expressed themselves strongly against such a plan as has now been put forward by Mr. Bryce, while most of those who pressed for the establishment of a new college were quite as satisfied to accept one in the Royal University as in Dublin University. In fact, the only witness who strongly urged the federal scheme was Lord Dunraven, who appears in this as in other matters, to be content to act as the mouth-piece of hidden powers. His authority in matters of education is, however, not apparent. For the proposed degradation of the Queen's College, Galway, no shadow of justification appears in the evidence. Except for one casual remark, by the Dean of St. Patrick's, there is practically no reference to Galway outside the evidence of its President. The truth is that the Arts School in Galway both in its present staff and in its past record is no way behind that in either Cork or Belfast, whereas to its medical school many distinguished Irishmen both at home and abroad owe their professional education.

Inspection of Restaurants.

An excellent example has been set to sanitary authorities by the Westminster City Council in taking vigorously in hand the inspection of bakehouses and restaurant kitchens. The bulk of the West End restaurants are situated in the area over which the Westminster Council exercises jurisdiction, and though it may be presumed that the high-class establishments which provide luncheons and dinners at half-a-guinea and seven-and-sixpence a head maintain something approaching decency and cleanliness in the kitchen domain, it is equally certain that a great many of the smaller foreign restaurants and workmen's eating-houses are filthy beyond description. The patrons of such houses are content to consume their meals, asking no questions for fear that their appetite might be impaired, but it certainly is the duty of public authorities to see that disease is not disseminated through the food and drink dispensed. The Westminster Council have now drawn up a series of rules and appointed special inspectors for all public restaurant kitchens for their district. These measures are such as will commend themselves to those who have the sanitary interests of the community at heart. The rules concern the structure and capacity of the kitchen, the drainage of the scullery, and the ventilation of the premises. No food is to be stored in any place where it may be exposed to infection or contamination; proper enamelled stoneware sinks are to be provided for washing vegetables in; all tables and benches are to be provided with wheels so that they may be easily moved, and shelves are to be fitted two inches from the walls, so that dirt shall not collect in corners. The employés are to have separate places for hanging their outdoor clothes, and every part of the premises is to be adequately lighted. If on this basis a sufficient staff of inspectors can secure "general cleanliness" of vessels and—let us add—the hands of cooks and waiters, the meals provided by the restaurants will taste none the less delicately, and they will certainly be distinctly less liable to produce gastric and intestinal disturbances in those who partake of them.

Personal Freedom o Public Officers.

A principle of great importance is at stake in the struggle which has been going on between the Medical Officer of Health and the City Council of Coventry. It appears that the Medical Officer of Health, Dr. Snell, is also Honorary Secretary of the local branch of a medical association, and in the latter capacity he came into collision with the management of a provident dispensary, which thereupon appealed to the City Council as to whether Dr. Snell's continuance as honorary secretary was in accordance with the wishes of the Council and with the due discharge of his duties as their officer. The Council appeared to think the duties of the two posts incompatible, and the matter eventually came before the Local Government Board. That sapient body in the course of a long letter explain that they do not object to Dr. Snell's occupying his leisure time as he thinks fit, so long as his occupation "did not prejudicially affect the due discharge of his official duties, or bring him into inconvenient conflict with the Council or their constituents." In reply, Dr. Snell relates that the "due discharge of his official duties" has on many occasions brought him into conflict both with the Council and their constituents. Last year, for instance, he reported to the Local Government Board the occurrence of an epidemic, with the deaths of seventy children, due to neglect on the part of the Council, after repeated warnings. He had also on various occasions to enforce the law against individual members of the Council. We congratulate Dr. Snell on the stand he has made against an overbearing piece of tyranny. The freedom of personal action in the case of employés of all public corporations must be secured at all hazards.

Cerebrospinal Fever in Belfast.

Considerable alarm has been caused in the north of Ireland by the outbreak of cerebrospinal meningitis which has appeared there during the past few weeks. The total number of cases is said to be nearly fifty, and the deaths over twenty. The disease appears, therefore, to be of a virulent type, and in several cases deaths have supervened on a few hours' illness. Of one family of five children four succumbed inside the space of twenty-four hours' Another victim was a medical student of the Queen's College, whose death also occurred very rapidly. The Public Health authorities are doing all in their power by means of isolation to stay the progress of the disease. There is, however, no disease in the face of which medical skill is more powerless, either in the way of prevention or of cure. Of the natural history or habits of the causal organism nothing is known, while treatment is only symptomatic. We can only hope that the present outbreak may be speedily stayed, and if any further knowledge of the disease should result from a study of its appearances in Belfast, then even the serious loss of life will not have been in vain.

PERSONAL.

Dr. James Taylor will preside at the dinner of the Edinburgh University Club of London, which will be held at the Criterion Restaurant on February 20th.

Dr. Theodore Thompson, M.A., M.D. (Cantab.), M.R.C.P., B.Sc. (Lond.), F.R.C.S. (Eng.), has been appointed an honorary physician at the London Hospital.

Mr. Frederic Eve, surgeon to the London Hospital, has been re-elected, and Mr. J. Ernest Lane, surgeon to St. Mary's Hospital, has been elected a member of the court of examiners of the Royal College of Surgeons.

At a meeting of the board of management of the Chester Infirmary on February 5th, a letter resigning his post of honorary surgeon was received from Dr. James Taylor.

Dr. Peter Reilly O'Connell, Surgeon to the Mater Infirmorum Hospital, Belfast, has been appointed High Sheriff for Belfast for the year 1907.

The report that Professor Behring had entered an asylum is declared by his relations at Capri to be unfounded.

Major Leonard Rogers, I.M.S., will deliver the Milroy Lecture at the College of Physicians on February 21st, 26th, and 28th on "Kala-Azar: Its Differentiation and Epidemiology."

Dr. Herbert E. Roaf, the recently-appointed senior demonstrator of physiology in the University of Liverpool, has intimated his intention to resign the research scholarship he held in connection with the Science Committee of the General Medical Council.

Sir Alfred Jones presided at a meeting of the African Trade Section of the Chamber of Commerce on February 4th, when Dr. W. T. Prout, C.M.G. (late principal medical officer, Sierra Leone), delivered an address dealing with the health and sanitation of West Africa.

Dr. Donald Macalister, M.D., LL.D., D.C.L., Fellow and Director of Medical Studies of St. John's College, Cambridge, Linacre Lecturer of Physic, and President of the General Medical Council, has been appointed Principal of the University of Glasgow in succession to the late Principal Story.

Dr. Whitcomb, medical superintendent of the Birmingham asylums, was entertained to a complimentary dinner at the Queen's Hotel on February 4th by the Asylum Committee in commemoration of his having completed 25 years in the service of the city. An illuminated address, handsomely bound, was presented to Dr. Whitcomb.

Our Edinburgh correspondent informs us that it is now officially recognised—notwithstanding contradiction by the Press Association—that Dr. Donald MacAlister, President of the General Medical Council, has been appointed as new Principal of Glasgow University.

A petition has been received from the London School of Medicine for Women in reference to a proposal, now before the Council of the Royal College of Surgeons of England, that women should be admitted to the examinations of the college. It has been determined to inform the petitioners that the matter is receiving the consideration of the Council.

A telegram from Hull states that a Chinaman from the steamer "Dundas" from Bombay has died in the infirmary from beri-beri. Two others are in hospital, and another died on the voyage.

A CLINICAL LECTURE
ON
THE TREATMENT OF NON-MALIGNANT GASTRIC ULCER.

By SIR CHARLES BALL, M.Ch., F.R.C.S.I., Hon. F.R.C.S.Eng.,

Hon. Surgeon to His Majesty the King; Regius Professor of Surgery, University of Dublin; Surgeon to Sir Patrick Dun's Hospital.

A consideration of the causes which produce gastric ulcer and the conditions which tend to interfere with its healing when once established is obviously of first importance in deciding upon the best form of treatment to effect its cure.

The more or less circular outline, flat base, and sharp-walled edges of ulcer of the stomach are very special characters which at once suggest the operation of some special cause and the exposure of the stomach surface to a highly acid digestive fluid has been assumed to be the explanation. That the normal stomach is immune to auto-digestion is of course obvious. Weinland ("Halliburton's Handbook of Physiology," 6th edition, page 489) considers that this immunity is due to the formation by the stomach epithelium of an antipepsin, and that in the same way the intestinal epithelium forms an antitrypsin. If, then, the mucous membrane is injured by direct traumatism from hard substances swallowed, by septic infection from the ingesta, or by necrosis following embolic infarction, this theory supposes that auto-digestion occurs in the damaged area, and thus the ulcer is extended in dimensions and its healing is interfered with. This theory has received very general acceptation, so we see even in the most modern text-books the disease spoken of as "peptic ulcer of the stomach." I am confident that this is one of the somewhat numerous fallacies which have been adopted from time to time in medicine without question, although opposed to directly ascertainable facts. The evidence obtainable by *post-mortem* examinations, by clinical observation, and by surgical experience, clearly demonstrates that peptic action has nothing whatever to say to the origin or maintenance of gastric ulcer.

It is common to find at *post-mortem* examinations cicatrices in the stomach showing that gastric ulcers have undergone spontaneous cure. If auto-digestion had been the cause of these ulcers, how is it possible that the delicate process of healing by granulation and epitheliasation could go on while exposed to the same influence? It is notorious that a large proportion of cases of gastric ulcer get well under treatment by rest in bed, rectal feeding, and little or no fluid nourishment by the mouth. Physiologists tell us that gastric juice is secreted independent of the ingestion of solid food, that the sight of meat to a hungry dog causes a free flow, and that fluid meat extracts stimulate secretion. It is a popular expression that at the sight of dainty food the "mouth waters." It would alike be true to say that under similar circumstances the stomach juices.

Let us take now the case of a chlorotic girl lying in bed in hospital undergoing the routine treatment for gastric ulcer. Possibly in the next bed may be a case convalescent from some acute disease. When dinner hour arrives the convalescent is provided with a succulent mutton chop; the stomach case with a rectal injection, and possibly a tablespoonful of chicken broth. Our knowledge of physiology tells us that the latter must have a free secretion of gastric juice, which, not getting the coveted mutton chop to expend its energies on, might reasonably be expected to act more vigorously on the ulcer than if she had received a solid meal.

Surgical experience tell us that stomach wounds, when closely sutured up, heal with the utmost facility. It is usual in such wounds to bring the divided edges of mucous membrane together by a continuous silk suture, which must produce a certain amount of necrosis, and which eventually cuts its way out into the lumen of the stomach; surely under these circumstances, if gastric digestion of living stomach tissue ever occurred these wounds would not heal, or, at any rate, leakage would be of frequent occurrence, but we know that with proper modern technique leakage seldom or never occurs. This satisfactory healing of stomach wounds appears to indicate that the immunity against auto-digestion is not confined to the mucous membrane, but is present also in the deeper coats. The theory, therefore, of Weinland that the gastric epithelium forms an antipepsin appears to be scarcely a sufficient explanation.

A consideration of these facts renders the theory of peptic action as a cause of gastric ulcer quite untenable.

Septic infection, especially coming from suppuration in connection with bad teeth, has been suggested as a cause of gastric ulcer, and in all probability this may frequently be an initial element of the disease, but it is hard to imagine that it can be the cause of a chronic ulcer remaining open for months or years, especially when we see that gastro-enterostomy performed when there is an open ulcer in the stomach so rarely becomes infected.

The mechanical effect of solid food being churned about in the stomach is sometimes mentioned as the reason why gastric ulcers which may have had their origin in traumatism, sepsis, or infarction necrosis, do not readily heal, and although hitherto it has usually been considered as of secondary importance to the peptic theory, I am convinced that it is the true explanation, not only of the characteristic appearance of gastric ulcer, but also of the known facts relating to spontaneous cure and the results of medical and surgical treatment.

Many years ago, as a medical student, I saw an old surgeon make an issue in the back of a patient's neck for the treatment of severe facial neuralgia. A piece of adhesive plaster with a small circular hole in it was first applied, and caustic potash was rubbed in so as to produce a circular slough of skin where it was exposed in the hole in the plaster, When the slough separated an ulcer was left, and as the neuralgia had not been cured, the surgeon decided to "keep the issue open." This was done by the simple process of keeping a pea in the ulcer by means of a piece of adhesive plaster. By this method the issue could be kept from healing as long as considered necessary, and the characters of the ulcer thus produced with flat base and sharp-cut edges closely resembled the appearances we are familiar with in chronic gastric ulcer. As the pea kept the issue from healing, so the frequent passage of solid food over the surface of a gastric ulcer retards its cicatrisation.

We know that pain, sometimes very severe, follows the introduction of solid food into a stomach which is the site of ulcer. This may be so great that the patient instinctively avoids solids, and thus affords the stomach that rest which is necessary to permit of spontaneous cure.

Our modern treatment of gastric ulcer, which is quite unintelligible on the peptic theory, is readily explained if we believe that the continuance of ulcer is caused by the mechanical effect of solid food.

It is certain that a large proportion of cases of gastric ulcer will get quite well by rest in bed, rectal feeding, withholding solid food, and strict limitation of the amount of fluids taken by the mouth ; but it is well to remember that there are limits to this plan of treatment, and that if carried too far it will defeat its object, as there can be no doubt that a condition of semi-starvation seriously interferes with the healing process, and that surgical operations undertaken under these conditions are not satisfactory. I would strongly urge that all cases of uncomplicated ulcer of the stomach should in the first instance be treated by a short but efficient course of rest and limited diet, and that those cases which do not show rapid and marked improvement should be dealt with by surgical operation, and that cases of recurrence of symptoms after apparent cure by rest and limited diet should at once be operated on.

The operation now recognised as best in these cases is posterior gastro-enterostomy. Excision of the ulcer can only be practicable in a small minority of cases, and although it may occasionally in suitable cases be considered as an addition to gastro-enterostomy, it should not be undertaken as a substitute, as the essential object of surgical operation should be the provision of a free outlet from the lower portion of the stomach into the jejunum, the free exit thus provided for the contents of the stomach affording the ulcer the rest essential for its healing, and tending to prevent recurrence in the future. My personal experience of gastro-enterostomy and pyloroplasty extends to forty cases, but in only four of these was uncomplicated gastric ulcer found present. All the four recovered well, and so far as I know, remain quite free from recurrence. The results obtained by others who have had larger experience show that the dangers of the operation are comparatively trivial, and the proportion of cases in which complete cure follows is large, in many instances patients who for months or years have been in misery being made perfectly well.

The brilliant results of modern gastric surgery have tended sometimes to engender surgical recklessness. We occasionally hear of gastro-enterostomy being performed in purely neurotic cases, in the gastric crises of tabes, and even in dyspepsia due to chronic renal disease. Such proceedings do much to bring discredit upon this operation, which in properly selected cases is often such a conspicuous success.

The immediate risk of posterior gastro-enterostomy in ordinary cases is probably not more than 2 or 3 per cent. It is, however, necessary to consider certain results of the operation which occasionally give trouble, and which are directly consequent on making a free communication between the stomach and jejunum, and of these the most frequent is the regurgitation of duodenal contents into the stomach producing vomiting. The recurrence of vomiting after gastro-enterostomy is an interesting physiological problem. We are accustomed to believe that the act of vomiting is caused by, first of all, a closure of the pylorus followed by a reflex peristalsis forcing the stomach contents up the œsophagus. If, now, a gastro-enterostomy is present, and, as it is unprovided with any sphincteric apparatus, it is reasonable to expect that an attempt to vomit would empty the stomach into the jejunum rather than up the œsophagus. It is obvious that for vomiting to take place under these circumstances there must be an associated spasm in the intestine, and also probably in the voluntary muscles of the abdominal wall.

Regurgitation of duodenal contents into the stomach, followed by persistent vomiting, is, however, not so troublesome with modern surgical technique as it was formerly. Katzenstein (MEDICAL PRESS AND CIRCULAR, Dec. 6th, 1906) states as a result of his investigations, principally on experimental gastro-enterostomy in animals, that a flow of duodenal contents containing bile and pancreatic juice into the stomach is constant for a considerable period after gastro-enterostomy, and adopting the peptic theory of gastric ulcer, he suggests that the neutralisation of the gastric juice by the alkaline duodenal contents is the explanation of the good results obtained by gastro-enterostomy. It must, however, be remembered, as pointed out by Ewald, that it is unsafe to draw conclusions from the results of gastro-enterostomy in animals, as the horizontal posture in them favours the flow of intestinal contents into the stomach more than in the case of man ; moreover, it is common surgical experience that bilious vomiting following gastro-enterostomy can generally be stopped by putting the patient in the sitting posture and so facilitating drainage Should, however, regurgitant vomiting prove serious, lateral anastomosis between the two limbs of the loop of jejunum involved in the gastro-enterostomy will usually prove effectual. In two of my forty cases of gastro-enterostomy this was necessary.

Another after-complication of the operation is the occurrence of so-called peptic ulcer, sometimes leading to perforation, in the jejunum. An interesting paper by Dr. Watts in the "Johns Hopkins Hospital Bulletin" for July, 1903, deals with this subject. The author performed gastro-enterostomy on a dog, and three months after it died of perforating jejunal ulcer. A review of the literature of the subject shows that up to date on fourteen occasions similar ulcerations have been recorded in the human subject ; it is remarkable that they all have been recorded in Germany.

The question whether such ulcers are really peptic is an interesting one. Although the jejunum is normally immune to alkaline trypsine digestion, it is quite possible that it may not be, like the stomach, immune to acid pepsine digestion; it is also unaccustomed to the presence of large quantities of undissolved food, such as it must receive after gastro-enterostomy. It appears at present impossible to say which of those factors is the most operative; at any rate, its occurrence is so rare that it cannot be held to be a contra indication to operation in suitable cases.

A curious sequence to gastro-enterostomy, which I have not seen described elsewhere, occurred in one of my cases; the portion of jejunum corresponding to the stomach anastomosis became dilated to quite four times its normal size, forming a sort of secondary stomach, and produced obstruction by kinking of the distal portion of intestine, with continuous vomiting. A lateral anastomosis below the dilatation quite relieved the symptoms; this was done a year ago and the patient at present remains in good health. I am quite at a loss to account for this condition.

In conclusion, I would urge, after the fullest consideration of the risks of operation, both immediate and remote, that all cases of uncomplicated gastric ulcer which have had a reasonable trial of treatment by rest, and limited diet, without very marked improvement, should be subjected to gastro-enterostomy. There are, however, many points, both pathological and physiological, in connection with this most interesting subject which still require further elucidation.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Wm. Alexander, M.D., F.R.C.S., Lecturer on Clinical Surgery, University of Liverpool; Surgeon to the Royal Southern Hospital, Liverpool, on "Hydronephrosis," with notes of an extreme case of that disease.*

ORIGINAL PAPERS.

NOTES ON CEREBROSPINAL MENINGITIS. (a)

By WM ELDER, M.D., M.B., F.R.C.P.EDIN.,

Physician to the Leith Hospital.

DURING the past few months the author had under his care five cases of this disease. Case I. was a girl, æt. 5, who was admitted to hospital in an unconscious condition, with a history of illness lasting for about twenty-four hours. She had marked head retraction, high fever, and vomiting. On lumbar puncture, turbid fluid escaped under considerable pressure. It contained numbers of diplococci with capsules, mostly extracellular, but a few in the cells. They were Gram-positive and had the character of pneumococci. Rienzi's antipneumococcic serum was injected, and subsequently the temperature gradually fell. Convalescence was slow, and was hindered by the development of a parotid abscess, but ultimately the child recovered, with complete deafness as a residuum of the meningitis. Case II., a boy, æt. 2, was admitted with the history that he had been unconscious for two days On lumbar puncture, turbid fluid containing leucocytes and Gram-negative diplococci was withdrawn. A crop of purpuric spots developed on the abdomen, back, and neck. The temperature was at first normal, and then rose to 102°–103°. Rienzi's serum was injected on two occasions, and convalescence was now established. The patient is, however, blind, though there are no changes in the fundi. Case III., a girl, æt. 9, admitted after a short illness, in much the same condition as the preceding patient, with all the usual symptoms of acute meningitis, and a hæmorrhagic rash on the neck and trunk. As before, Gram-negative diplococci were found in the turbid cerebrospinal fluid. The serum could not at the time be obtained, and the patient died in a few days. *Post mortem*, purulent leptomeningitis of brain and cord, with the diplococcus intracellularis, was found. Case IV. occurred in an adult, æt. 37. On the morning of admission he had vomited and complained of headache; he became unconscious in a few hours. He was extremely restless, pupils unequal, considerable rigidity of limbs. The fluid yielded by lumbar puncture contained the diplococcus intracellularis. It was Gram-negative. Although the patient was evidently dying, an injection of serum was given, but without avail. On *post-mortem* there was typical purulent cerebrospinal leptomeningitis. Case V. was a boy, æt. 2½, who took ill with fever, headache, and vomiting twenty-four hours before admission. He rapidly became unconscious, and had a convulsion. On admission he was cyanosed and collapsed, with Cheyne Stokes breathing. There was a purpuric rash. He died soon after admission. Lumbar puncture gave the same turbid fluid containing diplococci. On *post-mortem*, cerebrospinal meningitis was found. These five cases showed that cerebrospinal meningitis was epidemic in Leith. The symptoms of the condition might best be described as an exaggeration of what are seen in tubercular meningitis. The onset was sudden, and unconsciousness often supervened rapidly. The temperature was high, and the pulse very rapid. Purpuric spots are usually absent at the onset; probably many cases do not survive long enough to develop a rash. Lumbar puncture affords the only certain diagnostic. The meningococcus closely resembles both the pneumococcus and the gonococcus, but the pneumococcus may be distinguished from the others by being Gram-positive. Not all observers are agreed as to which particular diplococcus is responsible for these cases, some having ascribed them to the pneumococcus, others to the meningococcus. In the first case the organism resembled the pneumococcus, but Dr. Elder was not for this reason disposed to put it in a separate class for that reason. It seemed to him possible that they might really have to do with modifications of the same germ. Probably the pneumococcus and the meningococcus were at least allied, and just as we had sporadic and epidemic pneumonia, so we had sporadic and epidemic cerebrospinal meningitis. There was no evidence that the disease was infectious in the ordinary sense. The cases had come from all over Leith, and mostly from crowded, insanitary neighbourhoods. Two of his first cases had recovered, both after getting injections of Rienzi's antipneumococcal serum; in each case improvement was noticed after every injection. At the same time, in bad cases, the chance was small; no disease is so rapid and hopeless—indeed, in this respect it resembles acute fulminating septic peritonitis. Lumbar puncture always gave temporary relief; so did saline transfusion. Morphia was the most useful sedative.

(a) Abstract of Paper read before the Edinburgh Medico-Chirurgical Society. Feb. 6, 1907.

NOTE ON TWO FATAL CASES OF ACUTE MENINGOCOCCAL CEREBRO-SPINAL MENINGITIS IN YOUNG CHILDREN. (*a*)

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CASES of non-tuberculous meningitis they had hitherto been accustomed to meet with might be divided into (1) those due to pyæmic infection, with strepto- and staphylococci, &c.; (2) acute pneumococcal meningitis; (3) chronic or sub-acute posterior basic meningitis. The last-named formed the majority, occurred mostly in young infants, and was due to a special diplococcus practically identical with the meningococcus of Weichselbaum. Within the last few months, and particularly within the last week or two, they had met with a fourth group—acute cerebro-spinal meningitis, in which the cerebrospinal fluid contained typical meningococci in large numbers. These cases were far more acute than the ordinary posterior basic form, as if due to a much more virulent type of organism. The constitutional disturbance was greater, the fluid withdrawn by lumbar puncture was turbid or purulent, and the duration was measured by days rather than weeks.

Case I.—A boy, æt. 3½, was admitted to the Sick Childrens' Hospital with a history of feverishness and vomiting, which had lasted for three days. On arrival in the Children's Hospital he was unconscious, lying with his limbs flexed, and greatly resenting any interferences. There was no eruption. The pulse was 152, respiration 52, and temperature 102°. The abdomen was retracted; spleen not enlarged. The neck was rigid and slightly retracted, superficial reflexes normal; flexor plantar response; kneejerks abolished. Well-marked Kernig and *tache cerebrale*. No paralysis of cranial nerves. On lumbar puncture, very turbid fluid was withdrawn, in which meningococci was present. The patient died soon after admission.

Case II.—Child, æt. 2 years 2 months, was admitted with history of feverishness and vomiting lasting two and a half days; there had been no convulsion. She was well-developed and nourished; the extremities were cold, and the lips cyanosed. No purpuric or herpetic rash was present. She was very drowsy, and lay on side with head retracted. Pulse 140, respiration 32, temperature 98.2°. There was marked catarrh of the mouth and pharynx; the secretion contained staphylococci only. Abdomen not retracted; spleen not enlarged. There was marked opisthotonos with head retraction. The plantar and other superficial reflexes were normal. Knee and Achilles jerks normal, Kernig's sign absent. No affection of cranial nerves. After admission the vomiting continued; the head retraction increased, but the limbs showed no rigidity. Lumbar puncture yielded about 3 cc. turbid yellow fluid, and greatly relieved the head retraction. The fluid contained meningococci. There was a decided polymorphous leucocytosis. The patient died shortly after admission. On *post-mortem* examination no cutaneous hæmorrhages were present. There was an acute leptomeningitis of the brain and cord. In the brain the cortex was affected as well as the base, and meningococci were detected in the exudate. The organisms were typically Gram-negative. The other organs showed evidence of an acute toxæmia; there was no pneumonia. Histological examination confirmed the above appearances. The exudate in the brain showed little fibrin, numerous polymorphs, and large mononuclear cells, many vacuolated and degenerating, but many also actively phagocytic towards the polymorphs. The organisms in sections were scanty. The heart showed cloudy swelling and some interstitial myocarditis. There was cloudy swelling and fatty change in the other organs. Films from the cerebrospinal fluid removed during life showed great excess of polymorphs, with large numbers of typical meningococci, many showing involution forms. Cultures of typical meningococci were obtained from this fluid, but Gram-positive forms of the organism occurred in the culture, and in subcultivations the organism became strongly Gram-positive. On cultivation on serum agar pointed diplococci very like pneumococci appeared, and at one time it seemed as though two organisms were present. In subsequent culture, however, the typical shape of the meningococci was regained, though the organism was strongly Gram-positive. The authors believed that they were dealing with a pure culture of meningococcus, and were confirmed in their opinion by the observation of a similar alteration in the staining characteristic of the organism derived from a more recent fatal case in the Childrens' Hospital. Bacteriologically, posterior basal meningitis and acute cerebrospinal meningitis are identical, only differing in degree. The authors suggested that attenuated meningococci might exist in the nasal and other secretions of many children, just as attenuated pneumococci might be found, and that under certain conditions these organisms might become virulent, giving rise to posterior basal meningitis, or, still more virulent, to the acute epidemic form of the disease.

INFANT FEEDING. (*a*)

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[SPECIALLY REPORTED AND ABSTRACTED FOR THIS JOURNAL.]

YOU will recognise that this lecture is intended to be more or less popular, and I shall assume that I am addressing many mothers and nurses, as no doubt, in the main, I am. My purpose is to draw upon a fairly wide experience of the subject, and to speak of and recommend to you the foods which I have found to give the best results in the majority of infants.

At the outset I would say that, if possible, children should be fed by the natural method. I feel sure there is no need to labour that. And, fortunately, the natural method is not likely to necessitate much management on your part; but there are one or two points in connection with that part of the question which I want to lay stress upon. The first is the need

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(a) Abstract of Paper read before the Edinburgh Medico-Chir. Society. Feb. 6, 1907.

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for regularity in the feeding. This is where mothers often go wrong, and where you will probably be able to put them right. In the first few weeks of life the child should be fed every two hours, certainly during the day, and a couple of feeds should be given in the night. As the child gets older, the interval can be increased, first to 2½ hours, then to 3. Babies being creatures of habit, you will see the great importance of this.

Next, it is very important to have the child regularly weighed. This is your only criterion as to whether the child is thriving, whether it be fed by the breast or artificially. A child which is being fed on the breast should, to be considered satisfactory, gain 6 ozs. in weight per week during the first few months of life. After that, the gain will be slower. If the gain is less than that, you are justified in assuming that there is something wrong.

Next, I would warn mothers against being worried by a little sickness; there is no need to do that if the weight is progressing. I have known cases in which the child has been weaned unnecessarily early because it was sick.

Then, still assuming that the weight is right, it is important to know when to stop the feed One hears a good deal nowadays of the evils of neglecting to feed children at the breast, but enough is not heard of the disadvantages of keeping them at the breast too long. Over-lactation is one of the most potent causes of rickets; some of the worst cases of rickets I have seen were due to that cause. Not only does it produce rickets, but it is complicated by anæmia, sometimes to a profound degree.

With regard to the time for weaning, do not be guided by the popular notion that the appearance of teeth indicates that the infant should be weaned; so that it is assumed the mother should continue putting the child to the breast while it is without teeth. That is not only untrue, but it has done and is doing much harm. Many children who are kept too long at the breast get rickets, and rickets is a very common cause of delayed teething. I think you will not go far wrong if you recommend weaning at the tenth month or thereabouts. And the child which has had ten months breast feeding is more lucky than most.

But what you have chiefly come to hear about are the best methods of artificially feeding infants. I shall not labour the point as to what is the best substitute for human milk, because it is universally agreed that, on the lines of convenience, cow's milk must be the substitute. The great disadvantage of this substitute is the density of the clot which it forms in the stomach. Were it not for that, there would be practically no difficulty with infant feeding. That clot is due to the casein, the essential chemical constituent of cheese. The milk is liquid, but only outside the body. I show you tubes containing human milk and cow's milk combined with digestive fluid, so that you may appreciate the density of the clot in the cow's milk. It requires no knowledge of physiology to understand that the liquid one will be more easily digested than the solid one, because the process of digestion, in its essence, is the reduction of the food to a solution, as only in that form can it be absorbed. The whole purpose of the methods of modifying cow's milk is to overcome this solid clotting. There are various ways in which this may be done, and the diversity of the methods recommended for the feeding of infants depends on the various ways in which the milk is treated.

The first method is dilution. As there is less casein in a given quantity of liquid, the density of the clot will be less. Now, in embarking upon a course of modification for the feeding of infants, you must, to have success, have a definite plan of campaign; there is no use in plunging from one degree of dilution into another, and from one substitute for cow's milk to another, haphazard. I recommend you to never dilute more than half water and half milk. What shall your diluent be? There is a popular prejudice in favour of barley-water; and simply because it is somewhat mucilaginous when it is mixed with the milk, there is a less dense clot. But barley-water, as ordinarily made, contains 1 per cent. of starch, sometimes more, and starch is not a natural ingredient of an infant's diet, and every now and then you will find an infant with whom barley-water will disagree. Certainly there are cases where failure in artificial feeding is due to this cause; the starch passes unaltered into the stomach and intestine, and there undergoes acid fermentation, which in turn causes colic and discomfort. You will do wisely to employ water as the diluent. The nutritive value of barley-water is quite negligible. If you are doubtful about the source from which the water comes, boil it. Adding the same quantity of water as there is milk will bring the amount of casein to nearly what it is in human milk. But it will also bring down the other constituents—the sugar and the fat. You must correct that by adding sugar and cream. To every 6 ozs. of your mixture of water and milk I recommend you to add a couple of drachms of cream and 2 of sugar—I mean the ordinary dairy cream, having 45 per cent. of fat. That, in regard to its constituents, will closely approximate to human milk. Identical with human milk your mixture can never be; there are subtle differences which we cannot make good. If you weigh the child from week to week and find it doing well on this mixture, continue it.

But all infants cannot stand this degree of dilution. There are some, particularly below three months of age, for whom such a mixture is too strong. The tube I show you containing such a liquid shows that it is more flocculent than the human milk. What shall you do in such a case, supposing the child has sickness and vomiting, and there are green, unhealthy motions? I recommend you to see if you can chemically alter the casein without any further dilution. You may be tempted, as people always are, to say, "If half-and-half will not do, we will try two of water to one of milk." I can only say my experience is that that mixture is not satisfactory; at all events, one cannot at all rely upon succeeding with a greater dilution than half-and-half, and it is then very difficult to redress the balance of sugar and fat. In fairly recent times it has been found that with the addition of citrate of soda to milk you can reduce the density of the clot; it is a harmless vegetable salt which, so far as I know, produces no signs that it has been given. One grain of citrate of soda to every ounce of milk (*i.e.*, 2 ozs. of the mixture) will result in there being practically no clot at all, and children who could not digest the half-and-half food will thrive upon this. I show you citrated milk which has been treated with rennet, and you cannot clot that, even if you add rennet and hydrochloric acid. Therefore that will not pass along the bowel in lumps and cause colic. It is better that this citrate of soda should be used under medical supervision; one reason is that the mother may be stupid, and not understand how to do it.

Where the citrate method fails, we must go to the third stage, and that is, condensed milk in some form. I am almost afraid to stand up and recommend the use of condensed milk, because I am very likely to be accused by my professional brethren of preaching heresy. I know the indiscriminate use of unsuitable condensed milk is capable of doing much harm; but good condensed milk, rightly used, is capable of the greatest service in the matter of infant feeding. What do I mean by good condensed milk? In the first place, I mean one which contains all the natural fat, 13 per cent. Secondly, for all practical purposes, I mean the sweetened form. Theoretically, unsweetened forms may be best, but they are not so convenient as the sweetened because they do not keep long after the tin has been opened. There are at least four brands of sweetened condensed milk on the market. How shall you dilute it? I advise you to disregard all the directions on the tin, because they are misleading. Many of the failures in the use of them for infants are due to the makers' directions—they do not do themselves justice. Use it in the proportion of a drachm (an ordinary medium teaspoonful) to 3 ozs. of water. That, as regards the important constituent casein, is almost right—perhaps a little below a good sample of human milk. Where it does come short is in fat. But that is easily remedied by adding a teaspoonful of cream to every 3 ozs. of water. That is better than the half-and-half cow's milk and water, because it contains less casein. In the process of condensing the milk the casein seems to undergo some change which makes it more difficult to clot. You could not form it into junkets if you were to try. You will see, by the tube I shall show you afterwards, that it forms a very flocculent curd when mixed with digestive fluid, very different from that of pure cow's milk. In young infants condensed milk so used will give quite satisfactory results, and if people advise you never to use condensed milk, pay no heed to them. They are people who have never used it in the proper way. Do not continue this beyond the fourth month, or you are very liable to have rickets produced, and there are very few children of that age who cannot digest the half-and-half cow's milk and water. One gets to know by experience—almost by merely looking at a child—whether it is likely to be able to digest a half-and-half mixture. Remember that by continuing a milk or food which does not suit a child and gives it indigestion, you are apt to have difficulties during the rest of its infancy, even after the proper food for it has been found. If a child looks small and puny, and seems likely to have bad digestion, not having got on well with human milk, begin your plan of campaign right away with condensed milk in this form.

Assuming condensed milk does not suit, or that it is not available, what should you do? I think dried, desiccated milk will, in the future, have a great use, though I do not think it is yet in the region of practical politics. You may regard it as condensed milk carried a stage further, preserving all the properties of the milk, so that when dissolved in water it will reproduce condensed milk; so that when you add rennet it does not clot. I have known young infants able to take more desiccated milk than would be represented by ordinary cow's milk, dissolved in water, and digest it well. Desiccated milk cannot be said to be yet generally available, but I think it will be in great vogue in the future. It is comparatively sterile, and is an easily managed substitute for ordinary cow's milk.

If even condensed milk fails, you can try milk which has been peptonised. But a baby which is bad enough to be fed on peptonised milk is bad enough to be under the care of a doctor. So, although I have put it down as the last card to play in your campaign, it is one which you are not likely to use often on your own responsibility. I mean peptonising by one of the preparations which are on the market. After peptonising the milk, you can dilute it down to half-and-half, and you will find many children will thrive on this who cannot digest any other form. This does not clot. I show you some peptonised milk which has been pancreatised. The whole object of pancreatising is to do the work of the child's stomach for it.

Suppose that, after trying all these methods, you still have difficulty; that the child still fails to gain weight, and has unhealthy motions, what shall you conclude? I think you may conclude that you are dealing with one of those children who cannot digest cow's milk at all, no matter how you treat it. And in such a case as that, it is very difficult to know what to do. But I need not trouble you with these cases, because they should always be placed under the care of some responsible medical man. And they form a very small minority indeed of the total cases.

Next I want to say a few words about the technique of the feeding—that is, as to how you are to give those foods. I have given you a table of times of feeds and the approximate quantities. These are only approximate. There are people of an inquiring turn of mind who want to know exactly how many ounces each feed should consist of, but I think that should be left to the baby. You cannot tell how many ounces and grains any person in this room may want to eat at dinner. The appetites of grown-up persons vary, and so do those of babies, and there is no good in aiming at scientific accuracy in this matter. Still, there are some fussy mothers who think you should be able to tell them that.

With regard to the feeding bottle, I am glad to say that correct views are beginning to prevail on this matter. The tube bottle is rapidly being discredited, and I hope you will do your best to get the screw bottle equally discredited, as that does quite as much harm. Stale milk and added harmful matter gets harboured in the screw, just as in the tube, and both are not likely to be absolutely cleansed between each feed. The best is the plain oval bottle with a rubber teat in the top which you can turn outside in. All these elaborate arrangements to let in air and prevent a vacuum are not necessary. The human breast is not equipped with air-holes, and I do not see why feeding-bottles should be, either. You must see that the hole in the top of the bottle is big enough. I have known children nearly starved through neglect of this precaution. If when you invert the bottle of milk the liquid comes away at the rate of one drop per second, the child will feed easily enough. If it comes less quickly, the child may starve, or at least becomes exhausted; if it comes quicker, the infant may be over-fed. The "leech-bite" bottles are not regulated carefully enough in this regard.

Lastly, I have something to say about patent and proprietary foods. I have handed round a sheet showing the composition of most of the patent foods on the market. It is not quite up-to-date. I do not abuse patent foods all round; they undoubtedly have their place, and fill a useful purpose. But it is very rare for a child which cannot thrive on food prepared in one of the ways I have explained to do so on a patent food. Group I. in this table are to be used instead of human milk. Group II. have been starchy to begin with, but that starch has been converted into sugar. Group III. consists of foods which contain starch.

It is seldom you find a child able to take the foods in Group I. which could not digest condensed, or citrated, or peptonised milk. Sometimes one of the foods may happen to suit, possible because the child likes it. The foods in Group II. are useful when the child is about six months old, and when it has got a tooth or two, but cannot digest much starch. These foods should be only supplementary to the milk. With regard to the foods in Group III., one should discourage the use of them until the child has got teeth. Most of them are expensive, and can be substituted by simpler means—wheat flour, oat flour, boiled crusts.

Weaning should be carried out about the tenth month, whether the feeding has been by breast or by bottle. If you keep the child on milk too long, you will have a difficulty in getting it to take solid food at all. I have known mothers defer feeding until the second year. After weaning, commence feeding by means of something with a spout, and follow with a spoon. Do not give starchy foods until the child has got a few teeth through; let them be subsidiary to cow's milk, and use ordinary domestic foods in preference to patent preparations.

There are many different ways of feeding children, and those I have given are not all of them; but they are methods which, in the main, you can apply; they are not time-consuming, or troublesome, or expensive, and therefore they are peculiarly suitable to the class among whom nurses have to do their work.

TREATMENT OF PERITONITIS.

BY H. W. CARSON, F.R.C.S.ENG.,

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DURING recent years many investigators have been engaged on the problem of the resistance of the individual to disease, and it is now recognised that in disease the fight is between the specific organism and its toxins and the leucocytes in the blood, and that the incidence of infection is followed by an increase in the number of leucocytes (hyperleucocytosis). Issaeff, Loewry and Richter, Jakob and Salieri were pioneers of this work, and Salieri succeeded in causing hyperleucocytosis by injecting sterilised saline solution int the peritoneal cavity. Hahn showed that in hyperleucocytosis the blood had a higher bactericidal value. Mikulicz and Miyaké, by injecting saline solution and nucleic acid into the peritoneal cavity, succeeded in increasing the resisting power of the peritoneum to infection 16-20 times. Dudgeon and Sargent maintain that in peritonitis the first organism to appear is the staphylococcus albus, and that this organism, which is of low virulence, causes a fluid exudate containing innumerable phagocytic cells, which is essentially protective against the more virulent organisms which may appear later. Not only is the white staphylococcus the first to appear, but it is also the last to disappear, and Dudgeon and Sargent suggest that this may account for the well-known fact that in appendicitis the first attack is the most severe, subsequent attacks being of less severity owing to the persistence of the white staphylococcus. In this connection it may be mentioned that in my report of 100 consecutive appendix operations read at the Toronto meeting of the British Medical Association in August last, I showed that of the 70 acute cases

55, or 78.5 per cent., were first attack cases;
12, or 17 per cent., were second attack cases, and
3, or 4.5 per cent., had had more than two attacks.

Other facts of great importance in connection with the pathology of peritonitis may be briefly summarised:—

1. Muscatello of Turin proved that the diaphragmatic area is chiefly concerned in the absorption of fluid from the peritoneal cavity.
2. Injury to the endothelial coat of the intestines permits of absorption taking place directly into the vascular system, and if the fluid absorbed is pathogenic, toxæmia follows.
3. The virulence of intestinal organisms increases from the jejunum to the ileo-cæcal valve, decreasing again in the large intestine. This virulence is much increased in intestinal obstruction.
4. Organisms escape from the intestine as soon as it becomes inflamed and distended.

I wish to-day to consider the treatment of peritonitis as viewed from the standpoint of recent bacteriological research, to see how far our former methods were justifiable, and in what respects we must remodel our procedures.

It is now generally recognised that the operative treatment of peritonitis is the only course to adopt if the patient is to have a fair chance of recovery, so that we may fairly discuss treatment under the three heads—

1. Pre-operative.
2. Operative.
3. Post-operative.

PRE-OPERATIVE STAGE.

To the practitioner in general practice this is the stage of greatest importance. The most important point of all is the ability to diagnose the condition early. I do not propose to-day to enter upon the question of diagnosis, as time is limited. The diagnosis having been made, the question to be answered is not "How shall I treat it?" but "What can be done previous to operation to improve the patient's chance?" The patient is in great pain and distress, and one's thoughts turn naturally to some form of anodyne, and the points for and against the administration of morphia must be considered. Both clinically and bacteriologically many arguments can be adduced against this practice. From a clinical standpoint it is, I suppose, a truism that morphia tends, as the well-known phrase runs, to "mask symptoms." Every surgeon who has had experience in abdominal surgery will subscribe to this statement, and it has seemed to me that morphia has a special power in those cases which, bacteriologically considered, are not of extreme virulence. I refer more particularly to cases of perforative gastric ulcer. The administration of morphia may give an elusive appearance of wellbeing to these cases, which may lead to the deferring of the operation, and we know that in these milder forms of infection an early operation is followed by a very flattering measure of success. But this is not the only argument against morphia administration. It has been proved by the researches of Dudgeon and Ross that morphia has a definite action in *inhibiting leucocytosis*, that is to say, it takes from the patient his only weapon of defence. Considering that our whole aim in the treatment of peritonitis is to encourage leucocytosis, one recognises how fatal the use of this drug may be, and how directly it runs counter to the rest of our treatment. Next, morphia tends very definitely to *reduce intestinal peristalsis*, and this leads to distension of the gut and stasis of the intestinal contents. I have mentioned above that the intestinal organisms escaped from the intestines only when they were distended, and that in stasis of the intestinal contents the virulence of the organisms was directly increased, so that one sees that the administration of morphia increases the virulence of the infection and aids its dissemination. The dissemination of infection is also aided by the fact that owing to the relief of pain which follows on morphinism, the rigidity of the abdominal walls is reduced, and the diaphragm can move more easily in respiration. This tends to cause distribution of the infecting material, though our aim is of course to limit it to the primary area. The great argument in favour of morphia is that it relieves shock and saves the patient from the depression of pain. This is true, and in some cases of virulent infection it may have a definite value; but as a routine treatment I most unhesitatingly condemn it. It has been said that it is not the simple injection of morphia that is so dangerous, but the continuance of treatment by morphia, and that if a single injection does not relieve pain, or prevent its early recurrence, the case is one for operation. I must say I have a greater belief in the diagnostic powers of my fellow practitioners than to think that it is necessary to use morphia in order to estimate the need for a surgical operation. It has been urged that if the diagnosis is made and operation decided upon, morphia may be safely and advantageously administered. That certainly overcomes the difficulty of the "masked symptoms," but it does not answer the other objections I have raised, nor does it alter the fact that many patients, morphinised before operation, show evidence of definite motor paralysis of the intestines after operation, and I have many times had the greatest difficulty in counteracting this. To sum up, then, I would urge that although in exceptional cases morphia may be of value, its routine use is to be strongly condemned. What, then, shall be done before operation? I am convinced that of all methods the best is the administration of a turpentine enema. If this results in the passage of flatus, the relief to the patient will be immediate, and a step will have been taken to counter the intestinal distension which so definitely favours the passage of the intestinal organisms through the wall. The administration of small doses of calomel should, I think, be deferred until the nature of the lesion is definitely assured. As I shall mention presently, it is a very valuable post-operative measure. Further, I should recommend that the patient should be placed in such a position that the exudation will tend to gravitate towards the pelvis. This posture method, to which I shall refer in greater detail under Post-operative treatment, is adopted in order to prevent soiling of the diaphragmatic area, and thus to delay the absorption of the bacterial toxins. Finally, relief to pain may be obtained by the local application of heat—e.g., turpentine stupes—care being taken to avoid injury to the skin.

OPERATIVE MEASURES.

I have pointed out the danger of direct vascular absorption if the endothelial coat of the intestines is injured. This is the keynote of all operative measures. To avoid injury to the endothelium we must, above all, do our work quickly and gently. We must avoid rough handling, we must avoid antiseptics, we must prevent the peritoneal coat becoming dry, we must protect the peritoneum from soiling with the intestinal contents, and we must give up heroic measures of evisceration, extensive lavage, scrubbing with gauze, and so on. The researches of Crile show that the amount of shock is directly proportionate to the amount of traumatism. He showed that exposure of the intestines to air, manipulation, and sponging caused a fall in blood-pressure and an increase in the pulse-rate. He showed that flushing the abdomen caused a lowering in the blood-pressure, and you will find that anæsthetists will readily agree that the pulse is perceptibly weakened by this treatment. An important fact is noted by Crile, that most change in blood pressure occurred in operations near the diaphragm, and on all sides we find reasons for looking upon this region as the most important area within the abdomen. In this connection it is interesting to note that Crile reported that all operations on the female generative organs—hysterectomy, oöphorectomy, even perineorraphy—were associated with a definite *rise* of blood-pressure.

Our first duty is to the primary seat of infection. It is our object to so treat this that further infection from the spot may be impossible. That is, a perforated ulcer must be sutured, a localised abscess drained; a gangrenous appendix or portion of intestine removed, and so on. All these operations must be done with the minimum of manipulation, the greatest care being taken to avoid breaking down adhesions or in any way disseminating infection. If the abscess is circumscribed while the general peritoneal cavity is not shut off, as in cases of subcæcal appendix suppuration, the general cavity must be carefully walled off with swabs before the abscess is opened, and these swabs may be left in position for a day or two if necessary. If the peritoneum is widely infected, the question of flushing arises. The object of flushing is of course to free the peritoneum from infective organisms and their toxins. Dudgeon and Sargent have by their researches proved that much of the exudate is protective in character, and that in the earlier stages the virulent organisms, such as bacillus coli, have not appeared universally. With this in mind, it is obvious that if we thoroughly flush out the abdomen, while we cannot hope to rid the endothelium entirely of the infection, we run a practically assured risk of washing out the protective staphylococcus albus exudation, and in addition we may infect with virulent organisms parts of the peritoneal cavity which were hitherto free. Also, for thorough flushing, evisceration is necessary, and I have stated above how evisceration and flushing tend to lower blood-pressure. Local flushing is a different matter, and though this is difficult in the appendix region, it is capable of thorough application in the pelvis. And here I would remind you that antiseptics should not be used at all in the abdomen. Their effect is to injure materially the endothelium, and to interfere with the ability of the phagocytes to do battle with the infecting material. Experiments have proved that the untreated peritoneum is capable of neutralising the toxins of a much larger dose of bacillus coli than it can do if previously prepared by the injection of antiseptics. There is no doubt that much of the success that has of late years attended upon abdominal surgery has been due to the wide adoption of aseptic for antiseptic measures. At the two extremes of peritoneal infection it may be permissible to flush. These are, on the one hand, the very severe types of streptococcal peritonitis where infection is practically universal, and, on the other, the mild type found in hæmorrhage, or some cases of perforated gastric ulcer. In the former there is no risk of infecting a previously free area, and in the latter the virulence of the infection is so slight that the danger is reduced to a minimum. I do not think, however, that much is gained in either case, as in streptococcal invasions, flushing does not lower the mortality, and the mild cases do very well indeed with simple drainage. Murphy, of Chicago, indeed, stated at Toronto that in his last 36 cases of general peritonitis he had had several streptococcal cases, and although he did not flush in any case, he had only lost one of the 36 cases, and in that case death occurred six days after operation of double pneumonia, the peritonitis having quite cleared up. As an illustration of the dangers of flushing, it may be stated that in the five years 1899-1903 119 cases of appendicitis with diffuse peritonitis were operated upon in St. Thomas's Hospital; 100 of these were flushed out with large quantities of normal saline, and of these 80 died. The remaining 19 were treated locally by sponging and drainage, and of these 10 died (Dudgeon and Sargent). So that in this instance the mortality attending on flushing as compared with local drainage is 80 against 47, and allowing for the chance that many of the most severe cases are included in the first list, the difference in the mortality is striking. Drainage should be resorted to in all cases where infection with the bacillus coli or more virulent organisms is feared. In mild infections with the staphylococcus albus only, *e.g.*, hæmorrhage cases, drainage is not necessary, for we know that the staphylococcus albus is not capable unaided of causing a fatal peritonitis. The drain must be put in one of three places—either in the pelvis or the loins. A tube placed centrally to drain the small intestine area is useless. In the event of Fowler's position being adopted, drainage of the loin pockets need not be provided, as the contents of the lateral parts of the abdomen will drain by gravitation into the pelvis. We may then sum up our operative procedures as follows:—

1. Elimination of the primary cause.
2. Avoidance of manipulation, breaking down adhesions, flushing, etc.
3. Continuous drainage.

POST-OPERATIVE.

Our aim in the after-treatment of peritonitis is to promote leucocytosis, prevent the further infection of the peritoneum, and eliminate the toxic products of the infecting organisms before they can become absorbed into the circulation.

In the present state of our knowledge it is not possible to promote leucocytosis by the administration of any serum. The organism which it is most necessary to combat is the bacillus coli, and at the present time no serum valent against the varieties of the colon bacillus has been manufactured. With respect to other forms of infection, the streptococcus is so virulent that polyvalent antistreptococcic serum is of little avail, though its use is indicated if the streptococcus is isolated from the exudate. The other forms are not of sufficient virulence to require other than the ordinary treatment. But there is a method of causing hyperleucocytosis which is readily available. This consists in administering saline solution by the rectum or subcutaneously. In giving the rectal injection, the buttocks are raised, a multiperforated tube is passed just within the internal sphincter, and through it is passed, in a continuous stream from an irrigator, one or two pints of saline solution. This should be passed so slowly that one pint takes half an hour, and no fluid should return. Practically the fluid is absorbed as it is injected. The irrigator should be attached to a stand not more than 4-6 inches above the pelvic floor, and the nozzle can be strapped to the patient's thigh. This is a most valuable method of treatment, and it should always be resorted to even in less serious cases if the discharge tends to cease too soon. In my opinion, if in, for intance, a case of appendix abscess, discharge ceases or becomes much reduced in the first few days, it means that leucocytosis is low, that the patient is not making a sufficient opposition to the enemy, and unless steps are taken to overcome this, the result will be doubtful. The best method is this I have mentioned of rectal irrigation.

To *prevent further infection* it is necessary to prevent intestinal distension, and to promote peristalsis, and the passage of the contents along the intestinal tract. As I have told you, the organisms escape from the bowel during distension, and if stasis occurs the virulence of the organisms becomes much increased. With this in view, morphia is absolutely forbidden, no matter what the apparent necessity, and some such drug as aspirin used to relieve pain. The pain is, however, generally due to distension, and this must be combated by enemata preferably containing turpentine. Another method, and one of great value, is to administer by the mouth repeated small doses of calomel. These doses may be as small as one-sixth of a grain, and should not exceed one grain. They may be given every hour till some relief is obtained. In some cases they may be associated with a saline or potassium tartrate.

To eliminate the toxic products we must rely upon drainage, and knowing that the great area for absorption is the diaphragmatic surface, it is well to place the patient in such a position that the fluids tend to gravitate away from the diaphragm. This is obtained by placing the patient in what is known as "Fowler's position." The head of the bed is raised about 2 ft., and the patient supported by a pillow slung beneath the thighs, in a semi-sitting position. This position is always associated with a pelvic drain. The patient must be carefully watched to see that the raising of the head does not cause faintness. Now a final word as to the technique of our operation. The surgeon should bear in mind the necessity of protecting as far as he can the small intestine from the septic focus in the pelvis (for this, owing to gravitation, becomes septic in the majority of cases). He must recognise that if the small intestine is allowed to bathe in a collection of pelvic pus, he runs a very great risk of having to deal with an obstruction by kinking during the convalescence. To prevent this, he must pack the sigmoid or the rectum into the floor of the pelvis, and draw down the omentum and tuck it in beneath the uterus or bladder, so as to exclude altogether the small intestine from the pelvic area. In spite of all care, ileus may however occur, and it is necessary that it should be at once recognised if the patient's life is to be saved. It may be difficult to differentiate between true ileus and intestinal paresis from distension. In many points they resemble each other, but in my experience one of the most reliable points in diagnosis is that ileus is preceded by severe pain; vomiting, rise of pulse-rate, and inability to pass flatus supervening rapidly. In intestinal paresis the onset is generally much earlier after operation; there is no more pain than would be caused by the feeling of abdominal tightness, vomiting is not so urgent, and unless toxæmia is marked, the pulse rate is not so obviously increased. It will always be found that the point of kinking is in the last 6 in. of the ileum, and if the abdomen is promptly opened, the condition can frequently be satisfactorily dealt with.

OPERATING THEATRES.

ROYAL EAR HOSPITAL.

INFLUENZAL MASTOIDITIS, SCHWARTZE OPERATION.—Mr. MACLEOD YEARSLEY operated on a woman, æt. 43, who had been admitted with the following history: Five weeks previously she had been attacked by influenza; one week later severe pain with discharge occurred in the right ear; the discharge was more serous than purulent, and usually contained blood. Under treatment by Dr. Cardinall, of Sidcup, the discharge ceased, but pain of a severe neuralgic character, radiating over right side of the head and down the neck, remained, together with tenderness over the lower part of the mastoid process. On examination, the osseous meatus was found to be much congested, especially in its superior posterior part. Shrapnell's membrane, together with the handle of the malleus and the posterior superior quadrant of the membrana tensa, was injected; in the latter region was the scar of a recent perforation. Tenderness over the lower part of the mastoid process was marked, especially about the tip. The patient appeared ill; her temperature was 96.8°, but there was no nystagmus, vertigo, or other serious symptom, and her deafness was not very marked. At the operation, the mastoid was found to be of the pneumatic variety, and each cell was occupied by granulation tissue, the bony walls between them being soft and crumbly. The antrum contained no pus, but there was a fairly large granulation in the region of the aditus. The whole mastoid was cleared out and, on reaching the tip, pus welled out, verifying the diagnosis which had been made of an abscess in the tip cell. The meatus was thoroughly purified, and an incision made in the posterior segment of the membrane. The mastoid cavity was packed and the wound sutured in its upper two-thirds. Mr. Yearsley said that this case was very interesting as illustrating several important points in influenzal mastoiditis. Acute inflammations of the middle ear occurring in the course of influenza might, he pointed out, take one of three forms: (1) A distinctive type of hæmorrhagic otitis with a discharge often scanty and for the most part sero-sanguinolent (this apparently affected the patient just operated upon); (2) a primary mastoiditis due apparently to direct infection rather than to extension; (3) a rapid caries or necrosis of the ossicles or mastoid. A prominent feature of influenzal mastoid disease, present in this case, he remarked, was severe radiating pain of a neuralgic character. He had more than once seen cases similar to the present one in which serious mastoid disease was present with such equivocal symptoms as to almost merit the term latent, the mastoid complication existing after the middle-ear condition had practically cleared up. Another point prominently illustrated by this case, he thought, was the variety of mastoid specially attacked by influenza. As long ago as 1892, Politzer pointed out that this form was the pneumatic, in which there were numerous cells communicating with each other and with the antrum by very small openings. These tiny communications become closed by inflammatory swelling, a collection of pent-up pus resulting. These abscesses were to be found in the middle or inferior segment of the vertical portion of the mastoid, the tip cell being a common locality. Looking at the history of the case, and especially at the time which had elapsed (four weeks) since the onset of the aural symptoms, it appeared likely that the mastoid condition and the tympanic inflammation were part and parcel of one process rather than that the former was the direct result of the latter. One could not bear in mind too prominently, he considered, the fact that serious mastoid trouble might occur in influenzal cases without giving by their symptoms adequate indication of their extent and gravity. It behoved, therefore that surgeons should lose no time in temporising with such cases, but should act promptly.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, FEBRUARY 8TH, 1907.

The President, Mr. CLUTTON, in the Chair.

DR. FRANCIS HAWKINS (Reading) read notes of a case of

TYPHOID COMPLICATED BY PERICARDITIS AND HÆMORRHAGIC PLEURISY.

The patient was a girl, æt. 20, whose illness commenced with sore throat and a feeling of stiffness in the legs. Five days later she had a shivering fit, followed by diarrhœa. During the course of the illness no typhoid spots appeared, but the abdomen was distended and the bowels moved from twice to seven times daily. Widal's reaction was positive. Early in the third week she expectorated blood, and two days later the expectoration was typically rusty. The physical signs gave evidence of consolidation of the left base. Pericardial friction was heard during the fifth week, when the patient's condition became critical. The respirations were 42, the pulse 128. Paracentesis was performed, and 14½ ounces of hæmorrhagic fluid withdrawn. After paracentesis, the patient improved, but the temperature did not become normal till the seventh week. A systolic murmur was heard at the apex in the third week. Dr. Hawkins remarked on the great rarity of these complications in typhoid fever.

Dr. **WM. EWART** inquired as to details of the treatment employed.

Dr. **DE HAVILLAND HALL** suggested that the phenomena might have been due to a superadded rheumatic infection.

Dr. **HALE WHITE** suggested that the whole disease might have been one of pneumococcal infection. There was an assemblage of features, each of which individually was extremely rare in typhoid fever. The temperature chart was very unlike what is ever seen in typhoid, and there was no other clinical indication of the disease. He inquired as to the dilution of the Widal test and the frequency with which it had been done.

Dr. **FORSYTH**, in view of the origin of the complaint—sore throat and joint pains—asked what was the effect of salicylates. Was there any history of previous typhoid fever.

Dr. **HAWKINS**, in reply, said that he had treated the case with hydrochloric acid. He found this the best antiseptic to use as a routine measure in typhoid cases. The fever had fallen for a couple of days when salicylates were given, but had risen again. As to the Widal's reaction, it had been tested only once, the blood having been sent to a Clinical Research laboratory in London. As seven years had elapsed in the meantime, he could not recall the dilution employed, and there was no note of it. The patient might have had typhoid fever previously.

Mr. **JOHN R. LUNN** and Dr. **GORDON HOLMES** gave an account of the clinical and *post-mortem* notes of a case of

GENERAL PARALYSIS

in a boy, æt. 16. A clinical description of the case was presented when the patient was shown at a clinical meeting of this Society, January 26th, 1906. The patient remained in the same condition until February 15th, 1906, when he had an unconscious fit, which was accompanied by more weakness of his left arm and leg. In August, 1906, it was noted he had right facial paralysis, and a spasmodic spastic condition of the left arm and leg with incontinence of urine. On September 15th, he had another fit with conjugate deviation of his eyes to the left and increased knee-jerks. He died September 13th, 1906.

Post-mortem Notes.—The skull was opened from behind and the brain and cord removed. A recent blood clot of about eight ounces was apparently situated between the dura mater and arachnoid membrane, and had compressed the brain considerably on the left side. No rupture of any sinus could be found. After the removal of the brain, blood could be squeezed out of the cerebral veins in two places, one over the left frontal lobe, the other over the left occipital. This, it was thought, might possibly be the source of the hæmorrhage. No other lesions were found in the body.

Dr. **GORDON HOLMES**, in demonstrating on the screen a series of microphotographs, said the most marked changes found were as follows. :—There were striking changes in the blood-vessels throughout the brain, large numbers of plasma cells being evident in their sheaths. There was syphilitic endarteritis in some vessels of the lumbar cord. The tangential fibres of the cortex were greatly diminished. There was advanced granular ependymitis extending even to the fourth ventricle. The meninges were not thickened. The changes were quite pathognomonic of general paralysis of the insane, and thus fully confirmed the clinical diagnosis. He remarked on a curious tremor of the left hand, that the boy had had at times lasting for twenty minutes. He had previously seen a similar tremor only twice ; it indicated irritation of the arm area.

Dr. **WM. EWART** inquired as to the pathogeny of the changes.

Dr. **PARKES WEBER** asked about the microscopic appearances of the ependyma.

Dr. **GORDON HOLMES**, in reply, said that the changes indicated a chronic inflammation due to blood toxins. The ependyma showed interruption of its lining cells, and increase in the glia. It was not very vascular and the walls of the vessels were hyaline.

Dr. **MORLEY FLETCHER** and Mr. **BETHAM ROBINSON** read a paper on a case of

IDIOPATHIC DILATATION OF THE RECTUM AND COLON AS FAR AS THE HEPATIC FLEXURE.

A boy, æt. 12, admitted into the East London Hospital for Children on November 15th, 1904. There was a history that he had always had a " large belly," and been rather constipated, and that for the last fortnight there had been a great increase in the size of the belly, with more marked constipation, but no vomiting or passage of blood per rectum. On admission the abdomen was tense, with distended surface veins. The percussion note was resonant all over, and in the knee-elbow position a thrill was obtained over a small area round the navel. On palpation irregular masses were felt in the region of the transverse colon. On rectal examination the tone of the sphincters was normal, but the rectum was very dilated. While under observation for a fortnight there was no response to aperient medicines and only poor results from enemata. Abdominal section was done on November 29th, and extreme dilatation of the rectum was found, with enlargement of the colon as far as the hepatic flexure. The dilated bowel contained many pounds of soft dark fæcal matter which was squeezed out of the anus by gradual pressure on the gut from within. There was considerable hypertrophy of the bowel wall. No large or hard glands were felt in the mesentery ; there were no signs of peritonitis, nor any abnormal band. After this thorough emptying of the bowels, the patient's progress was most satisfactory. He was kept under observation, and in March last it was noted that he appeared to be perfectly well, his abdomen was quite natural and free from any abnormal distension. The bowels acted regularly and naturally without medicine. Rectal examination showed some ballooning of the gut. He was shown at a clinical meeting of the Society on April 23rd, 1905. He continued in good health until the evening of July 2nd, when he had abdominal pain without any distension ; there was diarrhœa which continued for several hours. Next day he was admitted into hospital in a comatose state, and shortly after died. The *post-mortem* corroborated the condition of bowels seen at the operation, only much less dilated. The lining membrane of the bowel was healthy, and no cause for the dilatation could be found. Most important points in the case were (*a*) the great improvement which followed simple emptying of the distended bowel, followed by careful dieting and regulation of the bowels ; (*b*) the sudden termination with coma, which suggested the ingestion of some toxic substance by mouth.

Dr. **A. E. GARROD** referred to two similar patients in his practice in whom repeated attacks of tetany occurred, indicating absorption of toxins. These were relieved by enemata.

Mr. **MAKINS** discussed the problem of treatment. He thought that anastomosis at the base of the dilatation was unjustifiable on account of the tendency for a new dilated loop to form. He instanced three personal cases in which this had occurred ; they were all in elderly people.

Mr. **CLUTTON** advised colotomy and a prolonged period of thorough drainage before attempting any of the more extensive operations.

Mr. **JOHN MALCOLM** spoke of the possibility after anastomosis of the hypertrophied lower portion of the gut forcing the fæces backwards into the dilated part as well as onwards.

Dr. **HALE WHITE** thought that if this mechanism were at work, then dilatation should be a much commoner condition than it really is. He commented on the extraordinary rarity of such cases ending in coma.

Dr. **DAVID FORSYTH** thought that Mr. Malcolm's view was supported by looking on the continuity of the intestine after such operations as having been restored anatomically, but not physiologically. The wave of peristalsis must be impeded by the scar tissue.

Dr. **PARKES WEBER** inquired as to evidences in the urine, such as the presence of indican, of absorption from the dilated gut. These were to be found as a rule more in cases of acute diarrhœa than in those of severe constipation.

Dr. H. A. **CALEY** thought that the present case might have been due originally to fæcal obstruction.

Mr. **MAYO ROBSON** remarked that the sphincter muscle in these cases sometimes showed pathological changes, particularly fibrosis.

Dr. **MORLEY FLETCHER**, in reply, said that the sphincter muscle was quite normal in the present case. He remarked that the circumference of the gut had diminished by five inches between the time of operation and that of the autopsy.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, JANUARY 18TH, 1907.

The President, J. M. **REDMOND**, in the Chair.

THE TREATMENT OF GASTRIC ULCER.

DR. LITTLE briefly referred to the morbid anatomy, the causation, and the symptoms of gastric ulcer, and dwelt on the paramount importance of rest in bed, on the value of fluid diet, and of various drugs for the relief of pain, the arrest of hæmorrhage, and the cure of persistent vomiting, and on the objections to uniting the stomach to the jejunum, and urged the attempt to cure the ulcer by medical means, though if it failed he readily invoked surgical assistance.

Sir **CHARLES BALL** discussed briefly the cause of non-malignant gastric ulcer, disowning any belief in the self-digestion theory, and laying great stress on the mechanical effect of food passing over an injured spot in keeping an ulcer from healing. He then gave his experiences of some 40 cases of gastro-enterostomy, pointing out the success of this treatment in non-malignant ulceration.

Dr. **LINDSAY** (Belfast) said he thought the disease must be decidedly common in the North of Ireland, as he found from the reports of the Royal Victoria Hospital that they had 110 cases in 1905, 70 the previous year, and 69 the year before that. As regards the conditions that would warrant the diagnosis of ulcer he was hardly prepared to admit that they must wait for hæmorrhage. He was inclined rather to say that in any young woman, especially one who was debilitated or anæmic, if she had much pain after food, occasional vomiting, and a small area of tenderness in the epigastrium, the evidence for ulcer was fairly satisfactory. Most cases of this kind had ulcer as their basis: There were, of course, differences of degree. Gastralgia should be diagnosed with caution, and only when ulcer could be fairly excluded. A period of complete rest was very important, with a restricted diet. They should also employ alkalies, and probably bismuth, as well as various remedies for the relief of pain, such as hot fomentations, poultices, flying blisters, opium and morphia. Such was a general idea of treatment, but there were differences of opinion and practice in regard to details. How long should strict rest be enforced? For an ordinary case he suggested a period of three weeks as an average, but that period might with advantage often be extended. As regards diet, he agreed with Dr. Little that they must not think only of the ulcer; they must bear in mind the constitutional condition of the patients, and the necessity for putting them in a favourable condition for promoting healing of the ulcer. In cases of recent hæmorrhage he put the patient for a short time on nutrient injections. This, however, he only regarded as a temporary expedient. It was not usually well tolerated for a period of more than a week or ten days. In other cases he had been in the habit of keeping the patient for three weeks at least on milk and strained soups or beef juices. In recent times there had been a considerable revolt in Germany against too strict a dietary. Leube allowed rice, sago, soft-boiled or raw eggs, calves' brains, and even boiled chicken and pigeon at the end of ten days, and scraped raw meat by the seventeenth day. Lenhartz allowed raw eggs with a little wine, milk freely, and sugar even from the first day. Senator allowed throughout gelatine, jelly, cream, almond solution, and iced butter. The general drift of such advice was to allow a considerable amount of liberty even from a very early stage, and even where hæmorrhage had been present. These recommendations had one point in common—the avoidance of the evils of under-nourishment. A diet rich in albumen had the further advantage that it tended to check hyper-acidity. Probably in these islands they had gone to the other side, and leaned rather to the advocacy of a dietary too exclusively designed for sparing the stomach. In view of German advocacy, he had lately given himself more liberty, though not to the extent of the quotations which he had made, and he had not yet seen a case where such liberty had led to mischief. He had allowed whipped egg, animal jellies, and butter and cream, from an early stage of these cases. There was much room for discretion in such matters, and the amount of pain was an important guide. He had already mentioned the use of alkalines and bismuth; he was not inclined to think very highly of nitrate of silver, nor was he inclined to favour the washing out of the stomach. He attached great weight to care during convalescence; much physical rest and cautious return to a generous dietary were points of great importance. In the treatment of hæmorrhage he recommended absolute rest, an ice-bag to epigastrium, nutrient enemata, but he felt doubtful as to the ordinary astringents. The symptoms of partial pyloric obstruction might be mitigated by a carefully regulated diet and occasional lavage. In his experience recovery in a good many cases was not complete, more or less pain and discomfort remaining after food. It was probable that in such cases they were dealing with a partially healed ulcer, or that adhesions had taken place. A second course of medical treatment might be undertaken, but he thought the time had then arrived for invoking the aid of surgery. In relapsing cases particularly he recommended the consideration of whether operative measures should not be resorted to. They might be able in that discussion to draw the line more clearly between the place of the physician and the surgeon in such cases. Nothing was more desirable than complete harmony and co-operation between both sides of the profession. The physician should recognise that the intervention of surgery in that field of practice had been a great boon to suffering humanity; he should be careful not to postpone too long his appeal for assistance to a surgical colleague, and he should seek that assistance in most, if not all, relapsing and chronic cases. On the other hand, the surgeon should recognise that his assistance was only required in a minority of such cases; that a full and even patient trial of medical measures was always the first duty; he should be chary of mere exploratory operations, which were likely to redound neither to the credit of surgery nor the advantage of the patient, but in such cases as those described by Sir Charles Ball, where the indications were fairly clear, he should intervene with promptitude and operate with boldness. Such intervention would undoubtedly lead to the best results.

Mr. **MITCHELL** (Belfast) said gastric ulcer is a much more serious disease than is generally recognised. The mortality is very difficult to estimate. Mr. Keeley puts it at 25 per cent., and states that at least 20 per cent. of chronic cases develop phthisis, while not less than 5 per cent. perforate. If these figures are even approximately correct, we are bound to consider much more frequently than we have yet done the question of operative treatment. Do not let us make any mistake; an abdominal operation of this kind is a serious thing to propose, and serious to carry out; but in competent hands the risk should not exceed 5 per cent.—in other words, it is no greater than the danger of perforation, in which the patient already stands. "Exploratory" operation is, in my opinion, an unscientific proceeding. There should always be some definite diagnosis, and operations should be undertaken with a deliberate object in view. In other words, we set out intending to perform posterior gastro-jejunostomy, but owing to various complications this procedure may require to be modified. This is very different, however, from *opening the abdomen to see whether it ought to have been opened*, for that is really what an exploratory operation generally means. Not at all infrequently there is little pathological to be seen in the stomach; but a few silvery adhesions here or there, or some enlarged glands in the omentum, will be found on careful examination, indicating damage to the mucous membrane. Tubercular disease of the stomach is, I think, commoner than is generally believed. I have had three undoubted cases in 48 consecutive operations. They all benefited decidedly, but progress is slower than in ordinary ulcer. As to cure, my impression is that a properly performed gastro-jejunostomy may pretty confidently be relied upon to cure 90 per cent. of cases, and those in which failure occurs will be found to have some other ailment militating against success. I have not yet had occasion to operate for the arrest of acute hæmorrhage, but do not feel inclined to do so. For recurrent hæmorrhage gastro-jejunostomy is the treatment. Operation is not to be recommended for all cases of ulcer, but unquestionably it should be resorted to more frequently than it has been. After a fair trial of thorough medicinal and dietetic treatment without satisfactory results, operation should at least be considered before the health of the sufferer is undermined, and the stomach so deformed or adherent as to require some elaborate and dangerous surgical procedure. The duration of treatment is a point of some importance. One month may be regarded a full time for complete cure by operation. Under medical treatment a patient is fortunate if at the end of a month she is timidly attempting an average diet.

Dr. Cox said his conviction and experience had been that the majority of cases had a tubercular history. Whatever the subsequent development had been, they were primarily tubercular as regards causation. From that point of view he regarded Dr. Lindsay's remarks as regards the question of generous diet as very important. The ulcer must not be regarded primarily as a local condition, but as an outcome of constitutional causes. He thought it was criminal to persevere for years with the washing out of a stomach which had baffled careful treatment; operation was clearly demanded, and it was unfair to the patient, to the surgeon, and to humanity to wait until a condition of hopelessness had been reached.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FEBRUARY 6TH, 1907.

DR. J. O. AFFLECK, President, in the Chair.

DR. CHALMERS WATSON read a paper on the

TREATMENT OF SOME DISEASES COMMONLY REGARDED AS OF GOUTY ORIGIN.

The conditions dealt with included migraine, "rheumatic" pains, recurrent nasal catarrh, and some vague and ill-defined symptoms often encountered after middle life. Dr. Watson cited in some detail a few illustrative cases out of several hundred such, which had come under his notice during the past five or six years; they were of the class commonly termed "gouty," and had proved obstinate to ordinary treatment. The line of treatment he had adopted consisted in restricting the allowance of proteid food, in using hydrotherapeutic measures, such as Turkish baths, freely, and in administering small doses of thyroid gland preparations. In his opinion the excessive ingestion of animal food threw an undue strain on the thyroid gland, tended to exhaust it, and thus indirectly affected the metabolism. The use of baths and measures directed towards increasing the functional activity of the skin, liver, and kidney promoted elimination, while the administration of thyroid stimulated metabolism. All clinicians, from Laycock onwards, agreed that there was a certain antagonism between gout and tuberculosis. Dr. Watson quoted descriptions of the typical "gouty diathesis," and the "strumous diathesis" in illustration of the different aspects of the subjects. Gout was a disease of well-grown vigorous subjects, and in its treatment the restriction of animal food was of special value. Tuberculosis, on the other hand, was a disease of less developed and less robust subjects, and in its treatment special value attaches to the use of a great excess of animal proteid food, as in zomotherapy. In the speaker's opinion, the subjects of inherited or acquired gout had acquired from their environment, which included diet, an abnormally active thyroid gland, working at high pressure, and liable to become exhausted. Subjects predisposed to tuberculosis had an inactive thyroid glandular system. The views formulated by the author on the basis of clinical observation had received confirmation from his experiments on animals. By feeding animals on a diet containing an excess of proteid food he had been able to modify the structure and function of the thyroid gland and other organs, and to produce in the offspring of meat-fed animals clear evidence of an altered functional activity of the same glands. The animals used for the experiments were rats, which were omnivorous, and, under certain natural conditions, as, for instance, near slaughterhouses, lived almost exclusively on meat, so that it could not be supposed that the changes he was about to describe were merely due to an inadequate or unsuitable diet. Sections were then shown on the screen illustrating the changes produced by a meat diet—the thyroid was over-active, and gave evidence of having an undue strain thrown upon it; the kidneys were larger than normal, while the bone marrow showed islets of cartilage amidst the blood-forming tissue. The mucous membrane of the frontal sinuses was in some, but not all, cases, thickened and catarrhal. Appearances which were very similar were also found in the offspring of meat-fed animals. The next demonstrated the organs of an infant which showed very much the same appearances. The child was the offspring of a tuberculous mother, who for a considerable time before and during the pregnancy had been fed on large quantities of raw meat. The child died in its second year from anæmia, and the changes in the marrow and thyroid gland very closely resembled those formed in the young of meat-fed rats. During life the clinical picture indicated to Dr. Watson that the symptoms, which were otherwise obscure, were the result of exhausted functional activity of certain glands, notably the thyroid and bone marrow. Dr. Watson next referred to clinical facts, showing that the diathesis of a tuberculous child could be favourably influenced by a prolonged course of dietary with excess of animal food. He instanced such a case, when the child was at first typically of the tuberculous constitution, and later became robust and suffered from irregular gouty symptoms. He concluded by pointing out that convergent lines of experimental and clinical evidence showed that the offspring of gouty subjects ought to receive little meat, no red meat under the age of six, while the children of tuberculous parents ought from their earliest years to receive a liberal quantity of red meat in their dietary.

Drs. JAMES and WILLIAM RUSSELL discussed the paper. The latter said that all were agreed as to the advisability of restricting the amount of meat in these irregular gouty manifestations. He doubted, however, whether the administration of thyroid had much to do with it. As to the experimental work, he thought the observations made, whatever their interpretation might be, were of great interest.

Drs. **John Thomson** and **Stuart McDonald** read a paper entitled

NOTE ON TWO FATAL CASES OF ACUTE MENINGOCOCCAL CEREBROSPINAL MENINGITIS IN YOUNG CHILDREN WITH PATHOLOGICAL REPORT ON ONE OF THEM.

Dr. **William Elder** read notes on five cases of

ACUTE CEREBROSPINAL MENINGITIS

recently under his care in Leith Hospital. Both these communications were accompanied by microscopic demonstration of specimens, cultures, and an exhibition of the organs. Full abstracts will be found on pages 172 and 173.

Dr. **J. C. Dunlop** gave the stitistics of fatal cases of cerebro-spinal meningitis in Scotland as shown by the Pegister nouse returns. The disease had appeared in Glasgow in May, 1906, and about a dozen cases had been certified every month since; in December and January the numbers had gone up considerably. Lately, too, a few cases had cropped up in other towns. Moreover, the Airdrie district, Edinburgh, and elsewhere.

Dr. **Cullen** said that in New York during 1905 and 1906 there had been 4,000 cases, and over 3,000 deaths from cerebrospinal meningitis.

Dr. **James Carmichael** said that while he had acted as physician to the Sick Children's Hospital he had on more than one occasion observed a somewhat unusual incidence of cerebrospinal meningitis, never, however, amounting to an epidemic.

Dr. **Edwin Bramwell** said he had seen the Leith cases, and also those in the fever hospital in Glasgow. The general impression derived was that it might often be impossible to distinguish these from posterior basic meningitis, which should be looked upon as a sporadic form of the disease. While some of the cases in the Glasgow epidemic were acute, like those described, the majority ran a more protracted course, and a fair number were recovered from.

Dr. **Fowler** had had five cases under his care in the Children's Hospital during the past month, only one being acute. He drew attention to the fact that the diagnosis was not always apparent in the less acute cases, for, although stiffness of the back was always present sooner or later, it might be very slight during the first few days. As an example, he quoted the case of a child in whom no sign of meningitis was present until about the fourth day, and yet on lumbar puncture pus was present. He had tried intraspinous injections without benefit. Lysol seemed to do no harm, but he had seen unpleasant symptoms follow the use of collargol. In one fatal case there was evidence that the injection had reached the base of the brain, so that it was reasonable to suppose that intraspinous injection with some suitable antiseptic might be useful.

Dr. **Painy** confirmed the observation that spinal rigidity might be absent for a time even in fairly acute cases.

Dr. **Ritchie** discussed the bacteriological aspects of the question. He said that, for exactitude, something more than staining films was required. He did not think one could rely on the differentiate of the pneumococcus from the meningococcus by this means alone. In all probability many of the cases attributed to the pneumococcus were due to the meningococcus. Referring to the reaction of the organism to Gram's stain, he pointed out that a great deal depended on the exact way in which the staining was done. Unless the classical method of Gram-staining was adhered to, confusion would result, and no comparison was possible. He inclined to the view that the change from Gram-negative to Gram-positive as described by Dr. McDonald was due to an impure culture.

Drs. **Thomson**, **McDonald**, and **Elder** replied.

The ninth case of small-pox in Cardiff within the past few weeks was notified yesterday. A case discovered on Thursday may regarded as the most serious, as the patient is the wife of a tramway conductor—a man constantly in touch with the public. Dr. Walford, the medical officer, states that so far the primary and direct source of the infection is not known.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, January 31st, 1907.

The Vice-President, G. G. **Stopford Taylor**, M.D., in the Chair.

A NEW REFRACTOMETER.

Dr. **K. Grossman** exhibited a new refractometer similar in principle to Marple's sciascope, but comprising all the spherical lenses likely to be required in retinoscopy, without combination, arranged in double rows in four hand instruments. The instrument could also be used for ordinary estimation by means of test-types.

SYPHILIS OF THE LUNG.

Dr. **R. J. M. Buchanan**, in describing the various forms of congenital and acquired syphilis of the lungs, paid special attention to the so-called "phthisis syphilitica," and contrasted the morbid anatomy and clinical symptoms of that disease with those of pulmonary tuberculosis. He urged the necessity of more careful clinical examination in cases of lung disease in order that syphilitic affections might not be overlooked. An illustrative case under his care was related, in which the symptoms resembled those of pulmonary phthisis for a year; no tubercle was found in the sputum after repeated examination; discrete areas of infiltration were present in both bases, one in the left lung circular in shape and about the size of a small orange, the one in the right lung oval, and the size of a hen's egg. These masses resembled hydatids, but a diagnosis of gummata of the lungs was made, and subsequently a history of syphilis was obtained. On examination with the X-rays the masses were clearly defined. The expectoration was stained with Giemsa's stain for 18 hours, and spirochætes were found. Anti-syphilitic treatment resulted in amelioration of all symptoms and disappearance of physical signs; a gain of 16 lbs. in weight in three months was recorded, and the patient has been able to resume his work, and expresses himself as perfectly well.

Radiographs taken by Mr. Thurstan Holland before treatment were exhibited, showing the original gummata and diffuse mottling of the lungs, and others showing the gradual absorption of the gummata and disappearance of mottling after treatment with mercury and potassium iodide.

Mr. **A. Nimmo Walker**, referring to Dr. Buchanan's observation of bodies resembling the spirochæta pallida in the sputum of his case, in contradiction of the usual statement that they were absent in tertiary lesions, said that he had had the privilege of being shown, by Staff-Surgeon Bankart, R.N., a section of syphilitic liver stained with silver nitrate, in which the spirochæta pallida was clearly demonstrated. He also alluded to the difficulty of finding the spirochætæ in patients under the influence of mercury, and considered that recent observations pointed to the contagiousness of tertiary lesions and to the value of mercury in their treatment.

Dr. **A. G. Gullan** referred to a case of syphilis (lip chancre) of ten years' standing in a woman 35 years of age. For two years she had suffered from cough, hæmoptysis and loss of flesh. Dr. McDougal had found a gumma of the left sterno-mastoid, and infiltration of the left vocal cord. Under anti-syphilitic treatment the laryngeal symptoms cleared up, but some lung symptoms remaining, the patient was transferred to Dr. Gullan's care, who found impaired movement, dulness, diminished breath sounds, and a few moist râles over the first, second, and third left intercostal spaces in front. Repeated examination of the sputum for tubercle bacilli gave negative results. Syphilitic treatment alone was continued, and the patient, in the course of a few months, made an excellent recovery.

Dr. **Crace-Calvert** also spoke.

THE SURGICAL TREATMENT OF FOCAL EPILEPSY.

Mr. **Damer Harrisson** restricted himself, in dealing with this subject, to cases of true focal or Jacksonian epilepsy calling for direct attack upon the brain or its membranes, including craniectomy, and deeper work upon the parts thus exposed. He attributed the fact that the results of operations in the past had not been more successful to two causes, viz. (1) The relatively late period at which operations had been performed, years having elapsed while the family physician had been experimenting with drugs until the patient was one in whom the epileptic habit had been thoroughly established. (2) The adhesions resulting from operations upon the skull, membranes, and brain. In his own experience, the use of fresh egg membrane, as recommended by Leonard Freeman in 1898, had largely met the adhesion difficulty. In speaking of the technique of the operation, he said that he reflected a large osteoplastic flap in almost all cases, using the chisel in preference to other instruments for work upon the bone.

His paper was illustrated by 24 cases (with 31 operations) of whom six had died. Of the six deaths not one was attributable to the operation, but to the extremly bad condition of the patient at the time of the operation. Of the 18 recoveries, 12 were successful and six were relieved.

Dr. W. **Carter** thought Mr. Harrisson's paper was most valuable. He mentioned the case of a woman, æt. 30 years, who had been epileptic twelve years. The intervals between the attacks became shorter and shorter, till at length she passed into the status epilepticus. After consultation it was decided to operate. On the day preceding the consultation there had been 80 seizures—all medicines having been omitted for a day in order that everyone might see her as she was when uninfluenced by drugs. The only localising indications were slight drooping of the right eyelid, and a reported commencement of the attacks in the left foot. Dr. William Alexander removed a piece of the calvarium four and a half inches long by two and a half inches broad from over the right Rolandic area, and as the dura mater looked healthy, though it bulged to the level of the scalp, it was agreed not to incise the membrane. The result was most satisfactory. The patient became conscious, intelligent, and bright. Some time later she was married, and remained free from attacks for twelve years. The next, and so far as was known, the only attack occurred at her husband's deathbed. Dr. Carter was present, and had her removed to a small ward, where she soon recovered consciousness and returned to her home. Nothing had been heard of her for three years. It was the belief of the entire hospital staff that she could not live many days, and that it was due to the operation that she was able to live an active and useful life for many years.

Dr. Stansfield and Dr. J. H. Abram also spoke.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, Feb. 10th, 1907.

At the Verein für Innere Medizin, Hr. Leo Hirschlaff showed a case of

Influenza Encephalitis.

The patient was a woman, æt. 28, the daughter of a drinker. She was very delicate after the usual infantile diseases, and was unable to run about until her fifth year. Menstruation first appeared at eighteen, and since then her health has been good. Three weeks before the commencement of the present illness she had a slight attack of influenza, but she was not obliged to give up work. On December 1st she suddenly felt sick, with heaviness of the right arm and leg; she also noticed a peculiar failure of sight—she could only see the half of people. She had no headache, but her mental faculties were somewhat astray; she was confused, and her speech was thick. The patient was admitted into hospital, when it was ascertained that her temperature was normal. A diagnosis of hysteria was made. First of all rest in bed was ordered, and then electricity. Improvement gradually set in, and the patient was discharged in about six weeks. Six days afterwards the patient came under the speaker's care. An examination showed that the right pupil was slightly wider than the left; it reacted to light and accommodation; there was hemianopsia, the ophthalmoscope showed slight shading of the papillæ of the right eye, with paleness of the right half, perhaps indicating a neuritis. There was no limitation of the field of vision. The hearing power was slightly diminished on the right side, and there were the remains of an otitis. There was also paresis of the lower facial, pharyngitis, palatal movements good. The sensibility in both arm and leg slightly diminished, but not in the face and trunk. The right arm was slightly thinner than its fellow, and the power diminished; the skin and tendon reflexes on that side were also lowered. The power of the right leg was also diminished. Articulation was imperfect. Primary memory was intact, secondary not so good. General intelligence was good, but reckoning even in its simplest form was impaired. The diagnosis he had formed from the condition present was influenza-encephalitis. In general the prognosis in this form of disease was good.

The Opium-Bromine Treatment of Epilepsy.

Dr. Kellner, the Director of the Hamburg Institute for Idiots and Epileptics, has published his observations on this method of treatment in the *Munch. Med. Wochensch*, 48, 1906. Amongst all the drugs made use of, bromine plays the leading part, he says. In almost every case the frequency and violence of the symptoms can be diminished by the systematic use of the medicine in doses not too small. But the hope of bringing about complete cessation is not fulfilled, and he has never seen an interval of more than a year between attacks in a single case. He then made a trial of the combined opium and bromine treatment, and he has become convinced that in this we possess the most reliable means of treating this illness.

He has employed this form of treatment for the last ten years, and in the following manner. The patient for fifty days gets a dose of ext. opii three times a day beginning with 0.05 grm. Every second day the dose is increased by 0.01 grm., so that at the end of the fifty days the largest dose has reached 0.29 grm. three times a day. The dose given on the fifty-first day is 0.3 grm.; it is given once, and with that the opium treatment ends, and immediately on this the bromide treatment begins. At midday and evening of the same day a dose of 2 grm. of mixed bromides is given, the mixture consisting of pot. brom. 1 part., sod. brom. 1 part, and ammon. brom. ½ part. On the fifty-second and fifty-third days 6 grm. of the mixture are given; on the fifty-fourth and fifty-fifth, 7; on the fifty-sixth and fifty-seventh, 8. From the fifty-eighth day 9 grm. are given, and continued a long time. The medicine is always given in a glass of fresh Seltzer water.

During the opium treatment the patient gets a tablespoonful of a 1 per cent. hydrochloric acid solution three times a day, but it is observable that this is not necessary, as constipation never follows the use of large doses of opium. Bismuth takes the place of the hydrochloric acid if desirable. Naturally the diet must be light and free from spices, with a preponderance of vegetables. The patient must move about a good deal in the open air, and the writer has always insisted that during the period of opium treatment the patient shall be free of all work—school work or any other. A third factor in the treatment is the baths, which are given as follows:—On the first day a bath at 24° C. of ten minutes, on the second day one at 23° C. of nine minutes, on the third day one at 22° of eight minutes, and so at the eighth day a bath at 17C. and of three minutes is reached. It remains at this up to the fifteenth day, then from the sixteenth to the twenty-third a bath at 17° C. is given for four minutes, from the twenty-fourth to the thirty-first one of 17° C. and five minutes, from the thirty-second to the fiftieth a bath at 17° C. for six minutes.

This treatment is not followed out in weak patients or those whose minds have already given way. It has been limited, therefore, to those who have retained some mental power or to epileptics who were otherwise in fair health, and the dose stated is reckoned for a full-grown healthy man and not for a child.

The results are as follows: Excluding five still under treatment, eighty have undergone the course. In sixteen (20 per cent.) of these the treatment had to be interrupted, as the opium could not be borne. In 6 (7.5 per cent.) the treatment failed; a diminution in frequency and severity of attacks was noted in 23 (29 per cent.) A considerable improvement in that the attacks return only at intervals of several months or their place was taken by attacks of giddiness, thirteen cases (10 per cent.). In twenty-two cases (27.5 per cent.) the patients have remained completely free since the treatment, in one case eight months after completion of the course; the others have been free for from two to six years. For success in this treatment it is very important that the patient should lead a very quiet life, free from all excesses both during and after treatment. When epilepsy comes on first later in life the prognosis is bad. Those cases that have remained free from the disease have all been between 15 and 30 years of age.

AUSTRIA.

Vienna, Feb. 10th, 1907.

BODY TEMPERATURE AND URINE.

ENGLANDER gave the members of the Gesellschaft a long paper on the value of taking the temperature of the body from the urine. This idea is rarely expressed in medical literature, although many authors refer to it as a possible means of measuring the temperature. The greatest objection to its utility is the rapid cooling of the secretion after emission, as the temperature of the air and the receptacle quickly alter the temperature. To obviate these difficulties he arranged his method into:—(1) Passing the urine directly into a receptacle without coming into contact with the air; (2) Selecting a suitable material for the receptacle which would not require the warming of the receiver; (3) Measuring the temperature in a current of urine, and not standing. The material Engländer used for a receptacle was strong filter paper. This form of vessel absorbs the urine and soon passes it through the wall of the receptacle, and thus prevents the cooling of the inflowing urine. With a funnel-shaped vessel of filter paper and a maximum thermometer, after 10 to 12 seconds, in which time 100 to 150 cubic centimetres will have passed through, the exact temperature of the body will have been registered. Engländer has now made use of this method of taking the temperature during the last two years, which comprises 250 patients, with the happiest results. He has tabulated the different temperatures for the two years, and finds that the next reliable guide for the temperature is the anus. The widest differences are observed during the summer months. He finds the axillary temperature very fallacious. He has long suspected this deviation, and determined to prove it by other collateral evidence. This method of urine testing was of great service in the outdoor department, where the patient could not be kept in bed sufficiently long to obtain anything like a reliable temperature.

Winternitz considered this method of taking the body temperature was a great advance on our antiquated and very incorrect manner of taking temperature, which was often an important factor in the correct diagnosis of a case; besides, the rapidity by which it can be obtained adds immensely to its value. All accurate observers acknowledge the axilla temperature to be very faulty, but tolerate it on the grounds of custom. He saw one objection to Engländer's method in females, and thought the vagina or rectum would be more practical.

Teleky thought the rectal temperature was sufficiently reliable, and could be taken in a few minutes. To this Engländer asked how he could rely on a temperature in the anus blocked with a large fæcal mass, which was often the case in outdoor patients.

MAZONUS' THEORY OF PERCUSSION.

Hamburger contributed a paper on the different theories of percussing the chest. He concluded in favour of Mazonus', which is a combination of Williams' and Skoda's. The percussion sound was due to the vibration of the costal walls and the air contents of the lung. Weil further contends that the intensity of the percussion sound is not only due to the amplitude of the vibrations, but depends largely on the mass—that is, the lung tissue and the contained air. He values the deeper sounds and not the superficial. The relative dulness of the liver is not entirely due to its peculiar vibration as to its proximity to the costal wall. The consideration of this superficial concussion has not only a theoretical and scientific interest, but a practical side also, such as in children where the costal walls are more yielding and elastic, and thus give a higher vibratory sound in the thorax wall of the child. This result makes it more difficult for the delimitation of the organs in a child than in an adult.

ISOLATED ASTHMA.

Riehl gave the history of four cases of ill-defined asthma which he described as "Macroscopic Asthma Spiralen." The disease commences with unpleasant forebodings, loss of appetite, heaviness, general malaise, and slight fever, followed by cough, spitting, and pain in the chest, with difficulty in breathing. Objective symptoms are disturbances of the nervous system, harsh breathing in the lung, looseness of the mucus in the region of the large bronchi, moist râles with difficulty of expectoration and no rhonchi. A large number of eosinophile cells were present in the sputum, but no Charcot Leyden's crystals. The most effectual treatment was morphia injection and iodide. He considered these variant bronchial asthma cases to depend on some changes in the bronchial ramifications not yet clearly understood.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

NEW PRINCIPAL OF GLASGOW UNIVERSITY.—It has been officially announced that the King has been pleased to appoint Dr. Donald MacAlister, Fellow of St. John's College, Cambridge, to this office. The new Principal is about 53 years of age; he is a native of Perth, and was educated at Aberdeen, Liverpool, Cambridge and Leipsig. In his university career he was especially distinguished in mathematics, having been both Senior Wrangler and Smith's Prizeman. He was for a time mathematical master at Harrow, and in 1879 became lecturer on Natural Philosophy at St. Bartholomew's Hospital. In 1887 he was selected to give the Goulstonian Lectures at the Royal College of Physicians, and is at present Linacre Lecturer of Physic, and Director of Medical Studies at St. John's College, Cambridge. He succeeded Sir William Turner as President of the General Medical Council, and in that capacity has shown great administrative and business ability. It is somewhat remarkable that two successive presidents of the General Medical Council should within so short a period have been appointed to the Principalship of Edinburgh and Glasgow Univeristies.

CEREBROSPINAL FEVER.—Cases of cerebrospinal meningitis continue to crop up throughout Scotland, but, except in Glasgow, there cannot be said to be an epidemic of the disease. Two cases have been reported this week from Haddington, five from Falkirk, three from Kirkcaldy, two from Greenock, five from Paisley, two from Aberdeen, while there have been several fresh cases both in Leith and Edinburgh. In a memorandum on the subject, Dr. A. K. Chalmers, the medical officer of health for Glasgow, suggests that the increased prevalence of the disease may have some relation to the exceptionally low temperatures registered during the week ending December 29th and January 26th.

ROYAL MEDICAL SOCIETY'S ANNUAL DINNER.—Prof. Osler, Oxford, was the guest at this year's annual dinner, which was held in the Society's Hall, on

February 7th. Dr. Drennan presided, and the company included the Lord Advocate, the Solicitor-General, Dr. Cameron Lees, Professors, Schäfer, Croom, Annandale, Chiene, Cuningham, the Presidents of the Royal Colleges of Physicians and Surgeons, and a number of other well-known Edinburgh medical men. In reply to the toast of his health, Professor Osler said he was a pure Celt. There were two types of Celts—one born under Saturn, a most unhappy person; he knew no more unfortunate mortal than the Saturnine Celt—he had no option in this world between Scots whisky and some form of Presbyterianism. That was not the Celt he was. He lifted up his hands occasionally and thanked heaven the Celts who were his forbears were born, not under Saturn, but under Mercury. For that gave a man the most fortunate thing in life—an optimistic temperament. To that he attributed a great part of whatever success he might have had; another element was a love of work. No one naturally liked work, man was born idle; but there was something in the profession of medicine through which, if you once got inoculated with it, you got a love of work, and with that, a love of your fellow-creatures. Prof. Osler next proposed the toast of the Royal Medical Society. In the course of his speech he said that perhaps with the single exception of the Royal Society of England there was no society in the world to-day which had so distinguished a list on its roll. Amongst the names of the eighteenth century he saw William Cullen, William Saunders, a professional son of Cullen, who taught the Londoners how to teach clinical medicine, Whytt, and Currie. It was not the names of these men that touched him closely, for to his astonishment he found that the men he had learnt to reverence in the United States and Canada were members of the Society. Benjamin Franklin was a member of the Society, and took back to Philadelphia the traditions and associations, mental and moral, received in that Society. On the following day Professor Osler addressed the students in the Macewan Hall on cerebrospinal meningitis. After a short lecture on the topic, he spent the remaining ten minutes of the hour in inculcating two maxims which should lead to honour and happiness. The one was the value of steady, not desultory work; the other the absolute necessity for living on good terms with one's professional brethren, and never quarrelling with them on any provocation whatever.

Scotch Poor Law Nurses.—In future the Local Government Board proposes to hold periodical examinations for poor law nurses, and to grant diplomas to those who qualify. According to a memorandum just issued, probationers must have been of good character, and have received a fair general education; the latter will be tested by the Board. The training will extend over three years, during which time the nurses will have to attend lectures by the medical staff. The examination subjects will include anatomy and physiology, hygiene and dietetics, nursing of medical and surgical cases, midwifery, and will be both written, oral and practical. The scheme will ensure that the Poor Law nurses receive as good a course of training, and will be as fully qualified, as those educated at any other institution.

LETTERS TO THE EDITOR.

"PROFESSIONAL MISCONDUCT" IN THE LAW COURTS.

To the Editor of the Medical Press and Circular.

Sir,—A year or so ago a distinguished Judge of the High Court declared that "medical law was in a state of fog." Everybody who knows enough about the matter has been aware of this for a long time, and to such persons the judgment of Mr. Justice Warrington in the case of Clifford *v.* Timms, commented upon in your leader of February 6th, can have caused no surprise. It is useless to find fault with a judge who has brought to bear an acute and practised intellect in interpreting laws with the imperfections of which he has nothing to do; and it is useless to rail at the Medical Council, which cannot go beyond the narrow statutory limitations imposed upon it. If there is to be blame for the present situation, the blame must fall upon the profession itself. Here are some 30,000 men upon whom the State lays onerous obligations before its accords them legal status. The legal status is virtually nominal. Appointments in the services of the State are restricted to legally qualified men; but this restriction is for the protection of the public. Beyond this the profession possesses neither privilege, power, nor protection. It can be conclusively demonstrated that regulation of the profession under laws similar to those provided for other professions such as solicitors—laws which work perfectly smoothly and effectually—would confer vastly greater advantages upon the public than upon the profession. The case for medical law reform is overwhelming; it needs only to be fully and clearly stated in order to be accepted by responsible politicians and statesmen. As I have over and over again urged in your columns, and in those of your medical contemporaries, the only available method of establishing the claims of the profession lies through the medium of a Royal Commission. This would be necessary even if the profession had on its side the newspaper press or a minority of leading papers; it is more than ever necessary now that the whole press, with extremely rare exceptions, is deriving one of the main items of its income from publication of quack advertisements. These papers prefer for gain to abet a nefarious traffic rather than to perform their ostensible duty in safeguarding the interests of the public. The evidence produced by a Royal Commission would, among other things, put an end to the present unholy alliance between the newspaper proprietor and the fraudulent quack. That it would in due course lead to a satisfying reform of medical law, I for one do not doubt. If this desirable consummation is to be achieved, the profession must concentrate its energies, and prepare for the needful sacrifices. Money will be wanted. A considerable expenditure would be needed in establishing the preliminary demand for a Commission, and, the demand acceded to, a much greater sum would be called for in preparing and presenting the case. Altogether a good many thousands of pounds would be necessary—perhaps a sum representing an average contribution of between 10s. and £1 from every active member of the profession. If the profession cannot be roused to help itself in the way I suggest, its case must remain hopeless, and the situation had then better be tolerated in dignified silence without futile discussion and expression of discontent, which cannot be satisfied by any available method save the one which the profession itself declines to adopt.

I am, Sir, yours truly,

Henry Sewill.

February 7th, 1907.

"THE SURVIVAL OF THE UNFIT."

To the Editor of the Medical Press and Circular.

Sir,—Assuming the correctness of the report to the Bedlington Council in a recent issue of your journal, one would like to ask Dr. Trotter more fully to justify and explain the statement you quote:—"When one finds the Legislature passing laws for the benefit and education of feeble-minded, defective children, one is inclined to wonder whether we are not a nation of fools, whether we should not benefit the nation more if we followed the custom of the ancient Spartans, and stamped such types out altogether." Surely, Sir, the proper counsel to be offered by the scientific physician is that the manufacture of the unfit should be put a stop to, not that the wretched products of bad breeding for which the State—the whole nation—is to blame, should be destroyed. Syphilis, tuberculosis, rickets, typhoid fever, alcoholism, ignorance of mothers, criminal cruelty by parents, wholesale neglect of sanitary laws by authorities charged with their administration—all these things and a score more of the same sort rush to one's mind when one considers the question of degeneration. Nearly all the causes of physical and mental unfitness are known; when these are removed the methods of Sparta will no longer need consideration. I am, Sir, yours truly,

Evolutionist.

February 2nd, 1907.

ASSOCIATION OF MEDICAL MEN RECEIVING RESIDENT PATIENTS.

To the Editor of The Medical Press and Circular.

Sir,—May I call your attention to a recent remarkable utterance of Judge Philbrick in the course of a County Court claim brought by the above Association against one of its members. The Judge went out of his way to cast absolutely unfounded and gratuitous aspersions upon a society of medical gentlemen formed for a perfectly legitimate purpose. Each member who obtains a resident patient through the society agrees to pay so much commission, which goes into a common fund. Not a single penny is paid to any officer, and members make no profit out of the transaction. Why, then, should a judge speak thus slightingly of a body of gentlemen of whose aims and organisation he must be profoundly ignorant? I trust a question will be asked upon the matter in Parliament.

I am, Sir, yours truly,

An Old Member of the Association.

[This matter is commented upon in our opening columns.—Ed. "M. P. and C."]

OBITUARY.

EDMUND COCKEY, M.R.C.S., L.S.A.

Mr. Edmund Cockey, the doyen of Frome medical practitioners, died on February 3rd, in the 90th year of his age. The deceased gentleman was in practice in that town for nearly 60 years, and for 55 years and 7 months held the post of medical officer at the workhouse, being appointed in October, 1843, and resigning in May, 1899. He was a member of one of the oldest and most highly respected of Frome families. The bells in many of the churches in Somerset testify to the skill of former generations of Cockeys. Mr. Edmund Cockey was medically educated at St. Bartholomew's, and took the qualification of M.R.C.S and L.S.A. as long ago as 1842.

JOHN GUEST GORNALL, M.A., M.B., B.C.Cantab., D.P.H.

We regret to announce that Dr. J. Guest Gornall, medical officer of health for Warrington, died at Grappenhall on February 4th. Dr. Gornall had been in failing health for a considerable time, and two months ago the Town Council granted him a long leave of absence in order that he might recuperate. Dr. Gornall only returned from Llandudno last week, and for the past few days had suffered from asthma. He was appointed medical officer, to succeed his father, in 1901. As medical superintendent of the smallpox hospital, he successfully coped with an epidemic which occurred in the town between 1892-4. Dr. Gornall was educated at Cambridge and St. Thomas's Hospital, and graduated M.A., M.B., and B.C. at the former University in 1892. He took the D.P.H. in 1896.

SPECIAL ARTICLE

UNIVERSITY EDUCATION IN IRELAND.

During the past week several important meetings have been held in connection with Mr. Bryce's scheme for the revolution of University education in Ireland. On Monday, January 31st, a largely attended meeting of the Senate of Dublin University was held, the Vice-Chancellor in the Chair, the following resolutions were unanimously adopted:—

"That we are of opinion that the scheme which Mr. Bryce outlined in his speech of January 25th, 1907, would be fatal to the best interests of liberal university education in Ireland, as well as unjust to Trinity College, and we are determined to oppose it by every means in our power."

"That the Senate appeals to all graduates of Dublin and other universities, and to all those, without distinction of party, who value freedom in research, teaching, and publication, to assist in maintaining unimpaired the constitution and position of Trinity College, Dublin, which, in the unanimous opinion of the Commissioners, 'as it stands to-day is a noble institution for the maintenance of sound learning, not unworthy of its great traditions and of the affection and veneration with which it is regarded by its children.'"

"That we protest against Mr. Bryce's scheme, because it provides, and can provide, no adequate safeguards against the introduction of sectarian divisions into the administration of the university."

On Wednesday the Council of the University met, and it was unanimously resolved—"That we are of opinion that the scheme which Mr. Bryce outlined in his speech of January 25th, 1907, would be fatal to the best interests of liberal University education in Ireland, as well as unjust to Trinity College, and we are determined to oppose it by every means in our power."

A public meeting convened by the Galway County Council was held on Friday in Galway, the Archbishop of Tuam in the chair, to consider the position of the Queen's College, Galway, as outlined in Mr. Bryce's speech. The following resolutions were passed:—

"That this public meeting, representing all sections and varied interests in the town and County of Galway, and the Province of Connaught, unites in a protest against the proposed exclusion of Galway as a Constituent College in the New University scheme outlined by Mr. Bryce."

"That it is the opinion of this meeting that if Queen's College, Galway, were given an equal position with the other Queen's Colleges, and were to have its constitution so modified as to bring it into greater harmony with its surroundings, and to make it acceptable to all the people of Connaught, there can be no question that it would quickly become an efficient University College, and would prove the prosperous centre of intellectual life and educational activity for the Province of Connaught."

At a meeting of the Governing Body of the Catholic University School of Medicine held on Friday, the Governors had before them the following resolution, unanimously adopted by the Medical Faculty at their meeting on the 2nd inst.:—"That a settlement of the University question on the lines laid down by Mr. Bryce would be acceptable to this Faculty provided that the details of the Bill are satisfactory to the Catholic hierarchy and laity, and that a real equality as to equipment and autonomy, as compared with Trinity College, Dublin, is given to the new college." The Governing Body unanimously approved of the resolution and directed that it should be published.

The Committee of Irish Catholic Laymen have adopted the following resolution:—"That, while desirous of expressing our gratification at the intention of the Government, as announced by Mr. Bryce, to provide for Irish Catholics collegiate education within the University of Dublin, we consider it premature, without fuller details, to put forward any opinions as to other parts of the scheme."

Lastly, the Corporation of Dublin has passed the following resolution, on the motion of Dr. McWalter:—"That as the Town Council of Edinburgh has been for centuries represented on the University of Edinburgh and with great advantage to that institution, the Corporation of Dublin requests that it shall have adequate representation on the governing body of any reconstituted university in Dublin. And, furthermore, this Council cannot accept as final any settlement of the university question that does not provide higher education for the sons of the workers of the country."

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT GYNÆCOLOGICAL LITERATURE.

Pathology of Chronic Metritis.—Fletcher Shaw (*Journ. Obst. and Gyn.*, Feb., 1907). In this paper the author gives the results of the microscopical examination of 38 uteri extirpated for chronic metritis alone, 7 extirpated for chronic metritis with some concurrent disease, and for comparison 23 normal uteri and 50 curettings. The conclusions arrived at are as follows:—Chronic metritis is a simple hypertrophy of the mesometrium, and is not a connective tissue hyperplasia. The percentage of connective tissue varies considerably in the different specimens of chronic metritis, but many normal multiparous uteri possess an equal or even greater proportion of connective tissue. The vessel changes are variable, similar affections being found in normal uteri. There is no evidence of active inflammation as shown by small-celled infiltration or cicatricial tissue. Chronic metritis is a slowly progressing affection of the uterus, first causing enlargement, and later hardness of the organ. It is never a primary affection, being usually secondary to chronic endometritis, but may be associated with any pelvic or uterine disease which leads to increased uterine contraction or vascularity—*i.e.*, fibroids, tubo-ovarium inflammation, carcinoma, prolapsus. The age of the patients is on the average about 38, well below the average age at which the menopause occurs, thus proving that the climacterium is not the usual factor in the complaint. The symptoms are mainly those of the primary disease, and in the early stage chronic metritis is indistinguishable from chronic endometritis. At a later period the great increase in the size of the uterus may produce pain in the hypogastric and iliac regions, due to traction on the broad ligaments and sacralgia. The diagnosis depends largely on the results of treatment. In the early stage of the affection all the symptoms disappear after dilatation and curetting the uterus, thus demonstrating that the endometritis is the primary cause. In chronic metritis and endometritis, local treatment of the endometrium may fail to relieve the symptoms, this being probably due to re-inauguration of the endometritis. Treatment consists of living a simple hygienic life, regularity of bowels, douching and curetting. These methods fail in some cases, and then hysterectomy is called for.

F.

The Radical Abdominal Operation in Carcinoma of the Cervix Uteri.—Wertheim (*Surgery, Gyn., and Obst.*, January, 1907).—After describing in detail the technique of his operation for carcinoma of the cervix, the author gives his histological findings. In 28 per cent. of the cases operated on the regional lymphatic glands were affected with cancer. The cancerous glands were always enlarged, and generally very considerably so; only in a few cases was the enlargement inconsiderable. In the elongated spindle-like glands, which, so to speak, only represent a thickening of the lymphatic ducts, carcinoma was never found. In a further 30 per cent. of the cases the glands were more or less considerably enlarged, but no carcinoma was found in them—only hyperplasia and infiltration. Places of predilection for the appearance of cancerous glands were the regions between the external and internal iliac artery, and the obturator foramen. In the great majority of cases, where diseased glands are found, they are cases of advanced cancer; in only a few of the cases were they present in the early stage. The histological examination of the parametrium showed that in 22 per cent. of the cases this tissue, though when investigated it was found to be soft and distensible, proved to be cancerous. On the other hand, in about 14 per cent. of all cases, though there was considerable infiltration, no carcinoma could be found. In answer to the question: In what stage of the disease are the lymphatic glands affected by cancer? it appears from our investigation that in 10 per cent., notwithstanding the absence of cancer in the parametrium, the glands were cancerous; and, *vice versâ*, in 27.5 per cent., though cancer existed in the parametrium, the glands were free from it. In 40 per cent. the parametrium and lymphatic glands were free from cancer, and in 20 per cent. both were affected. The author finally states that, in spite of many opinions to the contrary, he persists in retaining his view that carcinoma is never contained in lymphatic glands unchanged in size, shape, or consistence.

F.

A Cæsarean Section for Prolapse of the Cord is recorded by Pekarskaja (*Zentralbl. für Gyn.*, 1907, Nr. 4). His patient, a primipara, æt. 24, told him when he first saw her that the membranes had ruptured four days previously, and that she had had pains for two days. The pelvis measured 28.5, 26.5, 25, 17; conj. diag., 9.2-9.5; conj. vera, 7.25-7.5 cm. A generally contracted rachitic pelvis. The presentation was first vertex, head movable above the brim, cervix admitted one finger, and the prolapsed pulsating cord was felt. The membranes were ruptured; the fœtal heart good. As the cord could not be replaced, and the parents were very anxious that the child should live, a Cæsarean section with Fritsch's transverse fundal incision was performed, and a living boy, 50 cm. long, and 2,920 g. in weight, was extracted. During the first nine days of the puerperium the patient's highest temperature was 38.3 deg.; pulse, 94. On the 25th day the woman left the hospital in excellent health, her child weighing 3,960 g. During her second pregnancy premature labour was induced in the 33rd week. The child, which was 1,900 g. in weight, and 44 cm. long, only lived 4½ hours.

G.

Episiotomy.—Prokofjewa (*Zentralbl. für Gyn.*, 1907, Nr. 4) incised the perineum in the raphe during delivery in 23 cases. One was a multipara, the others primiparæ varying in age from 20 to 40. The incision was made with an ordinary scalpel when the head was passing over the perineum. The length of the incision varied between 2 and 5 cm., according to the requirements of the cases. The author never found the incision extending into a tear. Immediately after the child was born the incision was united with silk sutures and healed in every case by first intention. The author concludes that when there is not sufficient elasticity of the perineum, and the size of the child's head is large, episiotomy performed at the right moment prevents extensive ruptures of the muscles of the pelvic floor.

G.

The Treatment of Uterine Myomata.—A. Martin (*Zentralbl. für Gyn.*, 1907, Nr. 4) records the operative treatment adopted by him during 6½ years. Among his hospital patients suffering from myomata, operation was performed in 84 per cent. of the cases, 69 undergoing the radical operation, 88 the conservative. Among his private patients 76 per cent. were operated on, 65 radically, 59 conservatively. There were therefore 134 women on whom the radical operation was performed. Of these ten died (7.4 per cent. mortality). Among the 147 on whom the operation was conservative, 8 died (5.4 per cent. mortality); of the 124 who survived the radical operation, 94 have been since under observation; 9 have reported on themselves by letter. Of the 139 who survived the conservative operation, 102 have since been under observation; 15 have reported themselves by letter. Those who had the conservative treatment feel better than those who had the radical. As regards recurrence, the author reports 12 cases from his Berlin material, but not a single case among his material in Greifswald. In Berlin the author performed 270 enucleations with 4.4 per cent. recurrence. As a result of his observations the author concludes that conservative myomectomy has justified itself. In cases of uncomplicated myomatous disease, he operates by the conservative method up to the climacteric, so long as enough uterine tissue capable of performing its functions can be preserved for the patient. He lays stress upon the necessity of careful examination of the endometrium at the same time. The vaginal route has given him by far the best results. G.

A Contribution to the Pathology of the Lutein Tissue is made by Ulesko-Stroganowa (*Zentralbl. für Gyn.*, 1907, Nr. 4). In a case of total extirpation of a fibroid uterus a cystic ovary was also removed. When this was opened teeth and hair were found in it, and in the ovary near the cyst a piece of tissue was discovered which, according to position, was like a corpus luteum, but from external appearances looked like fat tissue. In another case, in which the patient was four months pregnant, a dermoid was removed per vaginam, and here also a piece of tissue similar to that which has just been described was discovered. Both were examined microscopically by the author. A great increase in the lutein cells, together with fatty degeneration and infiltration of them, was discovered. Considering the histo-genesis and the peculiarities of lutein tissue, it must be regarded as a particular species of epithelial tissue. It develops itself in the ovary in association with the different changes in the sexual organs which are accompanied by long-continued hyperæmia, whether it be pregnancy, myomata or any other disease. These conditions were present in the cases described by the author. In addition to this, it is also the author's opinion that the characteristic fatty contents of a dermoid has much significance in the degeneration of lutein tissue. The accumulation of fat must be looked upon rather as a fat infiltration, and not as a degeneration. G.

Retention of the Membranes.—Rissmann (*Monatsch. für Geb. und Gyn.*, Bd. 24, Hft. 5) advises active treatment for this occurrence. The danger of sepsis alone should prevent one leaving the expulsion of the membranes to the natural forces, which may not work, or at any rate very often work too late. Besides this, owing to the retention, the involution of the uterus is slower and not so complete, and now and again considerable hæmorrhage may occur. As treatment the author advises that the uterus should be made to contract as much as possible, and that it should be then compressed by a heavy sandbag or an icebag laid on the abdomen. After six to twenty-four hours, an attempt should be made to express its contents. If, in spite of this, membranes are still retained, they must be removed instrumentally. Retention will the more seldom occur the more expectant the treatment of the placental stage is. G.

Forty Cases of Eclampsia are described by Pomy (*Zentralbl. für Gyn.*, 1907, Nr. 2). They occurred from January 1st, 1888, to December 31st, 1905, among 3,282 deliveries in the Göttinger Frauenklinik—*i.e.*, 1.2 per cent.; 32 of the mothers, or 80 per cent., were primiparæ; 8, or 20 per cent., multiparæ. Among the latter 3 were ii.-paræ, 3 iii.-paræ, 1 iv.-para, 1 xiii.-para. As regards age, from 15-20 years there were 13 i.-paræ; from 21-25 there were 10 i.-paræ; from 26-30, 1 multipara and 6 i.-paræ; from 30-35, 2 i.-paræ, 2 multiparæ; from 36-40, 2 multiparæ; from 41-45 1 i.-para, 2 multiparæ; from 46-50, 1 multipara. In the years 1890-1892, 1894, 1896, and 1899 no case of eclampsia was observed, while in 1901 nine cases; 1904, seven cases; 1905, seven cases occurred. During the months from October to February fewest cases occurred. The number of convulsions varied between 1 and 40. In the majority of cases not more than 5 convulsions were observed. The cases occurred as follows:—Inter-graviditatem, 10; inter-graviditatem et intra-partum, 3; inter-graviditatem et post-partum, 3; intra-partum, 12; intra et post-partum, 5; post-partum, 7. Premature labour occurred 10 times; 5 times there was general contraction of the pelvis. In one case albumen could not be discovered; otherwise it varied between ½ per cent. and 4 per cent. In one case the patient had already suffered from eclampsia 10 years previously. The maternal mortality was 20 per cent.; 7 primiparæ, 1 multipara. Death occurred ante-partum, 1; intra-partum, 1; post-partum, 6. The fœtal mortality was 50 per cent.; of those dead nearly half were premature; 6 died ante-partum, 11 intra-partum, 4 post-partum. As regards treatment, at the beginning chloroform and diaphoresis were most adopted, venesection seldomer. As time went on, operative treatment came gradually more and more into use, and the greatest stress was laid on the fact that the delivery should be completed as quickly as possible. Forceps or version and extraction were performed where they were possible. When the cervix admitted a finger, the rubber bag was used for dilatation. To dilate the cervix enough to admit the bag, iodoform gauze or Hegar's dilators were employed. In several cases in which the maternal soft parts were completely unaltered, the classical or the vaginal Cæsarean section was performed. Bossi's dilator was never employed. G.

Atresia Vaginæ in a Married Woman.—(Henderson, Aberdeen, *Brit. Med. Journ.*, Jan. 19th, 1907). Under this heading is recorded the history of a woman, æt. 30, a v.-para, whose last confinement took place on March 23rd, 1905. She stated that all the children had been born at full, and never had had instruments used, but that the last labour had differed from those preceding by being prolonged, the child being "big." She was out in a week's time, but was longer in picking up than usual. The infant was suckled for ten months, and was weaned in the beginning of February; but, contrary to the usual course of events, the patient noticed there was no return of the menstrual flow before weaning. When seen a month later, she complained of bearing-down pain accompanied by dyspareunia. On inspection of the abdomen, a pear-shaped tumour, with its long axis vertical, was noted in the middle line. It extended to 1 in. above the umbilicus. It did not move with respiration, and was tender on deep palpation, and the percussion note was dull. On vaginal examination it was found that the finger could not be inserted for more than 1 to 1½ in., but per rectum a large fluctuating tumour could be felt bulging through the anterior wall. On March 21st, 1906, she was sent in the Aberdeen Royal Infirmary, and, after examination under chloroform, which showed that the vagina was occluded by cicatricial tissue, it was concluded that the lower end of the tumour consisted of retained menses; the pear-shaped tumour the uterus, and that the atresia was due to lacerations produced during the last labour. The following day a large quantity of reddish-brown fluid escaped per vaginam, and the flow continued for several days, unaccompanied by a rise of temperature, the tumour growing gradually smaller. Three weeks later normal menstruation set in, the uterine tumour having disappeared. About seven weeks after admission, the operation was undertaken to restore the vagina. A pin-hole opening at the apex of the cicatrix was seen, and on free incision of the latter a quantity of grumous matter escaped. A large-sized drainage tube was sewn in, and removed after ten days. Recovery was uneventful.

The Pembrokeshire Education Authority have awarded a Midwifery Exhibition of £20 to Lucy A. Morris, St. Dogmells.

MEDICAL NEWS IN BRIEF.

The Royal Academy of Medicine in Ireland.

AT a meeting of the Section of State Medicine held on Friday last, the following resolution was adopted :—"That the Section of State Medicine of the Royal Academy of Medicine in Ireland desires to express approval of the suggestion contained in the report of the Viceregal Poor-law Commission to convert the entire Poor-law Medical Service in Ireland into a national service, to be paid by the State, to be entered by a competitive examination, the members of such service to be jointly controlled by the central body and the local bodies, and that the medical profession should have one representative on the central body."

The Ethics of Locum Tenens.

The following resolution was passed at a recent meeting of the Council of the Irish Medical Association :—"The Council of the Irish Medical Association desire to give expression to their very strong views on the inexpediency of members of the above accepting the appointment of locum tenens unless requested to do so by the officer going on leave. The Council are also of opinion that all members of the profession ought to be guided in their conduct, under similar circumstances, by the same rule in ethics."

Man Who Looked for Himself.—Amazing Search with a Lighted Candle.

Councillor Tom Coward related an extraordinary experience at a banquet held at Llangollen recently. He said that he returned home one evening after a particularly busy day, and after his wife retired to rest he remained in the sitting-room reading for some considerable time. He went upstairs with a lighted candle and asked, "Where is Tom?" He declares he heard no answer, and remarked, "It is time he returned." He then retraced his steps downwards, but could not find himself! He finally went to bed, and next morning his wife questioned him as to his strange conduct, and said he stood scratching his head in confusion in the bedroom. He could not account for his behaviour and consulted a medical man, who solved the puzzle by saying that one-half of his brain was dormant while the other half was active. Such a case was not unknown in the medical world.

Suicide of a London Practitioner.

An inquest was held at Swindon on Saturday last on the body of Dr. Robert Perriman Fouracre, aged 72, who left his residence at Tollington Park. London, on Wednesday, and was found dead in bed at a Swindon temperance hotel on the following morning. The evidence showed that he had died as a result of poisoning, a bottle which had contained prussic acid being found in his room, as well as a note saying that no one cared for him, that he was tired of life, and the parish might end it. Dr. Fouracre's son said his father had been depressed, owing to the recent death of his sister. He was in practice up to the time of his death, and was known to have resorted to chloral for insomnia. A verdict of suicide whilst temporarily insane was returned.

PASS LIST.

Royal College of Surgeons, England.

AT a meeting of the Council of the College held on Thursday last, Mr. Henry Morris, President, in the chair, the following successful candidates were admitted Members of the College :—

R. C. Allen, G. F. E. Allison, A. K. Armstrong, C. J. Armstrong-Dash, F. J. Ayre, F. J. Ball, M.D., J. C. Balsara, E. C. P. Barnes, E. C. Barnett, H. B. Billups, M.A., W. R. Bristow, G. T. Burke, Frank Butler, Sydney Carter, C. P. Charles, T. C. A. Cleverton, A. FitzWm. Comyn, B.A., A. B. Coomber, H. B. Corry, B.A., K. K. Dadachanji, K. M. Digby, A. E. Evans, A. C. D. Firth, M.A., H. E. Flint, P. J. Franklin, H. G. Gibson, R. G. Gillies, J. H. Gurley, F. N. S. Hitchcock, H. G. Hobson, W. H. Hodgson, B.A., C. R. Hoskyn, A. J. H. Iles, J. P. Johnson, C. E. M. Jones, B.A., J. E. Jones, T. A. Killby, R. de V. King, H. A. Lash, C. J. Loosely, T. F. Lumb, F. E. McKenty, M.D., L. H. I. Mackenzie, W. C. McMurtry, M.D., D. C. Master, B.A., D. A. H. Moses, W. P. H. Munden, R. D. O'Connor, O. P. N. Pearn, F. E. L. Phillips, J. E. Prentis, H. M. Prins, C. P. Raikes, B.A., G. L. Ranking, B.A., R. J. Reynolds, J. S. Rowlands, M.B., H. C. Samuel, G. N. B. Segastian, Sidney Slade, J. T. Smalley, Charles Speers, F. E. Sprawson, W. R. Square, T. G. Starkey-Smith, R. W. Stephenson, R. W. Stocks, W. H. R. Sutton, B.A., H. H. Taylor, B.A., C. H. B. Thompson, C. B. Ticehurst, B.A., W. F. Todd, St. J. A. M. Tolhurst, B.S., G. S. Totseau, F. T. Turner, F. F. A. Ulrich, M.B., J. A. Venning, B.A., Behdjet Wahby, Harry Wales, T. N. Watt, S. H. West, M.B., H. O. Williams, W. H. Williams, B.A., John Winder.

Diplomas in Public Health were granted, jointly with the Royal College of Physicians, to the following candidates :—Dr. A. G. Banks, Dr. H. G. Bennetts, Mr. W. D. Betenson, Dr. B. Blacklock, Dr. R. B. Ferguson, Capt. J. H. Hugo, D.S.O., I.M.S., Capt. S. P. James, I.M.S., M.D., Major A. E. C. Keble, R.A.M.C., Capt. P. J. Probyn, D.S.O., R.A.M.C., Major O. L. Robinson, R.A.M.C., Dr. A. G. P. Thompson, Capt. A. L. A. Webb, R.A.M.C.

Examiners Appointed.—Mr. Frederic Eve, Surgeon to the London Hospital, was re-elected and Mr. J. Ernest Lane, Surgeon to St. Mary's Hospital, was elected a member of the Court of Examiners.

Diplomas for Women.—A Petition was read from the London School of Medicine for Women in reference to a proposal now before the Council that women should be admitted to the examinations of the College. It was determined to inform the petitioners that the matter is receiving the consideration of the Council.

Army Medical Service.

The following is an official list of the successful candidates at the recent Competitive Examination for the Royal Army Medical Corps, arranged in the order of merit. Seventy-six entered :—

W. K. Beaman, M.R.C.S., L.R.C.P.; C. Cassidy, B.A.Cantab., M.R.C.S.; A. D. Fraser, M.B., B.Ch., Univ.Aberd.; M. P. Leahy, B.A., M.B., B.Ch., Univ.Dub.; F. T. Turner, M.R.C.S., L.R.C.P.; A. I. Fortescue, M.B., B.Ch., Univ.Aberd.; H. G. Gibson, M.R.C.S., L.R.C.P.; J. L. Wood, B.A.Cantab., M.R.C.S.; S. Field, M.R.C.S., L.R.C.P.; R. D. O'Connor, M.R.C.S., L.R.C.P.; D. F. Mackenzie, M.B., B.Ch., Univ.Edin.; J. E. M. Boyd, M.R.C.S., L.R.C.P.; G. Carlisle, M.R.C.S., L.R.C.P.; E. M. Middleton, M.R.C.S., L.R.C.P.; O. R. McEwen, M.R.C.S., L.R.C.P.; J. H. Gurley, M.R.C.S., L.R.C.P.; F. H. M. Chapman, M.R.C.S., L.R.C.P.; A. C. Elliott, B.A., M.B., B.Ch., Univ.Dub.; J. du P. Langrishe, M.B., B.Ch., Univ.Dub.; W. G. Aviss, M.R.C.S., L.R.C.P.; W. B. Purdon, M.B., B.Ch., R.U.I.; H. M. J. Perry, L.R.C.P. and S., I.; J. C. Hart, M.B., B.Ch., R.U.I.; M. O. Wilson, M.B., B.Ch., R.U.I.; T. H. Scott, M.B., B.Ch., Ed.; L. A. A. Andrews, L.R.C.P. and S., I.; G. F. Rudkin, M.R.C.S., L.R.C.P.; V. T. Carruthers, M.B., B.Ch., Ed.; H. W. Farebrother, M.R.C.S., L.R.C.P.; F. Casement, B.A., M.B., B.Ch., Univ.Dub.

Of the foregoing successful candidates, 4 were students of Dublin University; 2 each of Edinburgh and Aberdeen Universities; 2 each of Charing Cross, St. George's, Guy's, St. Bartholomew's, St. Mary's, St. Thomas's, and the London Hospital Medical Schools; 2 each of Queen's College, Cork, and Queen's College, Belfast, and 1 each of Birmingham University and King's College, London.

THE Army Council have decided that administrative medical officers shall in future have administrative medical charge and authority as regards their areas as is now vested in principal medical officers. Administrative medical officers and senior medical officers of the larger stations will, before submission to higher authority, bring such questions to the notice of local commanders, in order that the latter may have an opportunity of expressing their opinions thereon.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs.15.12.

WANTED—A THREEPENNY PIECE.

He was an impecunious, seedy, out-at-the-elbows person, and the doctor, when he prescribed for him, knew better than to expect a fee. "For the inflamed eyes," said the benevolent physician, "dissolve as much boracic acid as you can put on a threepenny piece in half a glass of water." "Thank you, doctor," murmured the patient, turning away. A moment later, however, the door was opened and the patient glided in. "I say, doctor," said he, with an ingratiating smile, "where do I get the threepenny piece?"—*Exchange.*

Dr. H. L. S.-(1). Yes. (2). Yes. (3). We will enquire further, but our impression is that you could not obtain one without great trouble. A surgical instrument-maker might be able to give you information. However, we will enquire.

BRIGHT'S DISEASE.

The discoverer of Bright's disease was Dr. Richard Bright, of Bristol. He was born in 1789, being the third son of Richard Bright, the banker, who died at Ham Green in 1840. His eldest brother, Henry, was member for Bristol from 1820 to 1830. The next brother, Benjamin, became a banker, and his younger brother, Robert, Sheriff in 1852, married Miss Caroline Tyndall, daughter of Thomas Tyndall, of The Fort, Bristol.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 13th.

Hunterian Society (London Institution. Finsbury Circus, E.C.). 8.30 p.m.: Paper:—Dr. Langdon Brown: Acetonuria, its Clinical Significance and Treatment.

Dermatological Society of London (11 Chandos Street, Cavendish Square, W.).:—5.15 p.m.: Meeting.

University College (London) Medical Society (Medical Library, University College, Gower Street, W.C.).—8.30 p.m.: Paper —Dr. H. Head: The Grouping of Sensory Impulses. :

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. H. L. Barnard: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. G. H, Savage: Unsoundness of Mind not always Insanity.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Dermatological (Dr. Meachen), Ophthalmological (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Central London Throat and Ear Hospital (Gray's Inn Road, W.C.).—5 p.m.: Demonstration:—Dr. J. Atkinson: External Ear.

THURSDAY, FEBRUARY 14th.

Harveian Society of London (Stafford Rooms. Titchborne Street, Edgware Road, W.).—8.30 p.m.: Papers:—Mr. R. Johnson: A Case of Fatal Extravasation of Urine from the Ureter from Ulceration of a Minute Calculus. Dr. T. B. Hyslop: Psychorhythm and Recurrent Psychoses.

Ophthalmological Society of the United Kingdom (11 Chandos Street, Cavendish Square, W.).—8 p.m.: Clinical Meeting. Mr. L. Cooper: Paralysis of the Vertical Movements of the Eyeball. Mr. A. S. Morton: Case of Sclerosis of the Eyeball. Mr. M. L. Hepburn: A Case of Polychoria associated with Chronic Glaucoma. Mr. W. Tay: A Case of Tuberculosis Diagnosed from the Ophthalmoscopic Appearance of the Fundus.

British Gynæcological Society (20 Hanover Square, W.).—8 p.m,: Introductory Address:—The President (Mr. W. D. Spanton). Paper:—Dr. J. Oliver: A Study of Suppuration of the Ovary, with illustrative cases.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Mr. M. Morris: The Treatment of Some Common Skin Affections.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles), Cliniques: Medical (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Clinique:—Medical In-patient (Dr. Chappel). 4.30 p.m.: Lecture:—Dr. Whiting: Acroparæsthesia (with cases).

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: The Relation between Cicatrix, Keloid, Scleroderma, and the Treatment of each.

FRIDAY, FEBRUARY 15th.

Society for the Study of Disease in Children (11 Chandos Street, Cavendish Square, W.).—5 p.m.: Clinical Evening for the Exhibition of Cases followed by Discussion. Patients in attendance from 4.30 p.m.

Epidemiological Society (11 Chandos Street, Cavendish Square, W.).—8.30 p.m.: Paper:—Colonel D. Bruce, C.B.: Recent Researches into the Epidemiology of Malta Fever.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. A. Lawson: Clinique. (Eye).

North-East London Post-Graduate College (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Ophthalmological (Mr. Brooks). 3 p.m.: Clinique:—Medical In-patient (Dr. Leslie).

TUESDAY, FEBRUARY 19th.

Therapeutical Society (Apothecaries' Hall, Blackfriars, E.C.). —4.30 p.m.: Ladies' Day and Conversazione. There will be various exhibits and Dr. Crichton will read a Paper upon "The Metric System in Prescribing and Dispensing."

Vacancies.

Leyton Urban District Council.—Medical Officer of Health. Salary £475 per annum. Applications to R. Vincent, Clerk to the Council, Town Hall, Leyton.

Kidderminster Friendly Societies Medical Aid Association.—Qualified Assistant. Salary £150 per annum. Applications to Dr. Martin, 4 Lion Street.

Middlesex Hospital, W.—Resident Medical Officer. Salary £200 per annum, with residence and board in the Hospital. Applications to F. Clare Melhado, Secretary Superintendent.

Guy's Hospital.—Surgeon to the Actinotherapeutic Department. Salary £100 per annum. Applications to the Treasurer, Superintendent's Office, Guy's Hospital, S.E.

Guy's Hospital.—Medical Radiographer. Salary £100 per annum. Applications to the Treasurer, Superintendent's Office, Guy's Hospital, S.E.

Guy's Hospital.—Second Surgical Radiographer. Salary £100 per annum. Applications to the Treasurer, Superintendent's Office, Guy's Hospital, S.E.

King Edward VII. Sanatorium, Midhurst, Sussex.—Junior Assistant Medical Officer. Salary £100 per annum, with board, lodging, and attendance. Applications to the Hon. Secretary, 19 Devonshire Street, Portland Place, London, W.

Glasgow District Asylum, Gartloch, Gartcosh.—Resident Assistant Medical Officer. Salary £125 per annum, with board and lodging. Applications to the Medical Superintendent.

Brecon and Radnor Joint Counties Asylum, Talgarth, R.S.O., Breconshire.—Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

Shillelagh Union.—Medical Officer. Salary £130 per annum and £15 a year as Medical Officer of Health. Applications to J. Hopkins, Clerk of the Union. (See advt.)

Incorporated Dental Hospital of Ireland.—House Surgeon, Assistant House Surgeon, and Extra Assistant Dentists. Applications to W. A. Shea, Registrar. (See advt.)

Appointments.

Higgs, Frederick, W., M.B.Lond., M.R.C.P.Lond., Assistant Physician to the Belgrave Hospital for Children.

Johnstone, Thomas, M.D.Edin., M.R.C.P., Honorary Consulting Physician to the Coronation Hospital, Ilkley.

Lockyer, Cuthbert, M.D., B.S.Lond., F.R.C.S.Eng., M.R.C.P.Lond., Obstetric Physician to Out-patients at the Great Northern Central Hospital and Physician to Out-patients at the British Lying-in Hospital.

Martin, H. C., M.B., B.S.Edin., Assistant Medical Officer at the Newport Borough Asylum, Caerleon, Mon.

McIlroy, A. Louise, M.D.Glasg., Gynæcologist to the Victoria Infirmary, Glasgow.

Births.

Campbell.—On Feb. 5th, at Ruigh-Ard, Inverness, the wife of Robert B. Campbell, M.B., Medical Superintendent, Inverness District Asylum, of a son.

Haughton.—On Feb. 3rd, at Tannachie, Falmouth, wife of J. Welby Haughton, L.R.C.P.I., of a son.

Trotter,—On Feb. 9th, at Holmfirth, Yorkshire, the wife of Robert H. Trotter, M.D., of a daughter.

White.—On Feb. 7th, at Star Hill, Rochester, Kent, the wife of Clement White, M.D., of a daughter.

Woolley.—On Feb. 9th, at 25 Claremont Road, Surbiton, the wife of Edward John Woolley, M.D., of a daughter.

Young.—On Feb. 2nd, at Woolacombe, North Devon, the wife of Thomas Young, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

Goulden—Huyshe.—On Jan. 31st, at the Parish Church, Clyst Hydon, Devon, Herbert Edward Goulden, M.R.C.S., L.R.C.P., D.P.H.Cantab., of Clyst Hydon, only son of Mr. and Mrs. E. B. Goulden, of Emscote, Canterbury, to Ethel Julia, eldest daughter of the late Canon F. J. Huyshe, Vicar of Wimborne, Minster.

Ramsey—Pace.—On Feb. 9th, at St. Margaret's, Westminster, Andrew Maitland Ramsey, M.D., Glasgow, to Elizabeth Margaret Pace, M.D., daughter of the late Thomas Richard Pace.

Woods—Dickinson.—On Feb. 7th, at St. Saviour's Cathedral, Pietermaritzburg, Natal, William James Woods, F.R.C.S., to Mabel Eleanor Kathleen, fourth daughter of C. H. Dickinson, J.P., Ilfracombe.

Death.

Gay.—On Feb. 8th, at 137 Upper Richmond Road, Putney, Elizabeth Gay, widow of the late John Gay, F.R.C.S., aged 82.

HARLEY STREET.—One of the largest Houses in this street to be Sold. Full-sized billiard room on ground floor. Stabling for five horses.—Full particulars of A. B. C., Medical Press and Circular (London Office), 8 Henrietta Street, Covent Garden.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, FEBRUARY 20, 1907. No. 8

NOTES AND COMMENTS.

Naval Nurses.

IT is well known that the Admiralty have the question of nursing in the Navy under consideration at the present time, and it is rumoured that the sick-berth attendants are to be turned into a corps whose members are to be as highly trained in sick-nursing as ordinary hospital nurses are, and that a much larger use of female nurses is contemplated for shore work. Deceived, probably, by the equivocal gender of the word "nurse," the news is already being published that every battleship in the Navy will in the future carry a complement of trained female nurses as part of her crew. Advocates of co-education would probably find in such an arrangement a charm which the ordinary person would miss—the softening of the rough sailor's nature, the raising of his moral tone, and the bracing of the nurse's feminine instincts by contact with the virility of the tar. But it is doubtful whether Jack himself would like to be civilised by the presence of women on board, and certainly the cares of the internal economy of the battleship would be increased enormously for the captain and officers. Up to the present a truce has always been granted to matrimony and flirtations on board a man-o'-war, but it is difficult to foretell what might not happen in a three years' commission on some lonely station, and much as there is to be said for women nurses in naval hospitals, and even in hospital ships, it is hardly consonant with common-sense that they should form part of the crew of the fighting units of the fleet.

A Way they have in the Army.

THE nursing sisters in the army are beginning to find for themselves some of the practical difficulties of organisation among those not accustomed to discipline, especially when their exact pigeon-hole in the orderly-room has not been defined by long usage. Consequently there are complaints, and, naturally, frequent references to red tape and sealing wax. When the nurses become imbued with the tastes and habits of the service, however, they will probably find out how to jog along comfortably and how by methods of circumlocution to paralyse the official arm. But the spirit and traditions of a service are not picked up in a day, and in the meantime there are grumbles. At Colchester, for instance, it is said that the nursing sisters are upset because although they are allowed by government 13s. a week for messing, yet they do not see their 13s. and have no control over the way it is invested. The matron sees to all that. Now for food alone, 13s. a week for each of a number of people in a mess is a liberal allowance, and the matron ought to be able to do things very comfortably. If she does not the nurses should form a mess-committee and do their own catering, which is quite a "way they have in the army," and a sensible way too.

Legal or Medical Coroner.

THERE is some strong feeling at Leicester on the subject of a new coroner whom it is proposed to appoint. The same point has been raised over and over again, namely, whether a coroner should be a medical man or a lawyer, and it is solved in many cases by certain individuals combining the two qualifications. Against a man who is both a barrister and a medical man it is impossible to say anything if he has had the necessary experience and is possessed of the requisite personal qualities, but if there is no such candidate and the question lies between two men of equal personal qualifications, one a barrister or solicitor and the other a medical practitioner, which is likely to make the better coroner? The question is almost ludicrous to those who have had much to do with inquests. The function of a coroner being to enquire into the causes of mysterious deaths, it hardly seems worth arguing that a man trained and skilled in the diagnosis of disease is better than a man who knows nothing about life, death, or disease but what he reads in the newspapers. The amount of law required in the execution of the coroner's duty is exceedingly small, in fact almost non-existent if the individual himself has a clear head and sound conception of the principles of evidence. No man is condemned to any punishment as the result of the verdict of a coroner's jury, all that they can do being to find that there is a *prima facie* case requiring further investigation by a magistrate.

Behind the Inquests.

BUT important as is the function of holding inquests, the coroner has the almost more difficult one of deciding entirely on his own responsibility whether in each case reported to him an inquest should be held. Both from the point of view of public safety and from that of public economy, it is highly desirable that a medical man should determine these questions. Unnecessary inquests, and there are plenty of them, are mere waste of time and money, whereas by deciding against an inquest in any case a coroner may be covering up a crime. Only a man well acquainted with disease in all its manifestations is capable of coming to a wise conclusion in circumstances often of great difficulty in which a lawyer is sure to blunder. It is, then, in the quiet day-to-day work that a medical coroner can be of such special value to a town or district, and this point should be impressed on authorities who have the appointing of coroners and wish their work to be done to the greatest benefit to the public.

The Sanatorium Afloat. HAVING had to draw attention from time to time to the objections entertained by people to sanatoriums for the tuberculous being built in their neighbourhood, and considering that this objection increases rather than decreases, we regard it as a remote contingency that at some time in the future it will be impossible to get sites for the purpose—that is, if the present fashion in the treatment of tuberculosis continues to hold its own. It is a comfort, then, to know that there are even better prospects of cure for the consumptive in floating sanatoriums than in those founded on the land, and that an enormous kind of houseboat sanatorium is regarded as the ideal by some folk at least. One of these, writing in the *Scotsman*, claims that from the point of view of primary expense and of general upkeep the floating sanatorium would be more economical, and that if it were moored in Strait of Kyle, between Skye and the mainland, not only would there be no ground rent to pay, but the inestimable advantages of the Highland breezes would be enjoyed. We know the Scots are a hardy race, and no doubt their consumptives can stand a good deal, but we hardly fancy they would get the maximum of good from living on the water level through a winter on the West Coast. But so many startling things have happened in the treatment of consumption that it may turn out that there is more in this suggestion than is immediately apparent.

Sanitation and Surcharge. ZEAL for sanitary administration may at times go hand in hand with forgetfulness of formalities, and as has just happened at Stoke Newington with unfortunate consequences. The district auditor of the Local Government Board has been going through the accounts of the Borough Council of that district, and he finds that through an oversight on the part of the officials, application was not made to the County Council to pay half the salaries of the medical officer of health and sanitary inspectors, which of course should have been done. Moreover, the statutory time-limit, six months, had been exceeded, so that the auditor said he himself had not power to alter the conditions prescribed by the law, namely that the councillors should find the money themselves. Now as Stoke Newington has a pretty energetic organisation in its sanitary department the salary list is a large one, and the sum to be paid at present is the considerable one of £1,162 10s. This works out at £40 a member, and it certainly seems hard lines that the councillors should be saddled with this expense through a technical error. There are surely some loop-holes by which the irregularity can be got over, for sanitary authorities are not likely to be encouraged to increase their staffs when they run the risk of remunerating them out of their private pockets.

Police and Doctor. THE relations of the police and medical men are generally of the happiest character, each having learned the value of the other from experience under conditions of difficulty and danger. But while medical men yield to none in their admiration of the discipline and pluck of the police, it is important for the latter to recognise that a doctor is a man of considerably greater knowledge in matters of life and death than they, and to yield him precedence when such matters are involved. A disgraceful incident lately happened at West Gorton, in which the police not only arrested a would-be suicide in spite of the advice of a medical man who was attending to him, but summoned the latter for obstructing them in the execution of their duty. The medical man was acquitted on a technical point, and so was unable to state the circumstances, but we are glad that his colleagues are taking the matter up, as the medical ideal of the sacredness of life cannot be sacrificed to the rules of any service.

LEADING ARTICLE.

THE CONSCIENTIOUS OBJECTOR AND COMING LEGISLATION.

SINCE Mr. Balfour called the "conscientious objector" into existence a good deal of water has flowed under London Bridge. His new departure was clearly a sop thrown to the small but noisy crew of the anti-vaccinationists. It is even remotely possible that he and his colleagues, being swayed by the influences that appeal to all governments, had some sort of eye to conciliating a section of voters. Be that as it may, the plain outcome of his legislation in that particular direction has been to make the anti-vaccinationists more noisy and clamorous than before. The fact of the matter, it must be admitted, is that the "conscientious objector" has found himself to a great extent thwarted by the difficulties of proving his *locus standi* before the magistrates. So long as human nature exists on its present basis there must inevitably be objectors to any kind of legislative compulsion. In the case of small-pox the government were long ago persuaded that the only way to check the ravages of that terrible malady was to enforce the practice of vaccination. The wisdom of that policy has been amply vindicated by the practical disappearance of a loathsome malady that before the days of vaccination was well-nigh universal. At this time of day, there is no need in the columns of a medical journal to discuss the efficacy of vaccination both as a protective and a preventive agency. The experiences of the London epidemic a few years since proved once again in a most emphatic fashion that the incidence and the mortality of the disease were exaggerated to an extreme degree among that part of the population unprotected by vaccination. All these things are incontrovertible, and, as already said, more than justify compulsory vaccination. Under these circumstances that government would be bold indeed which would accept the responsibility of abandoning a system that has produced such marvellous results. The only comprehensible practical ground for opposition is the fallacy put forward by the anti vaccinationists who say that the diminution of small-pox, a fact that they are compelled to admit, is due not to vaccination, but to isolation and other measures of public health. Much the same line of argument might be used in the fairly analogous instance of the use of antitoxin in diphtheria. The fatality of the disease has been reduced by more than half since the introduction of antitoxin. Yet the antivivisection faddist is loud in his clamour against the introduction of "filthy serum" into the human body. Antitoxin may possibly in the course of time lead to the practical stamping out of diphtheria, just as vaccination has led to that remarkable result in small-pox. The antivivisectionists may say that improved sanitation alone will in the course of time lessen the incidence of diphtheria, but they may be reminded that the disease showed for many years a remarkable and rapid increase before the discovery of antitoxin, and that in the very days when public sanitation according to the anti-vaccinationists was doing away with small-pox, why should diphtheria flourish and small-pox diminish under improved public health administration? Moreover, when science furnishes the appropriate preventive or curative vaccine, or antitoxin, or serum for each specific infection we may hope to limit and ultimately to eradicate scarlatina, measles, whooping cough, and other infectious maladies that show no signs of abating in spite of the vastly improved conditions of modern hygiene. But the faddist is not given to the logical weighing of facts. It is enough for him that the practice of vaccination is in some instances attended by bad results and that it is compulsory. In this particular instance the good of the many has been secured at the expense of the unfortunate few, just as the safety of a country is sometimes paid for by the death of the soldiers in war. Mr. John Burns has announced that he is about to introduce fresh vaccination legislation at an early date, with a view of placing the conscientious objector on the stronger basis afforded by permitting a statutory declaration to take the place of a police court appeal. It is a pity that the Government, in dealing with so important a matter as "compulsory vaccination," have allowed themselves to be forced into any reactionary or false scientific position. With the accusation freely levelled against the medical profession to the effect that they make enormous sums out of public vaccination and are therefore interested parties we are not concerned. A similar attack might be made on any of the liberal professions, as well as a host of commercial and financial interests, and we have no fear that libels of that kind will have the slightest weight with Sir Henry Campbell-Bannerman's Government.

CURRENT TOPICS.

New Lunacy Law in France.

WHILE the lunacy law and administration of this country is being investigated by a Royal Commission, it is interesting to note what is taking place with regard to the corresponding arrangements in France. From time to time during recent years the French law regarding lunatics and the method of their certification has been under review, but no amendment to the old law, which is nearly seventy years old, has yet been made. However, after a long tussle the Chamber has just been induced to pass a bill which if confirmed by the Senate will materially alter the position of the insane. The chief motive that has operated in bringing about the passing of this bill is the need for greater protection of the individual, which, although practically seldom or never improperly infringed, was theoretically liable to be so by the old provisions. Indeed, all that was needed to consign a person to an asylum was a demand by a relative or friend, backed up by one medical certificate, or in the case of violence, an order by a magistrate or police commissary, also supported by one medical certificate. Apart from conspiracy, it is obvious that it was quite possible for genuine error to be committed under these circumstances, and though the superintendent of an asylum had to re-certify the patient at the end of twenty-four hours and again at the end of a fortnight, he would naturally be influenced greatly in his decision by facts alleged in the original certificate. The new law proposes that every lunatic shall have the power of resisting a certificate before a judge, who alone can make an order for reception, and much more thorough medical examination is required. The detention of patients after admission is dealt with on similar lines. Moreover, great changes in the administration and inspection of asylums are to be brought about. As in this country, only to a greater degree, inspection of and medical attention to the insane have been inadequate, but the staff of medical experts in both branches is to be increased. We trust our own Royal Commissioners now sitting will duly observe these points, as any provisions for the greater safeguarding the public from mistaken or improper certification would correspondingly increase confidence in medical men and diminish their liability to be sued by dissatisfied patients.

The Cerebro-Spinal Meningitis Invasion.

THE "spotted fever epidemic," to use its popular name, continues to spread, although it is to be hoped that its appearance in some instances is merely sporadic. The cases in Liverpool are approaching a hundred in number, with a high death-rate. Recently a case was reported in London by the Medical Officer of Health for

Lambeth, who at once removed the patient to hospital and adopted every possible precaution to prevent the spread of the disease. Should this not prove to be a sporadic case the outlook for the metropolis will be one of grave anxiety, when the acute and fatal nature of the malady is taken into consideration. For the next few weeks medical men both in hospital and in private practice will be keenly on the watch for cases of epidemic cerebro-spinal meningitis. As a matter of fact, the disease is readily detected if the medical attendant be not taken unawares A similar remark applies to typhus, a disease that has happily become unknown to the present generation of medical practitioners. Not many years ago a series of fatal cases were for a long time undetected in the Metropolis. There can be little doubt that sporadic cases of cerebro-spinal meningitis in different parts of the kingdom have escaped recognition, as there is great similarity between the different forms of meningitis, and the distinctive rash is absent in the majority of cases. The disease has so far invaded Belfast, Edinburgh, Glasgow, Leith, Lanarkshire, Hawick, Whitburn, Govan, Partick, Kilmarnock, Dunfermline, Chesterfield, Grangemouth, Wolverhampton, Longton, and London. This points to an extremely serious state of affairs, and demands vigilant and united action on the part of public health authorities throughout the kingdom. We are glad to know that the London County Council are about to take the first important protective step, namely to make the disease notifiable.

Poor Law Reform.

It is now stated that the Royal Commission appointed in December 1905 to enquire into the whole subject of the Poor Laws do not expect to complete their labours and report for another two years. The prospects of new legislation so urgently called for seem somewhat remote. No suggestion is made of publication of an interim report, which might enable the Government to deal at once with some of the more pressing questions, such as that of vagrancy. Upon this a Departmental Committee has already reported. Guided by the experience of Continental nations, many of which have worked out practical and successful systems of dealing with the vagrant, the unemployed and the so-called unemployable classes, this Committee had no difficulty in unanimously formulating a scheme to suit our home requirements, compatible with our ideas of freedom, and even respecting our prejudices. Reform of the Poor Laws lies at the root of social progress. Unless such questions are taken in hand and dealt with, the problem of raising the standard of our people, physically, mentally and morally to the level of leading Continental nations must remain unsolved. This is a national and an imperial question. So far as our profession is concerned—no doubt a comparatively personal and minor consideration—improvement in the position of Poor Law Medical Officers could be effected without new legislation. This perhaps may be brought about when the profession learns to combine, and demand that just treatment from the State which is now its due in so many different directions.

Physical Training of Recruits.

An important crusade has been undertaken by Lieutenant-Colonel F. A. Davy, M.D., late R.A.M.C., against the system of physical training imposed on recruits in the Army. As the result of various articles and letters he was asked this month to lecture at the Royal United Service Institution before an audience of officers, many of them gymnastic experts, and an instructive discussion followed the lecture. Colonel Davy is of opinion that the circulating troubles which so commonly develop in soldiers are due to the forced and abnormal position of the chest enjoined on them by drill-sergeants, and he holds that the physical efficiency of the soldier would be infinitely greater if he were allowed to adopt a natural position on parade and on the march. Revolutionary as this doctrine is of all that has been taught in the army since time immemorial, there are few of Colonel Davy's civilian colleagues who will not be found heartily to agree with him, and in spite of the opposition of the bulk of the military officers who spoke after the lecture, we fancy that drastic changes are likely to be introduced into the system before long. The *United Service Gazette* is strongly on the side of reform, and it is understood that the War Office contemplate abolishing the present methods in favour of some modification of the Swedish system. Commander Watson, Superintendent of Physical Training in the Royal Navy, is convinced of the superiority of the Swedish methods, and he made the interesting suggestion that the physical training of recruits should be handed over to and form part of the duty of medical officers. Considering that medical men are instructed in physiology and with departures from the normal in the structure and health of man, it would seem the merest platitude to assert that the physical development of the soldier should be placed under their supervision, but it is a sign of grace that the fact should be admitted, and indeed urged, by such an officer as Commander Watson.

Another "Marvellous" Cure for Cancer.

The way in which the public precipitate themselves into the pits dug by the hands of the quack would be comical in the extreme were it not overshadowed by the ever-present shadow of suffering and death. The man in the street runs after every will-o'-the-wisp of quackery that flits through the columns of his daily paper, while he is apt to neglect the crowd of silent, conscientious, highly trained and highly qualified medical practitioners for whose professional fitness the State has become voucher. If only the unqualified pretender can spend sufficient money in advertising, he is certain to attract a large following of dupes. He may sell a rheumatic ring, or a cure for alcoholism, or electric socks, or give himself out as able to cure locomotor ataxy, chronic kidney disease, or any other incurable malady—there is no claim too fantastic and extravagant for his purpose. The latest heaven-born healers are two brothers named

Evans, small farmers near Cardigan. They treat all kinds of diseases, including cancer, with some sort of liquid obtained entirely from herbs, which is painted over the affected spot and a dressing of fresh garden leaves, bruised by being rolled under a bottle, is then applied. Crowds of patients have placed themselves under the care of these two men, who are said to be possessed by a spirit of "deep religious fervour." The whole affair is a couple of centuries behind the times. It should be absolutely impossible under any system of government jealous of the welfare of its citizens.

University Schemes in Ireland.

As was anticipated, opinion hostile to Mr. Bryce's university schemes is rapidly finding expression in Ireland. Trinity College will offer an unyielding opposition. The Fellows and Professors have met, and with unanimous voice, have decided to take every means in their power to prevent the absorption of the College in any new university. In this attitude there is no doubt that the College authorities will have the full support of the body of graduates. It is claimed that there is no shadow of excuse for depriving an ancient, honourable, and successful corporation of its privileges and prestige. No one has heard as yet of a University with three hundred years of laborious work behind it being deposed to the position of a mere college. In the provincial centres of education the scheme is also exciting oppositon. Public opinion in Cork is strongly roused, and the local press is urgent against the absorption of the Queen's College in any university situated in Dublin. For Belfast, President Hamilton's evidence may be taken as representative, and he is strongly hostile. Public bodies in Galway are protesting against any degradation of the local Queen's College to a lower position than its sisters in Belfast and Cork, and indeed this proposed degradation seems a very gratuitous slight on an institution doing excellent work.

No Provision for Payment of Medical Fees.

The common attitude of the nation with regard to medical services seems to be that they are whenever possible to be secured gratuitously. In this way certificates of sickness are obtained wholesale at hospitals by friendly societies, by Council schools and by other bodies or individuals. That important and indispensable legal document, the certificate of death, was to be provided gratuitously by the medical practitioner, no matter what amount of money may be involved indirectly in his attestation. With a profound faith in the careless benevolence of the profession, the framers of the Midwives' Act made it imperative upon the midwife under certain circumstances to call in the assistance of a registered medical practitioner, but at the same time neglected to provide for the payment of such practitioner. It can hardly be wondered at if the medical practitioner is not particularly anxious to attend cases. The matter has been up in one form and another all over the country, and no decisive step has yet been taken. The question is one that cannot be postponed indefinitely, and should preferably be settled by Parliament.

Interest in the Public Health.

THERE are not wanting signs of an awakening interest on the part of the public in matters affecting the health of the community. In some cases the interest is sadly uninstructed, and can hardly produce good results. It is, however, the duty of medical men to act as guides in sanitary matters, and to encourage in every way the formation of a healthy and enlightened public opinion. We are glad, therefore, to note the establishment in Ireland of a Woman's National Health Association, for the express purpose of arousing women "to a sense of their responsibility regarding the public health, and to spread the knowledge of what may be done in every home and by every householder to guard against disease, and to promote the upbringing of a healthy and vigorous race." Among the problems to which the Association intends to devote itself are those of consumption and infant mortality, of pure milk supply, and of the hygiene of primary schools. It is a comprehensive programme, and well worthy of the exertions of the women of Ireland. We notice that among the methods to be adopted are lectures and addresses by medical men. The president of the Association is Her Excellency the Countess of Aberdeen, whose business ability is known to equal her philanthropic zeal. We wish the Association every success in the work it has taken in hand.

PERSONAL.

DR. MORGAN J. REES, M.D., D.P.H., has been unanimously elected Medical Officer of the Aberdare Urban Council at a salary of £500 a year.

DR. THOMAS H. A. VALENTINE, Deputy Health Officer, Wellington, New Zealand, has been promoted Inspector-General of Hospitals.

THE Senate of Cambridge University has paid Principal Macalister the compliment of asking him to continue to represent that University on the General Medical Council.

DR. GLYNN, Professor of Medicine in the University of Liverpool and Consulting Physician to the Royal Infirmary, has been elected a member of the Council of the Royal College of Physicians, London.

A PRESIDENT'S Dinner of the Royal Medical Society was held on February 7th in the Royal Medical Society's building, Edinburgh. The guest of the evening was Professor Osler, M.D., LL.D., F.R.S., Regius Professor of Medicine, Oxford. Dr. Drennan presided.

DR. C. E. BEEVOR will give the presidential address at the annual general meeting of the Neurological Society to-morrow. His subject will be "The Distribution of the Arteries Supplying the Human Brain."

DR. T. L. OWENS has been appointed Surgeon and Admiralty Agent at Holyhead.

A CLINICAL LECTURE
ON
HYDRONEPHROSIS, WITH NOTES OF AN EXTREME CASE OF THAT DISEASE.

By WILLIAM ALEXANDER, M.D., F.R.C.S.,

Lecturer on Clinical Surgery, Liverpool University, and Honorary Surgeon, Royal Southern Hospital, Liverpool.

Gentlemen,—We have had several cases of hydronephrosis in our wards lately, and a very rare and extreme example was discharged from hospital a few days ago. You all know that hydronephrosis means a collection of more or less watery urine in the dilated pelvis of the kidney, caused by a partial obstruction to the natural flow of urine through some part of the urinary passages. In all these cases of hydronephrosis the obstruction is a partial as well as a gradually increasing and an intermittent obstruction. Complete unyielding obstruction of a ureter by a ligature produces, not hydronephrosis, but atrophy of the corresponding kidney. The uncompromising pressure of the excreted urine upon the secreting cells and tubes of the kidney destroys their vitality. In the same way intermittent pressure on the skin of the foot produces a thickening of the epirdermis, but the constant pressure of a splint destroys the skin and produces an ulcer. Hence some surgeons, when a ureter is necessarily or accidentally injured in performing abdominal hysterectomy, tie it, knowing that that kidney will atrophy and that the opposite kidney will enlarge and so be able to overtake the work of two. The causes of obstruction, and consequently of hydronephrosis, may be either temporary or permanent. Amongst the temporary causes are kinking of urethra in movable kidney, small calculi that block the ureter and afterwards pass on into the bladder, renal calculi that sometimes block up the entrance to the ureter and cause hydronephrosis, and at other times fall back into the pelvis of the kidney. Uretritis and phosphatic deposits may narrow the ureter so that it does not drain the kidney efficiently. Both conditions pass away through subsidence of the inflammation or alteration in the composition of the urine, when the temporary hydronephrosis completely and permanently disappears. Hence a tumour in the loin, oval, smooth and mobile, that enlarges and diminishes from day to day coincident with a scanty or a profuse flow of urine, is sure to be a hydronephrosis. Permanent hydronephrosis may be produced by an impacted stone in any part of the urethral tract, by gradually increasing organic stricture of the ureter, by pressure of a tumour on any part of the course of the ureter, by a tumour of the bladder closing the lower orifice of the ureter, by stricture of the urethra, but this last cause rarely produces much hydronephrosis, because, although the dilatation of the pelvis exists, other and more serious inflammatory changes also take place and make the hydronephrosis secondary to the septic condition

I shall now briefly describe to you a case of recent hydronephrosis which some of you saw a short time ago, and I hope you remember the course and treatment of the disease.

Mrs. S——, æt. 39, married, the mother of five children, the eldest 17, youngest 18 months. Commenced to menstruate three weeks ago for the first time since her parturition 18 months ago. Felt "run down" after the strain of menstruation was added to the previous strain of nursing of her baby for 18 months, but, except for some degree of languor and weakness, she was quite well. A fortnight ago she went to bed as well as usual, and soon went to sleep. In the middle of the night she was awakened by a severe pain in her left side, so acute that her husband brought in a doctor at once, who administered morphia. When the effects of the morphia had passed off, the pain was less acute, and had become a "dull aching." She vomited occasionally, but never in any great quantity. Micturition for the past fortnight had been sometimes very frequent, say every ten minutes; at other times not at all frequent.

On examination the abdominal wall was loose and flaccid, moved freely, and was quite flat. On the left side a clearly-defined, distinct, small oval tumour could be seen and felt, having its long axis pointing downwards and inwards. It moved slightly on respiration, was tender to touch, could be pushed upwards under ribs, but not downwards. Fluctuation could not be elicited. The percussion note was clear all over the swelling except on the outer side, where the note was dull. Urine, clear acid, sp. gravity 1,030, contained a trace of albumen. An X-ray photograph of the renal uretral and vesical regions did not reveal anything further. After a week's rest in bed, as the tumour was enlarging and the pain increasing and the entire quantity of urine passed per diem only 8 to 10 ozs., we cut down upon the kidney in the loin, found its pelvis distended with fluid, and the entire kidney much enlarged, but otherwise quite healthy. The pelvis was opened through the cortex, the fluid allowed to escape, and a long whip catheter was passed down the ureter without meeting any palpable obstruction. With the fingers and needle, and both by exploration and palpation, the kidney was thoroughly examined, but no stone or gravel could be found. A piece of gauze was placed in the kidney wound to drain in the right direction the blood and urine that flowed for some hours from the incision. Next day the patient was found to have passed by the urethra 8 ozs. of blood-stained urine, and the dressings were soaked with blood-stained fluid. The passage of blood by the urethra was of great importance, as it showed us that the ureter was clear. Next day the blood had disappeared from the urine that had been passed naturally, but the dressings were still saturated with a watery fluid, mostly urine. In ten days the urine ceased to come by the wound; at the end of a month she was discharged, so well that she said she felt "a different woman."

It is difficult to say with certainty what the cause of obstruction in this case was, but probably it was a stone which we moved on by the passage of the catheter down the urethra. No stone was, however, seen or heard of, and we may have cured the case by relieving tension, by draining the kidney for a few days, but there is no doubt we cured the disease permanently. We do not always obtain such good results from drainage. Some of you may remember a young girl whom I operated on several months ago, and where the old symptoms of pain and distress recurred whenever the wound in the loin healed up. This patient required to wear a small drainage tube in the fistula opening, which I believe she is wearing still. She was told that if the wearing of the tube was too irksome, to come back and we would relieve her by a further operation. She has not yet come back to claim my promise. What we could do should she become dissatisfied with her state would be the same treatment that we dealt out to a case in the private ward about six months ago. A hydronephrosis had been relieved by drainage, but the loin tube was necessary, as distressing symptoms, such as fever, vomiting, pain, etc., occurred whenever it was removed. The continual use of the drainage tube became an intolerable nuisance to the patient, both on sentimental as well as on practical grounds. The cause of obstruction in her case was probably due to broad ligament inflammation of so old a date that an operation to free the ureter did not look either safe or practical. We ascertained by segregation that the right kidney was active and efficient, and we removed the hydronephrotic kidney completely. It was a mere shell. The patient is now an active, healthy woman.

In some cases aspiration of the tumour is practised, the relief of tension being sufficient to allow of the flow of urine through an orifice that greater tension will close. If carefully performed, the operation of aspiration is a safe one, but generally temporary in its relief. My experience has led me to drain from the loin as a surer way out of the difficulty, and one quite as safe.

Confident in aseptic surgery, we may now explore the ureters externally from the kidney to the bladder, or may catheterise the ureters from above or below, and thus cure the disease without any mutilation of the patient, but still in many cases the removal of a dilated and comparatively useless kidney will be the best practical treatment.

I will now call your attention to a monstrosity of a hydronephrosis, a case that, though rare, is not unique, and I will relate it as it appeared to the different observers who had to do with it.

L. E., æt. 23, a young woman, who had always lived with her parents, began to be troubled with a distension of the lower abdomen, accompanied by pain in the left ovarian region, that gradually became intolerable. It was diagnosed as an ovarian tumour by several medical men who examined her, and she entered a woman's hospital to have an ovarian tumour removed. An incision was made, a sac was exposed, the tumour tapped, and clear fluid was drawn off. The sac was so adherent everywhere that an attempt at enucleating was soon desisted from. Whether the tumour was drained or not I cannot tell; at any rate a fistulous opening developed just below the umbilicus. The patient was sent back to bed, and the urinous nature of the escaping fluid was soon placed beyond doubt by the usual urinary effluvia. She was sent home shortly after, and you may imagine the condition of the girl during the year she passed before coming to us, a nuisance to herself and everybody near her, her clothes constantly moist with urine and with foul odour clinging to her person, making her an outcast from society. Her doctor then asked me to take a case of urinary fistula into hospital, and when she was admitted I was surprised to find the fistulous opening half-way between the umbilicus and the pubis, instead of in the loin, where for some reason I expected it to be. The girl was fairly well nourished and in good health, had been relieved of pain by the previous operation, but was in greater distress since by the constant flow of urine. A catheter passed into the bladder seemed to pass up nearly to the fistulous opening, and in the absence of any definite history, we thought at first that the distress was due to leakage from the bladder, and had been caused by wounding that viscus in the operation of ovariotomy a year ago. I enlarged the fistulous opening so as to be able to introduce my forefinger into the cavity, and found an immense potential space that burrowed beneath the viscera away up to the left hypochondrium, down into the pelvis, towards the left to the flanks, and a little way to the right beyond the median line. The bladder was quite normal, and had no connection with the sac. I cut down upon the left renal region, and found no kidney, but only the sac of the hydronephrosis, which I opened with my finger introduced in the median line, and passed a large rubber tube from the middle line through the flank, so as to thoroughly drain the sac from the side and keep the patient drier than she had been. It was evident that we had to do with an enormous hydronephrosis, the sac of which occupied the whole of the left side of the abdomen, and that a left kidney still existed somewhere sufficient to secrete a large quantity of urine and to keep the patient during all her life most odorous and uncomfortable. We did not find a kidney in the usual place, and close questioning of the patient revealed a history of some urinary trouble for many years, incontinence, frequent micturition, and dysuria. Catheterism and radiography did not enable us to discover any calculus anywhere in the urinary tract. Digital examination failed to discover an pelvic disease of any kind. Segregation of the urine showed that the right kidney was secreting plenty of healthy urine, but that not a drop came from the left kidney. It was now plain that the patient had a good, active, sound right kidney that we could depend upon in case of need, and that our course was to find the left kidney, open up the pelvis, and try to establish communication with the bladder, or, failing this, to remove the kidney.

On June 15th, 1906, I made the usual oblique incision between the last rib and the iliac crest which is considered necessary to expose the left kidney. When I reached the circumrenal fat, I explored as far up as the spleen and the diaphragm, and down to the crest of the ilium, but no kidney could be felt, nor anything resembling a kidney. The wound was then extended downwards and inwards, so as to expose the brim of the pelvis. An elongated nodulated structure was now found lying over the sacro-iliac synchondrosis and dipping down into the pelvis. This at first looked like a colon contracted on small scybalæ. Further examination, however, revealed the colon itself distinct from this nodulated structure that lay behind. On carefully isolating the latter, it turned out to be the kidney we were seeking, displaced and deformed. From the pelvis of this kidney the sac extended down into the pelvis close to the bladder. This part of the sac was explored by finger, probe, and catheter, but no opening could be found leading into the bladder, and no course was left but to remove the kidney. The renal vessels were tied, the opening in the sac made by cutting across the pelvis of the kidney was closed by suture, and the large abdominal wound brought together by deep-buried catgut sutures and superficial silkworm-gut skin sutures. The old median abdominal sinus was left open to allow of the discharge of mucus that would for some time be formed in the sac.

The kidney, though deformed and much elongated in shape, was healthy, but we must remember that for the past twelve months it was working under normal conditions and had probably recovered its health and vigour, both of structure and function.

Whilst preparing this lecture for the press at the beginning of 1907, I wrote to the patient asking her to describe her present condition. She says she is quite well and very comfortable. About "half-a-thimbleful" of mucus comes from the old sinus below the umbilicus. She passes urine naturally, and is never wet or offensive.

It seems a very serious mistake to take a hydronephrosis for an ovarian tumour, a mistake that caused the patient much pain and distress for a long period. But let us, with the key to the case in our hands, project ourselves back into the position of the original observers. They saw a young girl, with a gradually increasing fluid tumour in the left ovarian region, that produced a good deal of pain and was accompanied by some dysuria, and it is most likely we would all of us, under the circumstances, have diagnosed ovarian disease, as they did. Had we segregated the urine, we would have found that no urine came from the left side, and we might even then have only diagnosed that the tumour pressed on the ureter so as to prevent the flow from the kidney. But who would have thought of segregating the urine which passed apparently naturally and in full quantity, the opposite kidney having at an early stage of the disease undertaken double work. The congenitally displaced kidney that lay in the pelvis instead of the hypochondrium was the point in the case that rendered correct diagnosis improbable. Had the kidney been in its normal position, its enlargement would at once have been referred to the true cause, and operation would have relieved the patient long before. As the tumour grew larger and larger, the probability of its ovarian nature increased still more and more, although perhaps the shape of the tumour might have put on the right track anyone who has had experience of such cases. But who has had such experience? We who are present at this lecture have had a very exceptional experience, one that few have had, and I hope that the memory of this case will be so vivid that when a similar case occurs to some of us we will be able to diagnose it. Had any of the previous observers thought of such a diagnosis, he could have proved it by segregation of the flow of urine into the bladder, examination of the aspirated fluid, etc. We who have studied this case and have had our efforts directed to it for some weeks will always think of it, and Nature will not be able to deceive us so readily as others who have not seen, but have only heard of extreme cases of hydronephrosis. The chances are, however, that none of us will see such a case again.

The case also shows the danger of jumping at conclusions or of judging from appearances, and the advantage of always considering seriously everything, no matter how improbable, that a tumour under consideration might be, before coming to a final conclusion. If this were systematically done, many errors of diagnosis would be avoided that only occur from want of thought.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by J. B. Story, M.D., F.R.C.S.I., Surgeon to the Royal Victoria Eye and Ear Hospital, Ophthalmic Surgeon to Dr. Steevens' Hospital, Dublin, on "The Treatment of Concomitant Convergent Strabismus."*

ORIGINAL PAPERS.

ACID INTOXICATION FOLLOWING GENERAL ANÆSTHESIA.

By ROBERT CAMPBELL, M.B.R.U.I., F.R.C.S.Eng.,
Assistant Surgeon, Royal Victoria Hospital, Belfast, etc., etc.

Most surgeons must, I think, have been impressed by the idea that, in certain cases of death following the performance of an operation, the fatal result has been largely attributable to the action of the anæsthetic It is only within the last year or so, however, that sufficient evidence has been forthcoming to clearly prove that the danger of a general anæsthetic does not end with the return of the patient to consciousness, and that death may ensue from its action alone as much as several days after the administration. So far back as 1852 Casper called attention to this subject, and different Continental surgeons have referred to it at intervals. To Dr. Leonard Guthrie, of London, belongs the credit of first directing the attention of the profession at home to this very important matter. In 1894 he published in the *Lancet* a communication entitled "Some Fatal After-Effects of Chloroform in Children." In this paper he gave details of ten cases which had come under his own observation, and described most clearly the symptoms and post-mortem appearances. But he did not succeed in convincing the profession of the truth of his observations. The writer of a leading article, which appeared subsequently in the *Lancet*, endeavoured to show that death in Dr. Guthrie's cases might with greater probability have been ascribed to the absorption of carbolic acid or the occurrence of fat embolism. In 1903 Dr. Guthrie returned to the subject. In the meantime one complicating factor, carbolic acid, had been almost entirely eliminated from operative surgery. His second paper appeared in the *Lancet* of July, 1903, and was entitled "On Fatal Effects of Chloroform in Children suffering from a Peculiar Form of Fatty Liver." Therein he gave a description of four additional cases, one of these being an adult. This paper was received with much less scepticism than the first, and in 1904 Mr. Stiles and Dr. McDonald, of Edinburgh, communicated to the Society for the Study of Diseases of Children a very valuable and exhaustive *résumé* of the whole subject, giving a minute description of the symptoms and post-mortem appearances presented by three cases which had occurred in their practice. Previous to the publication of this paper I had met with four cases of death following operation which had puzzled me greatly. I did not, however, suspect the anæsthetic. In two of these cases septic tuberculous sinuses were present, and I not unnaturally ascribed the deaths to septicæmia. The other two were certified as meningitis. Unfortunately, during the past year I have had three other cases following operation on children under chloroform. The clinical symptoms presented by these patients and the post-mortem appearances placed the cause of death beyond any reasonable doubt, and convinced me that delayed chloroform poisoning is a dread reality. I shall briefly describe these cases.

CASE I.—F. B., a boy æt. 4 years, was admitted to the Children's Hospital suffering from an inguinal hernia. So far as I could ascertain he was in fair health. He was, however, inclined to be constipated, and had recently shown a tendency to drowsiness, of which his school teacher had complained. This I naturally ascribed to the foul atmosphere of our national schools. The evening of the day of operation he vomited several times. The vomiting continued during the night, but next morning there was nothing in his condition to excite alarm. The vomiting recurred during the day, and early the following morning became severe. The child by this time was evidently very ill. The pulse had risen to 160, while the temperature was normal. He was seen by one of my colleagues, who was of opinion that his symptoms pointed to intestinal obstruction. Some hours later I saw him. He had then recovered to some extent; the vomiting had not recurred, but the pulse was over 120, and the child was restless and excited. Examination of the abdomen revealed nothing. Being very sceptical on the subject of delayed chloroform poisoning, and afraid that a piece of intestine might have slipped down and become strangulated, I unfortunately resolved to open up the wound. To do this a little chloroform was given. Nothing, however, was found wrong with the wound, which was sutured again. The child soon afterwards began to vomit profusely, became drowsy, then comatose, and died in the evening fifty hours after operation.

As this was the first case of death following operation for the radical cure of hernia in 362 cases operated on in the Children's Hospital, I was very anxious to ascertain the cause of the fatality. I accordingly got Professor Symmers to perform a post-mortem examination.

When the abdomen was opened the liver at once attracted our attention by its bright yellow colour—it might be described as canary-coloured. Not a trace of red liver tissue was to be seen either on the surface or in the sections. The tissue was friable and the cut surfaces had a greasy appearance. It was plain to the naked eye that the liver was a mass of fat. The cortices of the kidneys were in section pale grey.

Six weeks after this catastrophe two other cases occurred.

CASE II.—R. C. M., æt. 5 years, was operated on for a cleft involving both the hard and the soft palate. The operation was easily performed, and only occupied thirty-five minutes. During the night the patient was very sick and restless. The following morning he was still vomiting at intervals, but his appearance was good. During the afternoon he became drowsy. The drowsiness gradually increased, and slight cyanosis appeared. Eventually he became comatose, with Cheyne-Stokes respiration. The temperature rose towards the end to 102°. With my previous experience I recognised the condition, and ordered the administration of a purgative and the injection into the bowel of a large quantity of solution of bicarbonate of soda, and a hypodermic of strychnine, but he died thirty-eight hours after operation. Post-mortem examination revealed exactly the same condition of liver as in the previous case.

CASE III.—R. H., æt. 6 years, was operated on for the radical cure of hernia. He vomited at intervals during the night, and next morning suddenly took convulsions which affected the whole body and recurred at short intervals for half an hour. After the convulsions ceased he remained in a semi-comatose condition. Purgatives and rectal injections of solution of bicarbonate of soda were given, but the coma deepened, the respirations became Cheyne-Stokes in character, and he died thirty hours after operation.

The post-mortem examination showed the same intense fatty degeneration of the liver as in the other two cases. These three cases appear to be typical instances of so-called delayed chloroform poisoning. The fact that three deaths from this cause have occurred within a space of two months makes the subject one worthy of our most earnest consideration, and of immense importance not only to operating surgeons, but also to all who have occasion to use general anæsthetics. It is for this reason that I have brought them under your notice, and I hope that my sad experience may have the effect of forcibly directing your attention to what I am firmly convinced is a very real danger attendant on the administration of chloroform, especially to children.

I shall now proceed to discuss some points a little more in detail.

I.—*The Symptoms* naturally vary somewhat in different cases. It will have been noticed, for instance, that one child had convulsions and another became cyanosed, while in the third case neither of these was present. The symptom complex has been given by Bevan and Favill as follows:

(1) *Vomiting.*—This is generally profuse and prolonged, and tends to become coffee-ground in appearance.

(2) *Restlessness.*—Sometimes an expression of excitement or fear is observed.

(3) *Rapid Pulse.*—A rate of 140–160 is common.

(4) *Delirium.*

(5) *Convulsions.*

(6) *Coma.*

(7) *Cheyne-Stokes Respiration or "Air Hunger."*

(8) *Cyanosis.*

(9) *Icterus* is generally slight.

(10) *Smell of Acetone* from the breath and urine.

The resemblance of these symptoms to those of acute yellow atrophy of the liver is at once apparent; but in chloroform poisoning jaundice, if present, is slight, and there are no hæmorrhages. The absence of these may be due to the more rapid course of the chloroform cases.

II.—*The Post-mortem Appearances* are very characteristic. Indeed, Dr. Guthrie asserts that in no other condition except possibly phosphorus poisoning has he seen the same condition of liver. Stiles and McDonald, however, have observed it in some children who have died without an anæsthetic having been given. The liver is normal in size, or slightly enlarged, firm in consistence, and uniformly yellow The other organs are not affected to the same degree, but fatty degeneration of the cortices of the kidneys is plainly seen, and fatty changes are also observed in the muscles, especially those of the heart.

III.—*The Cause of Fatty Degeneration.*—That chloroform alone is capable of producing these changes has been conclusively proved. Experiments conducted on rabbits have shown that chloroform cannot be administered to them for an hour without causing death, preceded by symptoms of poisoning, and post mortem fatty degeneration of the liver is always found. Stiles and McDonald record some interesting observations on this point. A number of rabbits were anæsthetised with ether and a portion of the liver of each removed. After recovery from the operation the abdomen was again opened under chloroform and another portion removed. A few days later the rabbits were killed, and the livers examined. These were always found to have undergone marked fatty degeneration subsequent to the administration of chloroform.

If we admit, as I think we must, that deaths such as I have described are due to delayed chloroform poisoning, we have next to consider whether in these cases there may be some impurity in the chloroform, or some error in its administration, or some idiosyncrasy on the part of the patient.

I.—*The Chloroform.*—I have always used chloroform made from ethyl alcohol. Although I have no evidence to show that there was any impurity of the chloroform used in these fatal cases, still I have noticed that particular bottles of chloroform have had the effect of producing intense vomiting in every patient for whom they have been used. For instance, two private patients anæsthetised from the same bottle vomited most profusely after the performance of simple operations, viz., excision of varicose veins and radical cure of hernia. It might be contended that the varicose vein case was a prolonged operation and consequently a large amount of chloroform was used, but the radical cure of hernia lasted only twenty minutes, and yet this patient, a little girl of seven years, exhibited most marked symptoms of poisoning, profuse and prolonged vomiting, restlessness, and pulse rate of 160. Fortunately, after the administration of a purgative and large quantities of solution of bicarbonate of soda, she rapidly improved, and in forty-eight hours after operation was quite well.

The anæsthetist informed me that two patients of another surgeon for whom the same chloroform was used suffered in the same way.

After one of my fatal cases I endeavoured to get the chloroform that was left analysed, but unfortunately there was not sufficient for the purpose. We have no proof, therefore, that impure chloroform plays any important part in these cases.

II—*The Administration.*—It has been asserted by a French writer, who recently published an article on the subject, that poisoning is always the result of administering the chloroform vapour in a too highly concentrated state. He says that a 2 per cent. mixture of chloroform with air is the limit of safety. If this is so, and if chloroform is to be continued as a general anæsthetic, resort must be had to some other method of administration than those in general use. Some experiments published recently in the *Lancet* show that with a Junker's Inhaler 15 per cent. of chloroform vapour can be given off. The percentage certainly must vary greatly according to the quantity of chloroform in the bottle, the vigour with which the bellows is used, and the temperature of the operating room. As regards my own cases I have some reason to believe that possibly too high a percentage of chloroform vapour was given. On the occasion of two of the fatalities there were a great number of operations to be done, and the administration may have been unconsciously hurried. Certainly subsequent investigation showed that the amount of chloroform used was much above the usual quantity. It is also worthy of note that all the patients chloroformed on the same day were attacked with profuse vomiting quite as severe as in the fatal cases, but tending gradually to pass off. Most observers are agreed that the duration of the operation and the amount of chloroform used are important factors in the production of post-anæsthetic vomiting. All surgeons must have remarked how severe and persistent the vomiting is likely to be after a tedious operation such as the removal of tuberculous glands from the neck. But the operations in my fatal cases were all short, the longest occupying only thirty-five minutes. This fact directs one's attention to the patient, and makes us ask if there is not in fatal cases a susceptibility to the action of chloroform.

III.—*The Patient's Condition.*—The majority of cases of chloroform poisoning have occurred in children. Those suffering from rickets and infantile paralysis appear to be specially liable to it. Dr. Guthrie is of opinion that in all fatal cases there is a pre-existing fatty degeneration of the liver and that the chloroform merely acts as the "last straw." Mr. Stiles and Dr. McDonald, on the other hand, take the view that all the post-mortem changes may be produced by the chloroform alone, and quote in support of this the extensive degenerations produced in animals. In this connection I am indebted to Dr. Rankin for calling my attention to an important point. It is known to experimental physiologists that herbivorous animals take chloroform very badly. An analysis of the cases of death in children after CHCl shows that the most dangerous age is between four and five years. Now this is the period of life when children of the working class get the least proteid in their diet. They are fed mainly on bread and jam and potatoes and gravy. They are practically speaking herbivorous animals. Infants, on the other hand, who are fed entirely on milk, take chloroform very well. They very often do not vomit at all. Their food contains a large amount of proteid. This observation fits in with what has been noted about the susceptibility of ricketty children.

I have also some reason to believe that there is some hereditary cause which predisposes to chloroform poisoning. For instance, in one of my cases I learned from the father afterwards that two other children of the same family had died in much the same way without any anæsthetic having been used. These cases were certified by the family doctor as meningitis. In another case of unexpected death which I had some years ago I discovered subsequently that a brother of the child had died in exactly the same way the day after being operated on by one of my colleagues. These two cases certainly point to some family weakness.

Although most of the cases hitherto described have occurred in children, the condition is by no means confined to them. Within the past few months I have noticed in the medical journals two cases of acute yellow atrophy of the liver following confinement. In both these cases $CHCl_3$ had been freely used.

The influence of the anæsthetic in septic cases was most graphically shown in a recent paper giving the results of operation for suppurative appendicitis at the Edinburgh Hospital for Children. When $CHCl_3$ was the anæsthetic used; only four cases out of nineteen recovered. When ether was substituted the proportion of deaths and recoveries was almost reversed.

In discussing the question of susceptibility to chloroform poisoning Bevan and Favill give the following as predisposing causes:—

1. Age—children.
2. Diabetes.
3. Previous recent anæsthesias.
4. Septic infection.
5. Dead fœtus in utero.
6. Gangrenous mass in the abdominal cavity, *e.g.* a strangulated ovarian cyst.
7. Exhaustion due to hæmorrhage.
8. Starvation.
9. Carcinoma.
10. Lesions resulting in fatty degeneration, *e.g.* infantile paralysis.
11. Chronic disease of the liver and kidneys.

The frequency of deaths from chloroform poisoning is certainly much greater than has been hitherto suspected. In going over the operations in the Children's Hospital for some years back I find there have been thirteen deaths which, in the light of our present knowledge, may be fairly regarded as due to this cause. Seven of these have been under my own care, including the three which I have described in detail. The other four were an osteotomy, a tenotomy and myotomy for spastic paraplegia, and two cases of tuberculous sinuses. As the last two were septic, I concluded at the time that the scraping of the sinuses had disseminated the septic matter. Consequently I certified them as septicæmia. In the other cases the vomiting followed by coma suggested meningitis. In one of these, however, a post-mortem examination of the brain made by Dr. Lorrain Smith failed to confirm this view. Unfortunately we had not permission to make a complete examination of the body.

In addition to fourteen cases recorded by Dr. Guthrie, six or seven have been described by Mr. Stiles, and in the *Lancet* of November, 1906, Telford and Falconer give a detailed account of three fatal cases occurring in a few months at the Manchester Children's Hospital, viz., a case of cleft palate, a case of radical cure of inguinal hernia, and a case of osteotomy of the femur. That these cases of fatal chloroform poisoning are not confined to, although much more common in, children has been shown by Ballin, who has collected nine cases of so-called acute yellow atrophy of the liver following operations under chloroform in adults. Bevan and Favill have also collected twenty-seven cases of different ages.

How the Poisonous Effects are produced is still unexplained. It has been noted that after the administration of chloroform or ether acetone and diacetic acid appear in the urine, and it has consequently been suggested that these are the active poisons. Those of us who are in the habit of treating children are familiar with the fact that periodic vomiting is often associated with the presence of acetone and diacetic acid in the urine, and I think that it is quite probable that some deaths occur from this acid intoxication apart from the administration of an anæsthetic. In examining the urine of children before operation I have sometimes found diacetic acid in considerable quantities present. In three cases of infantile paralysis operated on recently it was present in large amount, and these are cases which are admitted to be very prone to chloroform poisoning. It is therefore possible that fatal cases are the result of the production of acetone and diacetic acid by chloroform in patients already suffering from acid intoxication. A long series of observations carried out at the Hospital for Sick Children in Edinburgh goes to show that symptoms of poisoning are most frequently observed in the cases in which an examination of the urine has revealed the presence of acetone and diacetic acid. On the other hand, these substances may be merely the associates of a poisonous material not yet recognised. The intense fatty degeneration of the liver must almost entirely destroy its power to prevent the passage through it of poisonous material carried from the intestines by the portal vein. I believe it has been shown that when large quantities of acetone are administered to animals no poisonous symptoms supervene. The subject is therefore one which requires still further investigation.

Treatment.

1. *Prophylactic.*—Adopting the view that acetone and diacetic acid play a part in the production of the symptoms, the detection of these in the urine of a patient requiring an operation should contra-indicate the use of chloroform. Ether should be employed instead. It is true that the administration of ether also leads to the production of these substances; but it is contended that the kidneys not being damaged in their excreting power by ether, rapid elimination of them takes place. With a view of neutralising the diacetic acid, alkalies should be administered before operation. Bicarbonate of soda in half-drachm doses may be employed for this purpose.

2. *Curative.*—Many patients who exhibit the preliminary symptoms in a marked degree recover, *e.g.* the little girl operated on for hernia whose case I have mentioned. When the symptoms arise a good purgative should at once be given. An attempt should also be made to restore the alkalinity of the blood. For this purpose copious rectal injections of bicarbonate of soda should be given. Dr. Thomas Houston informs me that lactate of soda is a much more efficient preparation for the purpose. In addition, hypodermics of strychnine are also advisable.

A consideration of the subject forces us to the conclusion that ether is a much safer anæsthetic than chloroform, both as regards the immediate and the remote mortality, and that it should always be employed as a general anæsthetic unless there is a definite contra-indication to its use.

REPORT UPON

CEREBRO-SPINAL MENINGITIS IN GLASGOW.

By A. K. CHALMERS, M.D. Glasg., D.P.H. Cantab.
Medical Officer of Health for Glasgow, &c., &c.

The recognition of this disease recently in Belfast and an increase in the numbers notified in Glasgow during the month of January have concentrated public attention on its movements and make some short statement of its present position desirable.

In the memorandum which was presented to the Glasgow Health Committee in May of last year in support of the suggestion that it should be included within the Notification Act, attention was drawn to the circumstance that many of the leading symptoms of the disease were closely allied clinically to certain other diseases, especially of the central nervous system, and also pneumonial, but that in certain cases a distinction could be drawn by the recovery of a micro-organism known by the name of its discoverer, "Weichselbaum." It was also noted, however, that the organisms might escape detection, especially in the later stages of the disease.

Before dealing, therefore, with the cases notified, it may clear away some misconception if we inquire whether any changes are discoverable in the group of diseases of the nervous system with which this particular form may most readily, by reason of its symptoms, become included. And for this purpose the most reliable source of information is a record of the deaths which have been attributed to one or other of these forms during recent years.

The groups here distinguished are—(1) cerebro-spinal meningitis (cerebro-spinal fever), (2) meningitis—inflammation of the brain, etc., and (3) tubercular meningitis.

TABLE I.

Glasgow, 1901–6.—Statement of Deaths Certified under the respective Groupings.

	1901	1902	1903	1904	1905	1906
(1) Cerebro - spinal meningitis (C.S. fever)	1	—	—	—	—	147
(2) Meningitis (simple) inflammation of the brain	438	414	411	388	363	329
(3) Tubercular meningitis	237	244	240	260	237	307
	676	658	651	648	600	783

The most prominent feature of this table is the evidence it contains that during 1906 fatal diseases referable to the central nervous system exceeded by 136 the average of the preceding years.

This results from an increase of 63 under "tubercular meningitis," and 147 ascribed to cerebro-spinal fever, against which must be placed a reduction of 74 from simple meningitis.

It is important to follow these changes a little more closely. Age plays an important part in determining susceptibility to meningeal affections, and a short statement of the relative prevalence at three age-periods will serve to explain why the subsequent inquiry is confined to ages under twenty.

In the year 1906 the deaths ascribed to the tubercular and non-tubercular forms of meningitis (excluding cerebro-spinal fever) at ages 0–5 numbered 449; at ages 5–20, 144; and at ages 20–60, 39.

Again, at ages 0–5 and 5–20 the numbers attributed to tubercular meningitis exceeded in this year the average number formerly registered, and at both of these age-periods the numbers attributed to simple meningitis are lower, with one exception, viz., 1905.

At the age period 20–60 the number of deaths attributed to both forms were 32, 39 and 39, and may therefore be excluded from further consideration.

Now we may follow the record into 1906, and restrict our inquiry into the deaths occurring under 20. For the present we shall exclude cerebro-spinal fever, meningitis, inflammation of brain, etc.

TABLE II.

Deaths Registered as due to Meningitis—Inflammation of Brain, etc., Ages 0–5.

Months.	Total Deaths, 1901–5.	Average Number Monthly.	1905	Departure from Average.
January	117	23	31	—
February	102	20	31	—
March	124	25	20	—
April	138	28	27	—
May	132	26	32	—
June	125	25	29	—
July	133	27	5	22
August	152	30	7	23
September	117	23	18	5
October	114	23	14	9
November	98	20	8	12
December	106	21	9	12
	1,458			83

On running down the line of figures under 1906 two facts are apparent. A change which is scarcely a natural one began in July. The shrinkage which then occurs has no parallel in former years. During 1901–5 the deaths occurring monthly were fairly uniform throughout the year, being on an average 123 in the first six months and 120 in the second. In 1906, on the other hand, 170 deaths are attributed to meningitis during January to June, and only 61 in July to December. The increase in the first half of the year is quite as striking as the shrinking in the latter half, but its significance differs.

Ages 5–20.—It will be sufficient here to reproduce only the half-yearly figures:—

Months.	Total Deaths, 1901–5.	Average Number Monthly.	1906.	Difference.
January to June	195	39	44	+5
July to December	146	30	20	−10
	341	69	64	−5

The departure from the average is still marked here, but less pronounced in view of the smaller number of deaths occurring.

Tubercular Meningitis.—It has already been shown that the number of deaths attributed to tubercular meningitis had increased during 1906. Again, therefore, it becomes desirable to discover during what part of the year this increase occurred, and we must follow a line of investigation similar to that adopted in Table II. in dealing with simple meningitis. This has, therefore, been done in the following table:—

TABLE III.

Deaths Registered as due to Tubercular Meningitis. Ages 0–5.

Months.	Total Deaths, 1901–5.	Average Number Monthly.	1906.	Departure from Average
January	66	13	15	—
February	74	15	13	—
March	76	15	16	—
April	95	19	14	—
May	83	17	15	—
June	62	12	12	—
		—91	—85	
July	79	16	21	5
August	64	13	25	12
September	60	12	21	9
October	73	15	18	3
November	56	11	21	10
December	68	14	27	13
		—81	—133	
	856	172	218	52

If we take as our basis for comparison the average number of deaths occurring in each of the half-years 1901–05 we find some tendency towards a decrease in the incidence of the disease during the months of January to June, but an increase from July to December. This difference is shown in 85 deaths in all being recorded in the first half of 1906 as against 91 in the corresponding portion of 1901–05, while from July to December the deaths attributed to it in 1906 number 133 as against 81 in previous years.

Ages 5–20.—Following again the shortened form adopted in dealing with the deaths from simple meningitis at these ages, the following statement of deaths may be made :—

Months.	Total Deaths, 1901–05.	Average Number Monthly.	1906.
January to June	171	34	35
July to December	151	30	45
	—	—	—
	322	64	80

Can we, then, from these figures form any concrete conception of the movement of meningeal disease in the period under review. We have seen that a fairly uniform incidence and seasonal distribution is maintained until the beginning of 1906, when already in the early months of that year an increasing prevalence is reflected in the deaths which for the first six months are attributed to ordinary meningitis. Deaths due to the tubercular variety of the disease are meanwhile uninfluenced, but in the second half of the year both undergo a change, which is without parallel in the previous periods. Deaths ascribed to simple meningitis decrease, while those from the tubercular variety increase. What circumstance aided in producing this change in nomenclature ? During the late spring months of 1906 attention had been directed to the recognition of a few cases of true cerebro-spinal fever, and in May the Hospitals Committee authorised the issue of a circular to medical practitioners, asking whether other cases of the disease had come under their notice. After the requisite procedure, the disease was made notifiable in August.

The questions now to be answered concern the actual proportion of cerebro-spinal fever in the total volume of meningeal affections. Apart from actual demonstration of the fact by post-mortem examination, I know of no circumstance which suggests that tubercular diseases, meningeal or otherwise, are increasing. Does the excess of deaths attributed to this form of meningitis in the later months of 1906 cover some which are true cerebro-spinal fever, and what proportion of both may be ascribed to simple change in nomenclature ? Neither of these questions can be satisfactorily answered at the moment, but they both indicate a need for the greatest care in scrutinising the deaths which are being attributed to the epidemic form of the disease. It has been said that we are still groping our way towards a true clinical picture of the disease, and that bacterial verification is sometimes impossible, even when the disease is present. Bearing this in mind, we may examine the cases which have been registered since the spring of last year.

It is convenient as well as instructive to consider them in groups, which will distinguish between those treated in the fever hospitals and those treated as home or in the general hospitals.

CEREBRO-SPINAL FEVER.

Cases Registered during 1906.	Total.	Bacterially Verified.	Not Verified.	Not Cerebro-Spinal Fever.
In fever hospitals ..	110	65	28	17
At home or elsewhere ..	103	22	77	4
	—	—	—	—
	213	87	105	21
Deaths—				
In fever hospitals ..	72	47	20	5
At home or elsewhere ..	76	18	56	2
	—	—	—	—
	148	65	76	7

The fatality of the Disease.—It is from this point of view that the "non-verified" case acquires its true significance. Of 105 cases belonging to this category 76 died, which is equal to a fatality rate of 72 percent. and the proportion of fatal cases scarcely varies whether we take it on the hospital or home deaths separately. And on comparing both with the fatal cases among the bacterially verified, the fatality rate corresponds almost accurately with that of the hospital cases, but falls short of that obtaining among the "home" cases, where the fatality rate is 82 per cent. Save, therefore, for the larger proportion of cases, not cerebro-spinal fever, occurring among the hospital group (seventeen in all, of which three were pneumonia and four tubercular meningitis), the inference from both is that we are dealing with a peculiarly fatal form of meningitis, and that it is being recognised without as well as within the hospital.

In dealing with the cases registered during January we may adopt the same classification, but cannot attach to the various groups the same rigid interpretation, as many are still under treatment.

JANUARY, 1907.—CASES REGISTERED AS CEREBRO-SPINAL FEVER.

Cases.	Total.	Verified.	Not Verified.	Not Cerebro-Spinal Fever.
In fever hospital ..	57	34	8	15
At home or elsewhere	50	11	37	2
	—	—	—	—
	107	45	45	17
Deaths.				
In hospital ..	23	18	—	5
At home or elsewhere	32	8	22	2
	—	—	—	—
	55	26	22	7

Death rates calculated on either the verified or unverified groups would seem to indicate a considerable reduction in the fatality—51 and 49 respectively—but at the moment any such inference would be unwarranted for the reason just stated.

Distribution of the Disease.—From the foregoing it will be seen that the cases registered during January show a considerable increase. This began in the second week of the year, since which the weekly numbers registered have been respectively 32, 28, and 28 for the three weeks ended February 2nd. While isolated cases in most wards are of occasional occurrence, the numbers tend to concentrate in the wards towards the eastern and north-eastern portions of the city and in some districts of the south side.

Age Distribution.—The age distribution of the cases follows in a general way what has already been referred to as characteristic of meningeal diseases in general—that is, about 56 per cent. are occurring among children under five years of age, 21 per cent. at ages 5–10, and 11 per cent. at ages 10–20.

Regarding the method by which the infection is conveyed, nothing of a definite character can be said. Multiple cases in households have been observed, but they have mostly been so closely related in date of onset as to suggest simultaneous infection. One of the most suggestive circumstances observed has been the occurrence of a considerable number of cases among breast-fed infants who had no known association with any family suffering from the disease. It was one of the older theories held concerning cerebro-spinal fever that infection reached the central nervous system along the nerve tracks, and the increasing prevalence of the disease during January may have some relation (through depressed vitality and the natural resistance to disease) to the somewhat exceptionally low temperatures which characterised the weeks ending December 29th and January 26th. Whether any definite relation to this can be finally established remains to be seen, but the association suggests that the utmost care should be taken to guard young children against the variations of temperature, and especially the low temperatures through which we are presently passing.

This, together with a rigid observance of absolute cleanliness of everything which may be placed in the mouths of young children, whether for food or other reasons, are suggested by the facts which have come under notice.

In households where cases occur it should be remembered that discharges from the mouth, nose, and ears have been associated with the occurrence of the disease in former outbreaks elsewhere.

EYE AND EAR SYMPTOMS IN CEREBRO-SPINAL MENINGITIS.

By CECIL SHAW, M.D.

(Surgeon to the Belfast Ophthalmic Hospital.)

These symptoms are found to vary greatly in different epidemics, often giving a peculiar type to an epidemic. They are of importance both in diagnosis and prognosis.

Eye Symptoms.—Conjunctivitis is an early sign in 60 per cent. of the cases; generally seen in first day or two.

The Cornea is frequently affected, becoming steamy and infiltrated. Often it clears completely, but it may become ulcerated.

The Pupils may be dilated, contracted, or unequal; there is frequently some photophobia in the early stages.

Iritis, Choroiditis, and Optic Neuritis may occur, together or separately. The two latter are serious as regards the prognosis for sight, for there is apt to be exudation into the vitreous, which becomes organised, drags on the retina and causes its detachment, and eventually destroys sight. Often there is no neuritis, but congestion of the retinal vessels. On the whole, optic neuritis is not so marked a symptom as in tubercular meningitis.

Orbital Cellulitis has been seen occasionally.

Paralyses of the third, fourth, sixth, and first division of the fifth nerve are not uncommon. There is a good description of what I believe to be such a case in *La Clinique Ophthalmologique* for 1901 (p. 225). The case, a lady, æt. 25, was seen in October, 1900, in Nantes; she gave a history of an acute illness in England three months before; violent headache, vomiting, temperature 104°, delirium for fifteen days, and stiffness of the neck, with complete paralysis of all the eye muscles except the external recti, and defective sight. All symptoms passed off except those in the eye, which persisted when seen. The eyes were then turned out by the unopposed action of the external recti, and vision was very poor, the fundus being hidden by a grey exudation. In some months the muscles recovered and vision improved, but remained only 1/15.

The Ear Symptoms are often marked. In the United Kingdom 12 per cent. of the children in institutions for the deaf and dumb are there as a result of meningitis, and no doubt some, though, perhaps, only a few of these, have been cases of cerebro-spinal meningitis. But in Jacksonville, U.S.A., institution, 14 per cent of the cases were the result of cerebro-spinal meningitis alone.

At Oberfrank, in Germany, with a population of 55,000, no less than fifty-eight cases were admitted to the institution for deaf and dumb in two years, as the result of this disease. Moos states that 59 per cent. of all his cases became deaf; and in several epidemics the majority of cases have suffered similarly. According to Knapp and Moos the deafness generally appears in the first or second week. It is generally complete and permanent, being due to inflammatory changes in the nucleus or trunk of the nerve, or in the labyrinth. According to Von Ziemssen, suppurative disease of the middle ear may appear about the twenty-fifth day, and may be complicated by mastoid disease.

The following case which I saw in consultation with Drs. Calwell and McCaul illustrates several of the points noted above.

The patient, a lad, æt. 13, became ill on January 25th, and on the third day suffered from vomiting and vertigo. That night he was found to be deaf. When I saw him on the fourth day he could hear nothing but the shrill sound of a Galton's whistle held close to his ear. The membranæ tympani were apparently normal on both sides, and as far as could be made out, there was almost complete nerve deafness. Blisters were applied over the mastoid on both sides, but no change has taken place, and the deafness seems, if anything, more complete. On the fourth day of his disease, when I saw him first, there was a little injection of the conjunctiva in the left eye, and on the seventh day, when I saw him again, this had increased to slight chemosis; the cornea was steamy and infiltrated, the pupil dilated, and there was a little string of pus running from the iris to the lens. A swab from the conjunctival sac failed to yield the meningococcus. A week later, on the fourteenth day, the conjunctiva was less swollen, the cornea nearly quite clear, the pupil widely dilated, with a thick mass of yellow exudate at its centre, apparently resting on the lens, and there was slight hypopyon. There was no perception of light, and the tension was - 1. The right eye remained normal. I have not been able to go out again since, but hear from Dr. Calwell that the boy goes on well, and can now see a candle at two feet with the left eye. Considering the way in which the cornea has cleared, I should be slow to give up hope of considerable improvement in the sight. The prognosis as regards hearing is very bad. As regards the differential diagnosis, the symptoms in connection with the eye and ear which would point most strongly to cerebro-spinal meningitis in a suspicious case would be an early conjunctivitis, an irregularity in the size of the pupils, steaminess of the cornea, iritis, with or without hypopyon, exudation in the vitreous, and sudden deafness.

CLINICAL RECORDS.

CASE OF GENERAL FŒTAL DROPSY.

By JAMES DUNLOP, M.B., C.M.

(Formerly Assistant Physician to the Glasgow Royal Infirmary).

This is an extremely rare condition, and has been given a number of different names. Hippocrates is supposed to have seen a case and described it as a fleshy fœtus (fœtus carnosus), but a definite case was first described in the seventeenth century. It is not even mentioned in any of the midwifery books in my possession, except Spiegelberg, and it was only when I got Dr. Ballantyne's book on "Ante-natal Pathology and the Diseases of the Fœtus" that I got any definite information about this interesting case.

I shall first give the history of the mother, Mrs. L., æt. 31. Has been married for three years. First child, a fine healthy girl, is æt. 2 years and 1 month, and never required any medicinal treatment. Four or five months after this birth she began to menstruate, but suckled the child for eight months, when she again became pregnant and ceased nursing. Second child was born at the eighth month, on March 10th, 1906; it had been dead for several days and was desquamating. In June, 1906, she again became pregnant for the third time, and felt life about November 1st. At this time she had an attack of influenza, but soon got over it and was in good health both before and after this attack. Fœtal movements were weaker during November, but she felt them distinctly up to the day before labour began. On December 7th, about 5 a.m., he had a slight red discharge, but no pain. In the evening slight pains began and continued all night; the child was born rather unexpectedly about 7.35 a.m. on December 8th. The pains were slight and not lasting long. It was a breech presentation, and nurse tied the cord, but fœtus was quite dead. On my arrival she called my attention to the peculiar swollen condition of the fœtus. It was a male, and resembled a case of acute Bright's disease, with general anasarca, with pitting on pressure. There was no desquamation and no emphysema of skin, but a true dropsy. The skin was smooth, pinky in colour, and showed a number of fine dilated capillaries. The arm was almost translucent on holding it up to the light. The eyelids were so œdematous that the pupils could not be seen when the attempt was made. The abdomen was distended with ascitic fluid and the splenal cavities were also dull to percussion. The scrotum was greatly distended. The weight of fœtus was not ascertained, but it was obviously larger and heavier than a usual six months' fœtus. The placenta was retained and found to be adherent and had to be stripped off by the hand introduced into uterus; it was large, pale and œdematous. Nurse stated that the liq. amnii was not very abundant; it was clear and had no smell. The mother made an excellent recovery. She is a healthy-looking woman, and has no kidney or heart affection, and no specific history. Her husband is a very healthy-looking man. As I have already said, this is an extremely rare disease, and I have never seen a case of it till now, and have never met any one who has had a similar case. I showed the specimen at the Obstetrical Society meeting, but none of the members had seen a case like it. Dr. Ballantyne, of Edinburgh, says in his book on "Ante-natal Pathology" that he has had the rare fortune to examine 11 cases of this disease, and remarks that he is now far less confident as to its pathology than he was after examining his first case, and the *usual clinical history may be summarised as follows:—*

Mother advanced in child-bearing period—over 30. Multiparous as a rule; large number of pregnacies as a rule. Health often bad; previous obstetric history bad.

Father's health—absence of specific history.

Symptomatology of the pregnacy.

Often terminated prematurely; mother's health seldom good; maternal dropsy; unusual degree of abdominal distension from large fœtus and placenta and abundant liq. amnii; fœtal movements feeble.

Third Stage difficult; large dropsical placenta; uterine inertia; rapid and favourable puerperium; weight and measurements of fœtus larger than normal; a general or local œdema; serous fluid oozes out; skin red, livid or pinkish; fluid in pleural pericardial and peritoneal sacs; ascitic fluid may be green, brown or clear; hydrocele or hydrocephalus. Placenta: large, soft, pale; cord thick and œdematous. Hydramnios. Causes of "general fœtal dropsy" looked for in three directions: (1) Morbid state of mother's health; alcoholism, hydræmia, nephritis during pregnacy. (2) A pathological condition of father, as anæmia, syphilis, etc. (3) A pathological condition of fœtus; closure of F. Ovale; cystic kidneys; leukæmic blood. Some have combined 1 and 3 as the cause. Some (Clay) thought placenta at fault, due to maternal syphilis or maternal nephritis, etc. The pathogenesis is very obscure, and needs further investigation.

Antenatal treatment suggested.

$KClO_3$. Fe. and Potass. Strychnini, and proper dieting.

If endometritis treat it: During labour may be difficulty from large fœtus; after labour danger from exhaustion, hæmorrhage and sepsis; hence careful use of antiseptics is necessary.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Gluteal Abscess due to Foreign Body.

By Peyton Beale, F.R.C.S.

Amongst the out-patients was a man, æt. 40, complaining of a hard and very painful swelling in the left gluteal region about in a position corresponding to the great sacro-sciatic notch. The history was that he had noticed pain in his pelvis about eighteen months previously, and that the pain had gradually spread downwards towards the buttocks; for the last fortnight only had the pain in this latter situation been severe. On examination there was found to be a swelling about the size of a tangerine orange apparently situated beneath the gluteus maximus and corresponding to the position of the great sacro-sciatic foramen. The skin over the swelling was very red and brawny, and surrounded by an area of œdema. It was obvious that the swelling was an abscess, but as the patient absolutely refused to have anything done to it on that day, a hot carbolic fomentation was applied and the man advised to come up two days later on a Saturday to have the abscess opened. He stated that if it were done on Saturday afternoon he would be able to rest that night and on Sunday. When he appeared on the Saturday there was a soft spot, showing that the abscess was pointing. With the usual preparations, it was opened, and the main cavity was found to be beneath the gluteus maximus, and possibly partly beneath the medius. On inserting a probe no track could be found extending either towards the rectum or through the sciatic foramen into the pelvis. On pressing the walls of the abscess to squeeze out the contents, a solid body was suddenly extruded; when this was washed it was found to be a much-swollen whole pearl barley seed. The cavity was washed out with lotion and a small gauze drain inserted. Mr. Beale said that there was no doubt about the pearl barley seed being the foreign body which was the cause of the abscess; the question was: Where had it come from? The most reasonable explanation was that it had come from the rectum, perforating its wall and forming a peri-rectal abscess which had burrowed. This, however, was extremely unlikely, for such abscesses invariably followed the line of the rectum and pointed as ischio-rectal abscesses. The unlikely but at the same time probable cause of the trouble was that the patient had, months ago, suffered from an attack of appendicitis, the pearl barley seed having been a foreign body within the appendix. Of this attack, however, there was really no definite history to be obtained beyond the fact that about eighteen months previously the patient had suffered from severe abdominal pain of about a week's duration. Mr. Beale was inclined to believe that the patient had really had acute appendicitis with a localised abscess into which the seed had passed, and had then made its way down behind the peritoneum into the pelvis, passed through the great sacro-sciatic foramen accompanied by pus, which had then pointed in the gluteal region.

OPERATING THEATRES.

CHILDREN'S HOSPITAL, PADDINGTON GREEN.

Operation for Ruptured Liver.—Mr. Arthur Edmunds operated on a child, æt. 7, who had been admitted three days previously with the following history: The patient had been hanging on at the back of a cart by his hands and had slipped, falling prone into the roadway; he was picked up and taken home not much the worse for his accident, and subsequently, some hours afterwards, brought to the hospital. The child was slightly collapsed, but there was nothing in his condition to suggest need for any immediate operation. In view, however, of possible future developments he was admitted to the ward for observation. His condition for two days remained about the same. There was no rise of temperature, no distension of the abdomen, no melæna, and nothing to indicate injury to the thorax or its contents; his liver dulness was normal. Mr. Edmunds was called to him late on the third night after admission, and found that his condition was becoming grave. The child was pale, his respirations a little hurried, his pulse quickened. His abdomen moved normally, was only slightly tender, but it was beginning to become distended, and his liver dulness was absent; otherwise percussion of the abdomen showed nothing abnormal. The train of symptoms, Mr. Edmunds said, presented one or two difficulties from the standpoint of diagnosis. The two great abdominal accidents, hæmorrhage, rupture of the bowel, and peritonitis, had to be considered. The accident might have produced either. The mobility of the abdomen was against peritonitis, but the loss of liver dulness was highly suggestive of some perforation of the bowel; this symptom was one to which a varying degree of importance was ascribed. It was certainly true that loss of liver dulness does not necessarily imply free gas in the peritoneum, but when the liver dulness disappeared under observation, its diagnostic significance was much greater. It indicated either free gas in the peritoneum, or some dislocation or distension of the colon. The child's condition was, on the whole, suggestive of hæmorrhage. It was, however, quite obvious that the condition was not clearing up under expectant treatment, and that laparotomy was inevitable. The abdomen was opened accordingly through the right rectus, this site being chosen on account of the loss of liver dulness. On incising the peritoneum, there was a little free serum, but obviously no peritonitis. On separating the coils of the intestine, free blood was found, therefore the spleen was rapidly examined and found to be intact. The anterior surface of the liver was also seen to be normal, but on passing the hand down into the right hypochondrium there was a furious gush of blood. A transverse incision was quickly carried through all the structures of the abdominal wall at right angles to the original opening, and a long roll of gauze packed as quickly as possible into the corner of the abdomen from which the blood seemed to be coming. This arrested hæmorrhage temporarily, so that Mr. Edmunds was enabled to clear the field of operation and investigate the exact state of affairs. An examination was made of the other organs of the abdomen, but nothing abnormal was found. It was obvious, Mr. Edmunds pointed out, that there was a tear in the liver towards its posterior surface, the liver being partially torn from its attachments to the diaphragm. On removing the packing this opinion was confirmed, and the hæmorrhage was arrested by firm packing into the right hypochondrium between the liver and the diaphragm. The point of interest was, Mr. Edmunds remarked, the long time which elapsed between the accident and the onset of grave symptoms. In arterial hæmorrhage the blood pressure is sufficient to overcome a very considerable resistance to the extravasation of blood, but in venous hæmorrhage very slight pressure will temporarily arrest the bleeding. In rupture of the spleen, for example, one has seen a series of attacks of hæmorrhage following slight movements; as long as the patient is kept perfectly still no hæmorrhage occurs; but the slightest movement relieves the bleeding spot of the pressure of the adjacent viscera and re-starts the hæmorrhage. In the present case, no doubt, the liver had been in contact with the posterior abdominal wall, and had automatically checked the hæmorrhage by its own weight; some movement had apparently caused the liver to fall away from this position and re-started the hæmorrhage. It was probable, he thought, that the displacement of the liver was the cause of the loss of liver dulness. The wound had to be left open and the packing was removed on the third day, and no hæmorrhage followed. The wound ultimately healed, and the boy is now well. He has a hernia over the incision, but it causes him no trouble, and it can well be left for treatment later.

TRANSACTIONS OF SOCIETIES.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, FEBRUARY 14TH, 1907.

R. W. DOYNE, F.R.C.S., Vice-President, in the Chair.

THE evening was devoted to the discussion of Clinical cases.

Mr. **LUDFORD COOPER** showed a case of Paralysis of the vertical movements of both eyes. The patient was a man in whom there was complete paralysis of the vertical movements of both eyes, which had come on suddenly and for which no explanation could be found.

Mr. **J. H. FISHER** had seen two similar cases, one in a girl, who was found one morning unconscious, with this paralysis. She recovered consciousness rapidly, but the paralysis persisted for a long time. The explanation he then gave was an embolism of one of the small arteries of the Corpus Quadrigeminum. The other case showed hemianopic pupil reaction, without a hemianopic field, a condition never before recorded, and *post mortem* a diffuse growth of the Lamina Quadrigemina was found.

Mr. **A. STANFORD MORTON** showed a case of a man, æt. 54, who, two years previously received a steel foreign body in his right eye. The sight of this was immediately affected. About a month later the sight of the left began to fail, and within three months was almost completely blind. Now the right eye showed typical siderosis, with atrophy of the nerve. The left eye showed a similar condition of the disc, the atrophy being of the post-neuritic type; there was marked arterial sclerosis in both eyes. The left pupil showed the Argyll-Robertson reaction. No sign of central nervous disease could be found.

Mr. **MALCOLM L. HEPBURN** showed a case of a man æt. 61, with polychoria associated with chronic glaucoma. The sight of the right eye had become dim recently, though for the last three years he had noticed coloured rings round the lamps; he had had no pain. The left eye was normal in every respect. The right eye showed an unusual appearance of the iris which he stated had been present from birth. There was a complete pupil placed down and in, which reacted to light, while the part between the pupil and the periphery was made up of 5 triangular-shaped bands of pigmented iris tissue, with their bases towards the angle. These bands enclosed clear spaces through any of which the details of the fundus could be plainly seen. In addition to these bands an almost complete circular stump of pigmented tissue was visible at the angle of the anterior chamber, in which the bases of the different bands were lost. The patient stated that the pupil used to be in the centre of the eyeball, but of late years it had gradually come to occupy its present position. The fundus showed glaucomatous cupping of the disc. The case was interesting from a developmental point of view, and two explanations were possible. One that the iris was originally complete, and by subsequent atrophy, as the result of inflammatory action or otherwise, had partially disappeared. The other was a faulty development, which was difficult to understand, since the pupil was perfectly formed. Mr. Treacher Collins suggested as a possible explanation the failure of the formation of some of the loops of vessels which go to form the iris.

Mr. **WAREN TAY** showed a drawing of an eye from a case of tuberculosis, which was only diagnosed after an ophthalmoscopic examination had been made. This occurred 22 years ago. He showed this in order to disprove the statement of an eminent physician who stated that this had never been done.

Mr. J. H. **TOMLINSON** showed a retinoscopy longarm to facilitate the practice of retinoscopy in children.

Mr. **HALLIBURTON MCMULLEN** showed a case of detachment of the retina cured by scleral punctures.

Other cases were shown by Messrs. G. W. Thompson and G. H. Pooley.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF ANATOMY AND PHYSIOLOGY.

MEETING HELD FRIDAY, JANUARY 25TH, 1907.

The President, A. F. **DIXON**, M.B., in the Chair.

THE MUSCULATURE OF THE VILLI.

MR. F. O'B. ELLISON (introduced by the President) presented a note on the above. He pointed out that the villi of the dog are club-shaped, not pointed or cylindrical, as is generally described, and as is the case in the cat. This club-shaped extremity contains a large quantity of smooth muscle which is not connected with the muscularis mucosæ. The latter consists of three layers—outer longitudinal, middle circular, and inner longitudinal. The fibres derived from the muscularis mucosæ in the cat pass round the glands of Lieberkühn, and form a sort of sphincter for the latter. A number of microscopic sections of villi were shown in illustration of the points indicated, and one of the specimens showed compound villi.

Professor W. H. **THOMPSON** said that the appearance of round spaces with transverse sections of muscle in the first section shown would come to some of them as a revelation of the amount of muscle that could be present in villi. When the specimen first turned up he thought these were engorged capillaries filled with blood, but careful examination would convince anyone that this was not so, and they would find undoubted evidence that they were muscle fibres. He had shown the section to certain examiners in London; at first they said they were blood capillaries, but they afterwards agreed that such was not the case. Further facts that Mr. Ellison had made out made it exceedingly probable that there was far more muscle in the villi than came up from the muscularis mucosæ. If so, it would make the working of the villi a mechanical process about which there would not be very much mystery. The investigation, however was not complete.

The **PRESIDENT** expressed the hope that research in the same direction would be continued. It was probable that as much difference would be found between the specimens shown and the villi of the human subject as there was between those of the cat and dog.

THE ESTIMATION OF UREA IN URINE, AND THE ESTIMATION OF HYDROXYBUTYRIC ACID IN URINE.

Mr. **WM. CALDWELL** (introduced by the President) read a paper on the above subject.

Mr. Caldwell then communicated a series of notes detailing the process by which he had succeeded in producing through the interaction of triethylphosphine with monochloracetal and monochloraldehyde a new chemical compound—triethylphosphine chloraldehyde or "phosphorus muscarine." Triethylphosphine combines with monochloracetal to give $(OC_2H_5)_2$. CH. CH_2. P $(C_2H_5)_3$. Cl., triethylphosphine-monochloracetal, which, on treatment with concentrated hydrochloric acid, yields the aldehyde CHO. CH_2. P$(C_2H_5)_3$. Cl., triethylphosphine-chloraldehyde. Monobromacetal likewise combines with triethyl phosphine. Monochloraldehyde unites with triethyl phosphine, with the production of a syrup having a beautiful green fluorescence. The syrup placed *in vacuo* over sulphuric acid crystallises in a few days. Monobromaldehyde also combines with triethylphosphine, forming a crystalline compound. The structure of these compounds is CHO. CH_2. P $(C_2H_5)_3$ X., where X denotes chlorine or bromine. The salts of this compound have been prepared, and their properties are being studied. On account of the similarity of structure of this compound to the corresponding nitrogen compounds, and inasmuch as muscarine occupies an intermediate position to choline and betaine it is proposed at the present to name this compound phosphorus muscarine.

The **PRESIDENT** exhibited a series of sections and X-ray photographs of the upper end of the femur to illustrate the arrangement of the cancellous lamellæ and of the structure known as the calcar femorale. The calcar femorale was shown to represent the posterior aspect of the bent upper end of the tubular femur. The bent portion of the tubular bone becomes oval in transverse section. In the young bone, what is afterwards the calcar forms the posterior surface of the neck, but, with the development of the trochanters and the projections for muscular attachments this part of the surface is covered over and comes to lie deeply, remaining, however, visible in section. When carefully examined in sections the outer and upper part of the lamellæ forming the calcar are seen to bend forwards so as to become continuous with the lamellæ which mark off the great trochanter and which form the upper and outer part of the neck of the tubular bone. In the young bone, before the great trochanter has become united, these lamellæ also form a part of the surface. The spirally-arranged supporting lamellæ, formerly described by Dr. W. S. Haughton and the author, are attached in right and left-handed spirals to the deep aspect of these sunken parts of the surface of the neck of the bone, in precisely the same manner as to the other parts of the inner aspect of the hollow shaft and neck. The tubular nature of the neck and the disposition of the spirally-arranged supporting lamellæ are well seen in X-ray photographs. Further, the arrangements of the parts as seen in photographs and in sections can be reproduced in a model constructed with right and left-handed spirally-arranged thickenings, placed within a tube and bent in the same manner as the upper end of the femur. The calcar femorale and the lamellæ which mark off the great trochanter are parts of the surface in the young bone, and in the adult they form parts of the physiological surface of the bent portion of the femur, considered as a structure through which the weight of the body is transmitted. Hence the lamellæ of the cancellous tissue which fill the neck of the bone are attached to them in a manner similar to that in which lower down they are attached to the inner wall of the upper part of the shaft.

Prof. E. P. **M'LOUGHLIN** said that the communication threw quite a new light on the significance of the calcar, and the sections showed this structure to be very much more extensive than has been generally described.

TWO ADULT MALE SUBJECTS CUT IN THE LONG MEDIAN PLANE.

Prof. **FRASER** exhibited the above. One had been cut four or five weeks previously, and the other, an ordinary injected dissecting-room subject (not specially prepared), the day before the meeting. The latter formed an object-lesson in the description of the hollow abdominal viscera, having the largest stomach that he had ever seen. It was equably dilated from cardiac to pyloric orifice. It had distended the right and left aspects of the body wall, and appreciably diminished the size of both liver and spleen. He referred also to the varying relations of the ventral aorta to the sternum, to the presence of the embryonic cranial flexure in the adult, which did not cease with the bony dorsum sellæ, but extended as soft supporting tissue to the roof of the fossa inter-peduncularis, a point which had great significance in the numerous measurements of the skull. He also drew attention to the variations in the distance between the perineal skin covering and the posterior extension of the body cavity in both male and female, and more particularly in the young. These sections were very instructive, and much appreciated by students in the ordinary dissecting-room teaching.

BRITISH BANEOLOGICAL AND CLIMATOLOGICAL SOCIETY.

MEETING HELD WEDNESDAY, JANUARY 30TH.

The President, H. SHIRLEY JONES, Esq. (Droitwich) in the chair.

Dr. **C. W. BUCKLEY** (Buxton) introduced a discussion on the

INFLUENCE OF CLIMATE ON GOUT AND RHEUMATISM.

He said that gout was affected by climate so far as the functions of the liver and excretory system, comprising both kidneys and skin, were concerned. In patients who were fairly robust and without high arterial tension or arterio-sclerosis, a bracing climate was desirable; humidity should be low and temperature fairly equable. In cases with high tension a more relaxing climate is best, and inland climates are generally better than marine. The south-eastern counties show a remarkable excess of gout in comparison with other parts of the country, partly explained by the class of population, and perhaps partly by the chalky character of the water. Acute rheumatism was not affected by climate except so far as unfavourable climatic conditions might lower the resistance of the system to infection. Muscular rheumatism and kindred conditions which were best described as fibrositis were unfavourably influenced by a high humidity, and especially by a damp soil, but temperature was of less importance, equability being more essential than warmth. Free air access was important, and stuffy hollows to be avoided. For the foregoing diseases there did not appear to be any advantage in sending the patient abroad. In rheumatoid arthritis, however, the desirable combination of warmth, equability and low humidity was hardly attainable in this country, though low humidity was still the most important factor. Probably the best climates in this disease were those of the Grand Canary, Teneriffe and Bermuda.

Dr. **GROVES** (Isle of Wight) expressed general agreement with Dr. Buckley's views, and pointed out the unreliability of statistics in determining the effect of climate upon the diseases in question. For those of early middle and later life suffering from or having a tendency to rheumatic and gouty affections, an equable climate with a marine atmosphere, not too humid to admit of free diaphoresis in connection with exercise in a locality sheltered from cold winds, is the most suited.

Dr. **PERCY LEWIS** (Folkestone) held strongly the view that chalk in drinking water had nothing to do with the causation of gout. Gout and rheumatism were considerably more a matter of the habits of individuals than of the climate in which they happened to reside.

Dr. **BEGG** (Bath) considered the influence of climate comes down to a question of wear and tear, and its ability to lower the resisting power of the organism to disease, and in that way alone can it influence. He thought of climates as divided for clinical purposes into two classes: (1) the bracing, (2) the relaxing or sedative, and his principle of applying them to cases was that which governs his administration of stimulants. When he would use malt liquors and nourishing port, he advised a sedative climate, and when champagne and spirts, he recommended a bracing one; when he wanted to build up a reserve force, the sedative, and where he wished to influence metabolism, the bracing.

Dr. **LEONARD WILLIAMS** did not believe in the existence of a disease which could be properly called chronic rheumatism. Most of the cases so described were chronic gout or some septic form of arthritis. Goutily disposed people were better in bracing climates, those with definite gouty manifestations in kidneys or arteries ought never to be sent to bracing climates, but always to relaxing ones.

Dr. **TYSON** (Folkestone) said that until we knew more about the etiology of rheumatism we must adopt such clinical methods as have been found more or less useful, such as a dry climate, as much sun as possible, and attend to the general laws of health, as regards clothing, proper ventilation, and suitable foods.

Dr. **JOHN LEON** (Southsea) agreed that patients should be instructed how to adapt themselves better to the place in which they happened to live. He thought that gout (apart from renal changes) was little affected by climate. In Southsea, arthritic patients generally did well owing to the equable climate.

Dr. **F. THOMPSON** (Bath) said that during a residence in Oporto, among a community where port wine is freely indulged in, he was struck with the comparative rarity of gout, both acute and chronic. This he attributed largely to the effect of the warm climate causing constant free action of the skin. He considered warmth of locality to be an important factor in the climatic treatment of gout.

Dr. **BUCKLEY**, in reply, said he was in agreement with Dr. Groves as to the importance of humidity due to ground water, and was very glad to hear Dr. Tyson's interesting proof of this. He considered it was a matter worthy of more investigation. He still believed that chalky water had an influence in gout, and also that it is absorbed from the alimentary canal. As to sunshine, he also maintained that its influence in rheumatism is purely psychical, but in rheumatoid arthritis he thought it might be of more importance. He feared he did not make sufficiently clear that he drew a decided distinction between acute rheumatism and fibrositis, as he felt sure that he was really in agreement with some speakers who criticised him on this point, but on the subject of chronic rheumatism he was very glad to hear that Dr. Thompson agreed with him that there was most certainly an arthritic condition to which the term may be applied without confusing either rheumatoid arthritis, gonorrhœal, or any other form of rheumatism. The report on the prevalence of the diseases dealt with from the Lancashire coast bore out much that he said.

Dr. **GEO. THOMPSON** (Buxton) said that year after year he noticed that many gouty patients came to Buxton from the south-eastern counties and generally complained of the chalky water. He noticed that many cases of a chronic rheumatic arthritis at the Buxton Hospital came from certain humid districts—from valleys, from river districts, from the Fen district and from Ireland.

Dr. **HEANEY** (Blackpool) said Blackpool and district had a climate of high average humidity and a very low mean temperature: the country was flat and winds constantly prevailed. Chronic rheumatic arthritis occurred with great frequency. But acute rheumatism was almost unknown there owing to the fact that in a frequently renewed atmosphere acute rheumatism, like other infective diseases, is less likely to occur. Gout was very rare indeed on the West Coast of Lancashire.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Meeting held February 1st, 1907.

Mr. L. A. Bidwell, F.R.C.S., in the chair, in the absence of the President, Dr. L. A. Mark.

The following pathological specimens were shown.

The President: Drawings from specimens of cancer of the tongue.

Dr. Coutts: (*a*) Congenital malformation of the heart; (*b*) Purulent pericarditis; (*c*) tuberculous pneumothorax; (*d*) sarcoma of the bladder.

Mr. J. Pardoe: (*a*) Calculi in both kidneys and ureters; (*b*) malignant growth of bladder invading iliac vessels; (*c*) malignant hype nephroma.

Dr. Lionel Provis: (*a*) Fibroma of ovary; (*b*) adeno-myoma of uterus with microscopic sections.

Dr. Chisholm Williams: X-ray photographs and lantern slides of patients treated by X-rays.

Dr. David Arthur: Skiagraphs and orthodiagraphic tracings of cases of aneurysm and heart disease.

Mr. Cecil Leaf: (*a*) Cyst of the breast with intracystic growths; (*b*) multiple cystic tumour of the breast.

Mr. Aslett Baldwin: (*a*) Enlarged fasciculated bladder due to enlarged prostate; (*b*) appendix containing a mulberry calculus; (*c*) large gall-stone causing intestinal obstruction.

Dr. Macnaughton Jones: A collection of specimens of uncommon uterine and ovarian diseases.

Dr. E. F. Travers: An early vesicular mole.

Dr. J. M. Bernstein: (*a*) Phlegmonous gastritis; (*b*) Chorion epithelioma of the testis; (*c*) tissues invaded by Bilharzia. and other specimens.

Dr. Adamson: Cultures and micro-photographs of ringworm.

Dr. Norman Meachen: Microscopic specimens of Leucotrichia annularis (ringed hair).

Dr. Eddowes: (*a*) Microscopic specimens of gout of the skin; (*b*) microscopic specimens of diplococci of Denne and Dahnhardt.

Mr. Percy Dunn: (*a*) Glioma of the retina; (*b*) sarcoma of the upper lid; (*c*) staphyloma of the cornea.

Mr. E. D. Shaw: Carcinoma of testis with secondary deposits in glands and liver.

Dr. G. C. Low: (*a*) Plasmodium of malaria; (*b*) Filaria; (*c*) trypanomiasis, specimens of morbid anatomy.

Dr. J. H. Dauber: Specimens of uterine, ovarian and tubal disease.

ULSTER MEDICAL SOCIETY.

Meeting on February 7th, and adjourned Meeting on February 14th, 1907.

The President, Dr. D. P. Gaussen, in the Chair.

DISCUSSION ON CEREBRO-SPINAL MENINGITIS.

Professor Symmers opened the discussion by describing the *post-mortem* appearances in five cases which he had examined. In a typical case, which had died after two or three days' illness, the whole surface of the brain was found bathed in pus. The internal appearance of the brain was normal. In all cases there was a distinct pericarditis, and endocarditis in none. In two there was suppurative pericarditis. In the small intestine, and specially in its lower part, there was in every case undue hyperæmia, and distinct enteritis in two. The mesenteric glands were greatly enlarged, a point to which he called special attention. He found hyperæmia of the pelvis of the kidney, and signs of pyelitis in most cases, and extraordinary hyperæmia of the bladder in one. In one case an organism like the meningococcus was found in the mesenteric glands, suggesting the possibility that the child had died from disease spreading from the bowel. The meningococcus was almost identical both microscopically and on culture with two other organisms, the gonococcus and the micrococcus catarrhalis, the latter being found in the nose. Though generally considered as not staining by Gram's method, there was some reason to believe that it might so stain when the specimen was young and vigorous. It is exceedingly difficult to cultivate. It is found easily in the pus, but never in the blood. It is never found in animals, and as regards insects there is no positive evidence, though Dr. Turner, a South African writer, thinks he has found it in fleas. As regards the serum we lack knowledge as yet; it is difficult to see how it can be prepared from an organism so difficult to cultivate, or how it can be standardised when it is not infective for animals.

Dr. Robb (physician to the Fever Hospital), said it was too early to generalise, and all he could do was to describe the epidemic so far as he had seen it. They had had 37 cases admitted to hospital, of which 16 had died, and some more were very ill. In the first family affected, five members were admitted in four days, and of the next family five members were taken ill in less than twelve hours; four died in 30 hours, and the last ten days later. In two cases two members of a family were affected close together. In general characteristics the epidemic was more like one of acute pneumonia than anything else he had seen. One-third of the cases were of the acute fulminant type. König's sign was marked in practically all. There were no convulsions, and when death occurred it was from cardiac failure. In all the severe cases there was delirium, in some quite maniacal. The pupils were dilated in nearly all. The glands were enlarged and "shotty." Petechial spots were not common. Eye symptoms were not common; he had seen nystagmus twice and squint twice.

Professor Lindsay confined his remarks to a brief description of a case.

Dr. Calwell described two cases, leaving the most striking symptoms of one of them, the eye and ear symptoms, to be described by Dr. Cecil Shaw.

Dr. McCaw described five cases, most of them seen in the Belfast Children's Hospital. He also described several cases seen last autumn, which he now believed were cases of this disease. He did not believe in the contagiousness of the disease as generally accepted.

Dr. Cecil Shaw, who was absent owing to an attack of influenza, sent his notes to the hon. secretary, Dr. Howard Stevenson, who read them. They will be found in full on page 203.

Dr. Dempsey had seen four cases, and spoke specially of the differential diagnosis, which he thought was from acute pneumonia and typhoid.

Dr. Austin said he had seen the first case of the present epidemic, and had at first considered it one of ptomaine poisoning, as the patient had eaten largely of tinned salmon. There was a profuse purpuric eruption.

Dr. A. B. Mitchell spoke of the differential diagnosis from such affections as abscess of the brain. Drs. Darling, McKisack, Burns and O'Neill also spoke, and in the absence of Professor Symmers, Dr. Robb closed the discussion.

Vote of Condolence.—A vote of sympathy with the Rev. Dr. Graham, of Comber, co. Down, on the death of his son, Dr. R. A. L. Graham, was passed at the conclusion of the meeting.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Feb. 17th, 1907.

Treatment of Sweating.

It is calculated that the average quantity of sweat evaporated from the body (in perceptible perspiration) in the normal state is about one pint. More marked in general on one side of the body, it shows itself with greater intensity in certain regions, such as the palms of the hands, etc. It is alkaline in its reaction, but can become acid by reason of fatty acids, and this acidity increases with organic combustions, but diminishes with the abundance of the secretion. Sweat is colourless, of a saline taste, and characteristic odour, which varies with individuals.

The secretion is stimulated under the influence of divers causes: elevation of the surrounding temperature, a considerable proportion of water in the blood, increase of cardiac activity and contraction of the blood-vessels, muscular exercise, effect of certain medicinal agents (pilocarpine, strychnine, camphor, preparations of ammonia). There exists a certain antagonism between perspiration and the urinary secretion.

Where the perspiration is excessive and persistent it becomes a morbid symptom, and belongs to the domain of therapeutics.

Sweating is either general (hyperhidrosis) or local (ephidrosis), and is either, says Professor Weber, idiopathic or symptomatic. As an isolated symptom it comprises all the varieties of partial sweats, and one very frequently occupying all the parts of the body—face, scalp, axillæ, groins, genital organs, palmar and plantar regions.

Facial ephidrosis accompanies sometimes migraine, facial neuralgia, or simple mastication. Perspiration of the head is observed in arthritic or gouty individuals, and can be one of the causes of early baldness. In the bend of certain joints the sweating provokes frequently irritation (intertigo) of the skin, as well as beneath the breasts in stout women. Excessive perspiration of the legs would be, according to Verneuil, a good sign in varicose veins.

In palmar ephidrosis the hands are cold and clammy, the patient is generally neurasthenic, but the same phenomena can be observed in incipient phthisis or in certain syphilitic women (secondary period).

Plantar ephidrosis is perhaps more frequent still, and almost always accompanied with a fetid odour, especially in red-haired individuals (bromidrosis).

In symptomatic sweating the sweat appears over the whole body. When very abundant it is accompanied by eruptions (erythema, sudaminæ) or intolerable itching.

In certain febrile affections, the perspiration is very abundant, and notably in that curious malady known as the sweating sickness, where the miliary eruption is general; its termination is announced by an abundant emission of urine.

Generally speaking, perspiration accompanies the defervescence of the febrile condition, but it can be provoked by the treatment employed (antipyrine, phenacetine, diaphoretic infusions).

On the other hand, it can constitute one of the symptoms of certain maladies, of which acute articular rheumatism holds the first place. Here hyperhidrosis is frequently very excessive, prolonging convalescence.

Sweating represents a crisis or turning point in many maladies, such as pneumonia, erysipelas, mumps, eruptive fevers, grippe, cerebro-spinal meningitis, chronic pulmonary tuberculosis.

Hyperhidrosis is observed in all cachectic conditions: uræmia, cancer, ataxy, infantile paralysis, and, above all, phthisis.

The treatment, says Professor Weber, of idiopathic sweating is very complex. As it generally belongs to persons of a nervous temperament, bromides, antispasmodics, hydrotherapy in all its forms should be employed.

Where the perspiration is observed in the course of a febrile affection, it should be respected in general, as it represents a providential emunctory, and in any case it is not very abundant, except in sweating sickness, when it plays a preponderating rôle.

Certain medicinal agents are specifics against sweating, quinine for that observed in ague, and salicylate of soda for that of acute rheumatism. But, on the other hand, the sweating resulting from cachexia is almost rebellious to all treatment. Tonic treatment of the system when possible is about the only remedy.

Generally speaking, as soon as the perspiration, by reason of its abundance, is capable of weakening the patient, the patient will be advised to change his linen, or even his clothes, to avoid refrigeration of the body from its rapid evaporation, and to rub his body immediately afterwards with a spirit lotion (lavender or eau-de-Cologne), and finally, if erythema be present, to powder with talc or starch.

As to drugs employed, their efficacy varies more or less. Those most prescribed are atropine ($^1/_{200}$), given every two hours in pills or tabloids up to five or six a day if necessary, agaric, camphoric acid. The atropine should be closely watched, as in some patients it produces toxic effects.

M. Weber recommends the following formulæ:—

Agaric, dr. 1.
Extract of opium, gr. 8.

Divide into 40 pills; 2 or 3 at night.

Or,

Tellurate of soda, gr. 2.
Proof spirit, oz. 2.

A teaspoonful morning and evening in sugared water.

This drug communicates an odour of garlic to the breath. It has been also accused of making the hair fall.

Or,

Camphoric acid, gr. 30.
Proof spirit. q.s.
Syrup of orange, dr. 4.
Water, oz. 2.

A teaspoonful to be taken two hours before the evening meal.

Or,

Ergotine, gr. 10.
Tannate of quinine, gr. 10

Divide into 20 pills; 2 or 3 in the evening.

Or,

Oxide of zinc, gr. 4.
Extract of belladona, gr. $^1/_5$

For one pill; 3 daily.

Perspiration of the hands and feet:

Hands:—

Borax, dr. 4.
Salicylic acid, dr. 4.
Boric acid, dr. 1.
Glycerine, oz. 2.
Proof spirit, oz. 2.
Water, oz. 2.

Rub the hands three times a day.

Feet:—

Fœtid sweating of the feet is very difficult to cure. General treatment is necessary (arthritism, lymphatism, anæmia, etc.). The patient should bathe the feet twice a day in an alum bath, to which is added half an ounce of borax and a tablespoonful of tincture of benzoin, besides which he will paint the toes with naphthol and glycerine (5 per cent.), and powder his stockings with—

Talc, oz. 2.
Subnitrate of bismuth, oz. 2.
Permanganate of potash, dr. 1.
Salicylate of soda, dr. ½.
Tannoform, dr. 2.

GERMANY.

Berlin, Feb. 17th, 1907.

AT the Verein für Innere Medizin, Hr. P. Fraenkel spoke on

POISONING BY LYSOL.

He said that very few opportunities occurred of obtaining preparations of poisonings by lysol, as when medical aid was at all timely, by far the greater number of cases recovered. He was in a position to show a stomach from a case of lysol poisoning. It was one in which nothing had been done for the patient, so that the changes produced by the poison were not influenced artificially. There was a great resemblance to poisoning by carbolic acid, only the soapy character of the mucous surface of the stomach and the alkaline reaction were the distinctions between the effects of the two poisons. Cauterisation of the stomach was frequently only superficial, but it was also often serious, and reached into the duodenum and jejunum. Sometimes no cauterisation at all was met with, notwithstanding a fatal termination, a proof that it played only a subordinate *role* in the poisoning.

Hr. Ewald spoke on

ULCERS OF THE STOMACH AND GENERAL CARCINOMA.

He said that the diagnosis of cancer of the stomach had now reached the "dead point"; the ordinary means of recognition were exhausted. With the large material that was at his hands, however, there were still cases that, from their atypical behaviour, were of interest, such as the following :—A woman, æt. 35, had typical hæmorrhage of the stomach at her nineteenth and thirty-second years. She had, however, completely recovered from her last attack, when in July last she began with pain and loss of appetite, with subsequent extreme loss of vigour and loss of weight, so that when admitted into the Augusta Hospital, the patient, who was a slightly-built woman, only weighed 27.4 kgm. Examination showed ptosis of the stomach, the lower border of which lay a hand's breadth below the umbilicus ; there was no palpable tumour, no glandular swelling. There was slight dulness over the base of both lungs posteriorly, vesicular breathing, slight rales, sputum was scarcely expectorated at all ; no tubercle bacilli were found in the small quantity that could be obtained. There was plenty of free hydrochloric acid in the stomach. A diagnosis of ulcer of the lesser curvature was made. During her stay in hospital, from December 24th to January 30th, 1907, the patient got steadily weaker, although her weight increased to 28.8 kgm. Towards the end of life the peculiar kind of breathing called by Kussmaul "grossesathem," or "big breathing," such as is observed in diabetic coma, came on. The patient died on January 30th. The autopsy showed deep falling of the transverse colonr, at the upper part of the stomach, which was placed vertically, was an hourglass contraction, and an ulcer on the lesser curvature. There were, moreover, cancerous metastases in all the abdominal organs ; the pancreas especially was full of them (no sugar had been found in the urine), and the lungs also. There were a number of cancerous nodules in the thoracic duct, probably a result of the transference of cancer material into the lungs. Possibly the case was one of primary cancer of the pancreas, and possibly also there was a slight cancerous degeneration of the gastric ulcer. During life there had been no symptoms of this, even if the rapid falling off of the patient's strength had pointed to it ; there was no lactic acid in the stomach, however, but on the contrary, copious free hydrochloric acid. The fever was not the hectic of cancer, but due to bacillary toxæmia.

At the Medical Society, Hr. G. Klemperer related a case of

SEPSIS FOLLOWING PYONEPHROSIS.

The patient had been brought into hospital ten days before under suspicion of typhoid fever. He was æt. 26, slightly feverish, heavy and dull ; he had free diarrhœa and meteorism. Besides this, there was dribbling of urine, which was mixed with pus. On the second day there was swelling of the right elbow-joint. A diagnosis was formed of sepsis following cystopyelitis. The patient's heart gradually failed, and he died. The autopsy revealed pronounced sacculated kidney (pyonephrosis) resulting from a large renal calculus. It was remarkable that but very slight symptoms had been set up by the calculus, and that then formidable symptoms of sepsis had suddenly developed. The calculus was formed of phosphates. This kind of calculus was not, therefore, so harmless as it was generally considered to be.

Hr. Westenhoeffer showed (and also at the Verein für Innere Medizin, on the 4th inst.) preparations from a case of

MENINGOCOCCOUS PHARYNGITIS.

A little girl, æt. 6, had died of typical epidemic cerebrospinal meningitis. At the autopsy the meningococcous pharyngitis described by the speaker was distinctly visible, and which was present in every case in the initial stages of the disease.

AUSTRIA.

Vienna, Feb. 17th. 1907.

PAPULOSIS PERSTASIS.

AT the Gesellschaft, Lang showed a young boy, æt. 15, with that disease which appears in literature under different names, such as pityriasis chronica lichenoides, &c., but which Lang considers more appropriately should be designated papulosis perstasis. The disease is somewhat mixed up with pityriasis and psoriasis, which it so resembles at different stages of its history that no clear conception can be formed from these compound terms.

The most interesting part in this case seems to be in the family history, where a sister of the patient had a similar cutaneous affection. The patient has suffered for the last seven years from an exanthematous eruption, varying from the size of a millet-seed to that of a pea, with a papulose appearance and depressed centre surrounded at the base with a reddish efflorescence from which a fine scurf could be rubbed off. This efflorescence was not well defined, but sometimes had a dark margin surrounding it. On the trunk these papules were strewn over in groups where they seem to be largest, leaving behind an atrophic cicatrix. The seventeen-year sister had cicatrices over the body varying in sizes similar to her brother, which were depressed in the normal skin but could be brought easily forward by a little traction ; but if the nail of the finger were again drawn over the part they sink back to their former position. These were white round markings well defined at the margin and having an umbilical appearance in the centre. According to her own history these recent changes occurred about two years ago, following an eruption similar to that of her brother five years previously. Her parents maintained that pustules never formed, and that all forms of treatment proved unavailing, as it has done in her brother just exhibited. It appears from these two histories that this is the turning point between the papular condition and the cicatricial state in which the sister is at present, and which Lang considers the term, papulose perstasis, to justify a full description of the case where it ends in atrophy.

Nobl remarked that the combination of psoriasis and lichenoid diseases were more easily defined than the above. He thought this disease lay more in the direction of a polymorphic eruption coming under the designation of "Pityriasis lichenoides chronica," which were annually becoming more frequent at our clinics.

ARTIFICIAL TEETH ACCIDENT.

Professor Chiari showed a young man, æt. 38, who accidentally swallowed his artificial teeth during sleep, thirty days before seeking any surgical advice. Several symptoms pointed to a foreign body in the œsophagus, but from the history of the case it was thought advisable to examine the canal with the Röntgen rays, when a shadow representing this body was observed behind the sternum, and in front of the spine. After cocainising the throat, an œsophagoscope was introduced ; when 20 cms. below the lower jaw a thick œdematous swelling was observed closing up the lumen, preventing the further passage of the instrument. Again painting the œdematous mucous membrane with cocaine, the instrument was further introduced and brought into contact with the foreign body. A smaller tube was then introduced, the foreign body caught, and the whole extracted without any force or injury to the parts. The teeth measured 4½ cms. in length, and 2½ cms in breadth. Freund related a similar case that he successfully operated on two years ago.

DR. HERBERT WILLIAMS, Medical Officer of Health for the Port of London, in his report, just issued, states that during the past two months twenty cases of beri-beri had been discovered on two vessels on their entering the river. There were 19 cases on the s.s. "Banca," of Sutherland, which came from Kobe and one on the ss. "Ava," of Glasgow, from Rangoon.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

ROYAL COLLEGE OF PHYSICIANS' LABORATORY.—The council of the college have been fortunate in securing the services of Profesor Ritchie, Oxford, as superintendent of the Laboratory. The post has been vacant for more than six months, but this delay is more than compensated for by the announcement made last week. Professor Ritchie's return to Edinburgh will be welcomed by all his old friends, and it is felt that under his guidance the laboratory will again become a very important centre for scientific research.

CEREBRO-SPINAL MENINGITIS.—On February 12th the Local Government Board issued a circular requesting medical officers of health to report to them any cases of this disease which came under their notice, and offering advice and assistance where necessary. The board also advises that cerebro-spinal fever be made a notifiable disease for a limited period. According to corrected figures given by the superintendent of the Statistical Department, Register House, there have been, during January 1907, 66 deaths in Glasgow, 5 in Edinburgh, 1 in Paisley, and 2 in Leith. Since last May there have been 147 deaths in Glasgow from the disease. During the past week one or two more cases have occurred in Edinburgh, but the total number in this city is quite out of all proportion to the amount of attention which has been paid to the outbreak in the public press.

BELFAST.

CEREBRO-SPINAL MENINGITIS.—One or two new cases of this disease have been notified each day lately, but there has been no rapid spread of the epidemic. In all about 80 cases have been notified, with a mortality of 58 per cent. The affection has been made notifiable in all the districts round the city, and it is hardly likely that any cases can now escape the eye of the authorities.

TYPHOID AND THE WATER SUPPLY.—On the 13th inst., Professor Symmers wrote to the Public Health authorities saying that he had found in two samples of tap water which they had sent to him for examination an organism in every way identical with the bacillus of typhoid, so far as he had been able to carry his investigations. As a number of cases of typhoid have lately occurred in the district from which these samples of water were taken, the report has naturally caused considerable alarm. The Water Commissioners have telegraphed for their analyst and bacteriologist, Professor Frankland, to hold a consultation with Professor Symmers, and, meantime, the Public Health authorities have issued placards advising us to boil all water and milk before use.

DEATHS IN THE PROFESSION.—Two medical men have passed away during the past week, both sincerely mourned, but as wide as the poles asunder. One was the type of good old country practitioner, Dr. John Dysart, of Portglenone, Co. Antrim, who died in his 87th year, after sixty-four years in practice—a record not often surpassed. Dr. Robert A. L. Graham, on the other hand, was the best type of young specialist, a brilliant man, with a brilliant future, as all his friends thought. He graduated in Arts and Medicine at the Royal University, finishing in 1898, then studied in London, Freiburg, and Munich. He obtained the diploma in mental science in 1899, and the next year took the Hutchinson-Stewart Scholarship of £200. He was appointed assistant medical officer at the Belfast Asylum, and Demonstrator of Pathological Neurology in Queen's College. He brought a keen scientific mind and abundant enthusiasm to all his work, and it was always a pleasure to meet him in the College laboratories and talk with him over any medical problem. He was singularly modest and retiring, and it is not too much to say that he was more than liked, he was loved by all with whom he had to do. Three weeks ago he contracted typhoid, from which he died on February 13.

LETTERS TO THE EDITOR.

AN ANTI-VACCINATION ORATION.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—It must have been a proud moment for Mr. Lupton when he arose on Thursday evening last in the House of Commons to move an amendment to the Address demanding the repeal of the penal clauses of the Vaccination Acts. The Editors of *The Times*, who always give the fullest reports of distinguished speakers, were no doubt filled with dismay when they found that owing to pressure upon their space they could not afford room for more than a meagre summary of what was evidently a deeply reasoned, as well as an eloquent discourse. The curious thing is that not only the statements as to facts, but also the frequent impassioned outbursts were punctuated throughout with "laughter." To us it seems that the speech might almost have made the angels weep. What could be more blood-curdling than the hon. member's denunciation of "the most wicked invention, that of opening a vein, cutting through the skin and putting into it pus from a diseased cow"? Then fancy the levity of hon. members laughing continuously at passages like these:—"The human race had existed for a long time, and they were all proud of its history. They had read of Moses and David, of great conquerors like Alexander and Cæsar, Demosthenes and Cicero, Nelson, Wellington, and Napoleon; and this country claimed the parentage of such men as Spenser, Shakespeare, and Milton. Did any hon. member believe that these men had been vaccinated?" This oration was not needed to enable the world to form a correct estimate of the intellectual calibre of the chief champion of anti-vaccination—he had furnished more than enough evidence already. What, one asks, can be the mental capacity of followers led by chiefs of this quality, and how much consideration do their childish outcries deserve from the Government of a people claiming a front rank in civilisation and enlightenment? I am, Sir, yours truly,

Bradford. ONLOOKER.

THE UNIVERSITY QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The Dublin University Defence Committee have issued the appended Form of Protest for signature by all Graduates of the University. Will you kindly allow us to give it publicity through your columns, and to request Graduates either (*a*) to call at No. 35, Trinity College, Dublin, and affix their signatures; or (*b*) to authorise us by letter to do so on their behalf?

We are, Sir, yours truly,
EDWARD P. CULVERWELL,
EDWARD GWYNN, Hon. Secs.
Dublin University Defence Committee,
35, Trinity College, Dublin.
February 12th, 1907.

FORM OF PROTEST.

I desire to record my protest against the reconstruction of the University of Dublin outlined in Mr. Bryce's speech of January 25th, 1907, which I regard as fatal to the best interests of liberal University education in Ireland, and unjust to Trinity College.

THE FALLING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The falling birth-rate has, within late years, formed the subject of a most exhaustive discussion from almost every conceivable point of view in your pages, and I do not propose to re-open it now. It may be well, however, to note a few salient facts from the Registrar-General's Report for 1905, just issued. The total births for the year constitute the lowest rate since civil registration was established, and mark the steady progress of a fall which has continued since 1876. The significant fact is pointed out that up to 1882 there were six European States in which the fertility of wives was less than that in England, whilst now the rate in England is lower than that of any European country excepting France. It is noted, further, that the rate of fertility amongst wives has fallen below the level prevailing in New South Wales. About 17 per cent. of the total decline in the birth-rate is due to a decrease in the proportion of married women of conceptive ages, and 10 per cent. is due to decrease of illegitimacy. The most suggestive statement derivable from the report is that which points out that the greater part of the remaining 73 per cent. of the fall is due to the deliberate restriction of child-bearing on the part of parents themselves.

In the hope that some of your readers may contribute to the discussion of this vitally important subject, I remain, yours truly,

London, February 18th, 1907. M.O.H.

THE VAGRANT ACT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—According to reports in the daily papers, several of the recent sentences at the County of London Sessions were for so-called indecency, but as the birch rod was ordered as well as a term of imprisonment, the men must have been convicted under the Vagrant Act, of which indecency is one of a number of offences for which the punishment of the birch rod is admissible.

It is admitted on all hands that the power possessed by magistrates presiding at Quarter Sessions in regard to the infliction of corporal punishment under an ancient Act of Parliament should be taken away in the interests of the community. One can hardly believe that in Christian England—the country of the free—men are birched for begging and sleeping out. Yet a recent return issued by the Home Office shows that out of 11 such birchings inflicted during 1905 and 1906 5 were passed by the Dorset Shallows for sleeping out!

Ten years ago Sir Mathew White Ridley (who was strongly opposed to flogging for many offences) brought in an amendment of the Vagrant Act which provided for the abolition of birching by leaving out Section 10, under which such punishment is authorised. But the Lords restored the power, and the Home Office of that day was too feeble to resist. Later a Bill was introduced into the House of Commons which proposed to abolish flogging for vagrancy. The proposal received the support of the Association of Chairmen of Quarter Sessions, but as the Bill had for its main object the extension of flogging in other directions, it was defeated by an overwhelming majority.

I believe that if a short Bill were brought forward to abolish flogging for vagrancy, the present democratic House of Commons would pass it without a division. Yours truly,

February, 1907. AMATEUR CASUAL.

OBITUARY.

JAMES EDMUND HUXLEY, M.D., M.R.C.S., L.S.A.

WE are sorry to announce the death of Dr. James Huxley, which took place at Maidstone last week. Dr. Huxley was brother of the late Professor Huxley, and though he did not attain the pre-eminent scientific position of his distinguished relative, he held for many years the post of Medical Superintendent of the Barming Heath Asylum, where his skill and administrative abilities had full play. Dr. Huxley, who was 87 years of age, took the M.R.C.S. of England as long ago as 1843, followed by the M.D. of St. Andrews and the L.S.A. in the following year.

ROBERT THOMSON FORBES, M.B., C.M., GLASG.

WE regret to chronicle the death, at Sandiacre, near Nottingham, of Dr. Robert Thomson Forbes, formerly a medical practitioner in Moffat. Deceased, who was 57 years of age, was a son of the late Rev. John Forbes, parish minister at Symington. He was one of the promoters of the original company which started the Moffat Hydropathic, which was opened in 1878, and for a number of years acted as a director and resident physician of the establishment. He was educated at Glasgow University, and took the degrees of M.B. and C.M. in 1871.

SPECIAL ARTICLE

UNIVERSITY EDUCATION IN IRELAND.

THE most important occurrences during the past week in what may be described as the University battle have been, first, the sending of a deputation by Trinity College to Mr. Birrell and to Mr. Balfour, and, secondly, the announcement by Mr. Birrell that a University Bill would be introduced at an early date. The deputation from Trinity College consisted of Dr. Anthony Trail, the Provost; Rev. T. T. Gray, Senior Fellow; Mr. Beare, Professor of Greek; Mr. Edward Gwynne, representing the Junior Fellows; and Sir Charles Ball and Professor Joly representing the Professors. The proceedings were private, and all that is known of them is that it is believed the interview with Mr. Balfour was of a more satisfactory character from the Dublin University point of view than that with Mr. Birrell. Indeed, it is evident from subsequent proceedings in Parliament that both Mr. Balfour and Lord Lansdowne intend to oppose any attempts to interfere with the University of Dublin.

Sir West Ridgeway, in a letter to *The Times*, strongly condemns Mr. Bryce's scheme as following the line of most resistance and as retrograde. He also points out that Trinity College has many friends on both sides of the house who will fight desperately in defence of its interests. He outlines an alternative scheme as follows:—"The two thriving colleges in Ireland outside Trinity College are the Protestant Queen's College at Belfast and the Roman Catholic University College at Dublin. Both, especially the latter, require more money for their development. Increase the funds at the disposal of the Royal University, and leave the Senate to make the necessary grants to both institutions, sufficient to provide University College, like Queen's College, Belfast, with the necessary buildings which it now so sadly requires. The condition might be imposed that there are to be no tests, that the Colleges should be open to students of all creeds, and that the majority of the governing body should be laymen. I believe that this compromise would be accepted by the Irish Roman Catholic Hierarchy, that it would not be too bitterly opposed by the Orangemen of Ulster, and I do not understand how English Nonconformists could reasonably object. It is not an ideal settlement; it is not final, but it is practicable, and it is capable of automatic development. There will be no destruction. Trinity College will not be touched, the Royal University will be preserved, and even Queen's College, Galway, will be given breathing time. Above all, there need be no legislation."

A meeting of the Higher Education Committee of the Presbyterian Church has been held, but as yet no pronouncement of its views has been made. A subcommittee has, however, been appointed to prepare a report on the subject, and to submit it to a further meeting of the Committee.

As will be seen from a letter which appears elsewhere in the present issue, a "Form of Protest" has been drawn up by Trinity College, and all Graduates of the University have been asked to sign it. Another protest in the following terms has been drawn up by the Alumni Association, Queen's College, Galway:—"We, the undersigned members of the Alumni Association of Queen's College, Galway, protest against the attempt to place our Alma Mater in a position inferior to that of the other Queen's Colleges in the new University scheme proposed by the Government."

On the other hand, a declaration in favour of Mr. Bryce's scheme has been drawn up by the Catholic Graduates and Undergraduates' Association and is being circulated for general signature. It states that the scheme "merits our strongest support; and we affirm our conviction that to be in consonance with Catholic ideas and acceptable to the Irish people, such new College must (1) possess whatever faculties in Arts and Science, equipment, academic privilege, and public endowment any other constituent college of the common University may possess, and should (2) be granted the fullest possible measure of autonomy."

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Salomon's Test for Gastric Carcinoma.—After a period of twenty-four hours on fluid and albumin-free diet, Salomon washes out the stomach in the evening, and again on the following morning with physiological saline solution. He states that the morning fluid gives an intense cloudy precipitate with Esbach's re-agent in all cases of gastric cancer, while no such deposit is obtained in chronic gastric catarrh, in gastroptosis, or in nervous dyspepsia. According to Reicher *(Archiv. für Verdauung's Krankheiten*, Bd. xii., Hft. iii.), this test depends upon the exclusion of mucin and its peptone-like reduction products. Albumoses and peptones are always present in small quantities, but they cannot influence the test. Nucleo-proteids and purin bases derived from the nuclei of degenerating cells give a very delicate cloudiness in normal cases; but cloudiness followed by a flocculent deposit is strong evidence in favour of the presence of an ulcerated carcinoma. In order that the test may be of any value the washing must not be mixed with food products. M.

The Various Types of Carcinoma Cervicis Uteri.—The *Johns Hopkins Hospital Bulletin* for January, 1907, contains an important paper on the above subject by Professor Sampson. It embodies the result of 27 examinations made on specimens removed by abdominal operation, and on one specimen obtained at autopsy. The author divides the varieties according to their histological structure, their topography, and their morphology as follows:—(*a*) Squamous-celled and columnar-celled; (*b*) those of the vaginal portion of the cervix, and those within the cervical canal; (*c*) everting, cauliflower type, and inverting ulcerative type. He discusses the types *seriatim*. i. Squamous-celled carcinoma of the portio vaginalis—everting. This may occur as a pedunculated or sessile tumour, often of large size. Clinically, it bleeds readily, and is the least malignant of cervical cancers. ii. Squamous-celled cancer of the portio vaginalis—inverting. This is the most common form of cervical cancer; it is of the scirrhus type, and spreads deeply, often involving the parametrium early in the disease, and reaching the bladder. Clinically, it is very malignant. The inverting and everting types are not sharply defined from one another, but may co-exist. iii. Squamous-celled cancer of cervical canal—everting. This is a rare type, and presents the important clinical feature of indentation, retraction, and puckering of the portio vaginalis caused by the growth invading it from above. iv. Squamous-celled cancer of cervical canal—inverting. In this type bleeding is often a late symptom. The cancer tends to spread chiefly in the cervix itself, so that the cervix may be converted into a thin shell lined by cancerous tissues. Ultimately, however, it extends to the surrounding parts. v. Adeno-carcinoma of the cervix. This is apparently the most malignant of all the cancers of the cervix. It is usually of the everting type, and may give rise to extensive metastases. Recurrence seems liable to take place even after very early removal. M.

The Blood of Normal Young Adults.—Dr. Emerson puts on record the results of blood examinations made during the last few years on the students at the Johns Hopkins University (*Johns Hopkins Hospital Bulletin*, January, 1907). The red cells have been enumerated on several occasions in 171 different individuals, aged from 23 to 35 years, and the extreme limits in number per cm. were found to be 4,500,000 and 6,800,000. The average number appears to be about five and a half million, and this does not vary with age, as is shown by separate tabulation of the students between 23 and 28 years of age, as compared with the entire number of students. As most of the counts have been made in the autumn and winter, the records cannot show any seasonal variation; but as far as they go they seem to point to some changes occurring at the different periods of the year. In estimating the hæmoglobin, it has been found necessary to revert to the use of one instrument, in order to obtain satisfactory results, and the one now being employed is the new Sahli hæmometer. The results obtained with the use of other instruments gave a colour index of about .87, while 21 examinations gave an average ot 2.63 grams total hæmoglobin per 1,000,000 red cells. The white cell counts gave an average in 167 cases of 8,400 cells per cm., but the variations were from two to fourteen thousand. The averages obtained in women students, 16 in number, were slightly below the above figures both for red and white cells and for hæmoglobin. M.

Cammidge's "Pancreatic Reaction" in the Urine.—Dr. Cammidge defends this test, as now employed, in the *Edinburgh Medical Journal* for February, 1907. The present technic is as follows: 40 cc. of filtered urine, from a twenty-four hours' sample, free from albumin, sugar, and bile is taken, and to it is added 2 cc. of strong hydrochloric acid. The mixture is gently boiled on a sand bath for ten minutes, and, after cooling, is again made up to 40 cc. by the addition of water. The acid is then neutralised by the addition of 8 grammes of lead carbonate, and the mixture filtered. Eight grammes of tribasic lead acetate are now added to the filtrate, and filtration is again performed, after which the excess of lead is removed by sulphuretted hydrogen, and the solution filtered. Ten cc. are now taken, and made up to 17 cc. by adding distilled water; then 2 grammes of sodium acetate and .8 gr. of phenyl hydrazine hydrochlorate are poured in, along with a little dilute acetic acid. The mixture is boiled for ten minutes and set aside to cool, when in positive cases a yellow flocculent precipitate slowly forms. Dr. Cammidge has examined 400 urines by this test in the last two years, and claims a large amount of success in diagnosis by relying upon it. M.

The Diagnosis of Gastric Ulceration.—Hemmeter describes a new test for the diagnosis of gastric ulcer (*Archiv. für Verdauung's Krank.*, Bd. xii., Hft. 5). The patient takes at night time a large glass of warm water with a drachm of bismuth subnitrate. If no food is taken the bismuth should have disappeared from the gastric mucous membrane in from three to six hours; but if any ulcerated patches exist the bismuth will adhere for from 24 to 36 hours, and this persistence can be detected by means of X-rays. In order to make the test of value in the detection of the site of the ulcer, photographs must be taken from different positions, and, as a rule, mere screening is not sufficent to complete the diagnosis. M.

A Hitherto Undescribed Urinary Sediment.—Richartz (*Zentralblatt für Innere Medizin)* describes the case of a patient, æt. 44, of a neurotic disposition, who came to him complaining that his urine was cloudy and white. On first examination by ordinary tests the condition was regarded as being ordinary phosphaturia, but when the sediment was examined under the microscope, it was found to consist of very large crystals, some of which were 1.5 mm. in length, and from .3 to .6 mm. wide. In appearance they somewhat resembled sheaves of corn, similar to tyrosin crystals, but on a larger scale. Each needle of the sheaf ended in a sharp point, and the entire crystal was quite colourless. The writer, after examining them thoroughly, comes to the conclusion that they may be calcium diphosphate crystals, as they possess many points in common with the known crystals of that salt, but calcium diphosphate in the sense only that one atom of calcium had been displaced by magnesium and ammonium, so as to produce the formula Mg. Ca. $(NH_4)_2$ $(PO_4)_2$. The crystals were only occasionally present, and appeared to be only found when the patient was on a vegetable diet. M.

Functions of the Nucleus.—Adami (*Brit. Med. Journ.* December 22nd, 1906) discusses the physiology and pathology of the nucleus. His main thesis is that the nuclear matter controls all the essential activities of the cell. (1) A cell which has lost its nucleus, either naturally or artificially, may continue to live for a considerable time, but neither grows nor reproduces itself. Such a cell may exhibit some metabolic activities, but the higher metabolic activities are absent. (2) The nucleus undergoes certain gross changes during the activity of the cell. Thus, in some cases, it alters its position; in others it alters its shape. (3) Certain minute changes in the cell during activity start from the nucleus. Thus, Ogata showed that in secreting cells there is a passage of small granules from the nucleus into the protoplasm. His observations have been supported by Lukjanow, Macallum, Carlier, and several others. Macallum has shown a similar process in the developing ova of the Lake lizard and of the frog, and Thies in the nectar cells of flowers. (3) In various pathological processes, changes in the nucleus are concurrent with changes in the cell. Thus, it is generally admitted that in tumour formation there is an excessive but disorderly activity of the nucleus, shown by atypical and irregular mitoses. In the various degenerative processes, the nucleus, equally with the cell-protoplasm, undergoes morbid changes. (5) Viewed from the chemical side, the nuclear material is found to possess potentialities superior to those of any ordinary constituent of the cell body. (6) The nucleus is, as Loeb has shown, the centre of the oxidative processes of the cell, and it is also, in all probability, the most essential part in the production of ferments. R.

Carbon Monoxide Poisoning.—Nasmith and Graham (*Journal of Physiology*, December 29th, 1906) publish the account of an investigation into the action of carbon monoxide on the body, and particularly on the blood. The animal employed was the guinea-pig, and the usual method was to expose the pig continuously to such an atmosphere of mixed air and coal-gas as would saturate a definite proportion of the animal's hæmoglobin with carbon monoxide. The authors conclude:—(1) Carbon monoxide acts as a poison solely by its ability to prevent the normal supply of oxygen from reaching the tissues, and thereby deranging normal metabolism. (2) Guinea-pigs living continuously in a dilute carbon monoxide atmosphere so that the oxygen-carrying power of the blood is diminished, are able, by increasing the quantity of hæmoglobin and the number of red corpuscles, to compensate for this loss and maintain an oxygen-carrying capacity approximately normal. The experiments supporting this statement were made by exposing animals to such an atmosphere as caused 25 per cent. saturation of the hæmoglobin with carbon monoxide. As a rule, on the second day the blood showed degeneration of the erythrocytes, and on the third normoblasts appeared. After a few days the degeneration disappeared, and the number of corpuscles rose to the normal, keeping thereafter at a fairly steady level. The animal kept in good health, usually becoming fatter. In a similar manner the amount of hæmoglobin gradually increased to reach a little above the normal. In animals exposed to atmospheres causing higher saturations, the damage to the red corpuscles was extreme, the protoplasm being almost completely destroyed. Nevertheless, it was found that some animals developed a compensation to 35 per cent. saturation, but 50 per cent. saturation, if prolonged, was fatal. (3) Carbon monoxide poisoning gives rise to a leucocytosis of the eosinophil and pseudo-eosinophil forms. A moderate saturation produced a moderate toxæmia involving, like other moderate toxæmias, an eosinophilia. A high saturation caused a severe toxæmia, in which, as in other toxæmias, the eosinophilia disappeared. (4) The effects of carbon monoxide on the number of the red blood corpuscles are similar to those of high altitudes. If the conclusions may be safely translated from animals to man, then it will follow that chronic carbon monoxide poisoning does not occur, nor is it a cause of anæmia. R.

Experimental Lymphocytosis.—Harvey (*Journal of Physiology*, December 29th, 1906) investigates the mode by which pilocarpin and other drugs cause lymphocytosis. It had often been noticed that the exhibition of pilocarpin caused an immediate crowding of the vessels with lymphocytes. In an ordinary leucocytosis, on the other hand, the increase in the number of cells is gradual, taking at least a couple of hours to reach its maximum. As pilocarpin causes active contraction of the muscle of the spleen and lymphatic glands, it was thought that this might be the explanation of the lymphocytosis. It was found that when the splenic vessels of a cat were cut, pilocarpin had no effect in the direction of lymphocytosis. On the other hand, stimulation of the splenic nerve in a dog caused a lymphocytosis similar to that induced by drugs. Atropin, moreover, inhibits the effect, if it precede the administration of the other drug. Harvey concludes, therefore, that the lymphocytosis caused by pilocarpin, muscarin, or barium chloride is a purely mechanical one, brought about by the contraction of the plain muscle of the spleen and lymph glands. R.

Diurnal Variations in the Excretion of Uric Acid.—Leathes (*Journal of Physiology*, December 29th, 1906) describes certain diurnal variations to which the excretion of uric acid is subject. He finds that when a uniform purin-free diet is taken, the excretion of uric acid is most active in the early waking hours and much less active at night. This cannot be due to a change in renal activity, since the excretion of nitrogenous substances in general is as high by night as by day. It must, therefore, be due to a variation in the formation of uric acid. Leathes also observed similar but less marked variations in the excretion of creatinin. R.

Human Chyle.—Hamill (*Journal of Physiology*, December 29th, 1906) has had an unusual opportunity of examining human chyle in the case of a patient suffering from chylous fistula in the right groin. (1) Human chyle varies in colour from bluish-white to yellowish as its fat-content increases. Its reaction is alkaline, and it clots rapidly on removal from the body. Oxalates prevent its clotting. Microscopically, fine particles of fat, leucocytes, and a few red corpuscles are found. As much as five litres of chyle was collected in twelve hours. The experiment had than to be stopped, owing to the exhaustion produced. (2) The fat content varied considerably during the day, being greatest six hours after the principal meal. (3) When a mixture of higher and lower fats is given in the food, the ratio of the higher to the lower fats is greater in the chyle than in the food. (4) Petroleum given by the mouth cannot be recovered from the chyle. R.

Paratyphoid Fever.—Since the first recognition of paratyphoid fever some five or six years ago, the number of cases on record has rapidly increased, and the disease cannot now be regarded as a rare one. Castellani (*Lancet*, February 2nd, 1907) describes thirteen cases of one or other type of the disease which have come under his notice in a comparatively short space of time in Ceylon. In six of the cases an organism identical with the "Paratyphoid A (Brian and Kayser)" was isolated. One of these cases ended fatally, the ileum presenting ulcerations identical with those of typhoid fever; the typhoid bacillus, however, was absent, but the paratyphoid A was recovered in pure culture from the spleen and lymphatic glands, and was found with the bacillus coli and other organisms in the ulcers. In one case there was a concurrent staphylococcæmia, which gave rise to boils. In the remaining seven cases the "Paratyphoid B (Shotmüller) bacillus" was found. In one there was a concurrent malaria, in one a concurrent pneumococcæmia, and in one a concurrent typhoid infection. The last case gave serum reactions to both organisms, and both were recovered from the stools. R.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons, England.

HUNTERIAN FESTIVAL.

The 179th anniversary of the birth of John Hunter, the founder of the museum of the College, was celebrated at the Royal College of Surgeons on Thursday last. In the afternoon, Mr. Henry T. Butlin, D.C.L., Consulting Surgeon to St. Bartholomew's Hospital, delivered an oration before a large company, and in the evening about 100 guests dined at the College at the invitation of the President and Council.

Mr. Butlin's oration dealt mainly with the objects of the life of John Hunter, and the manner in which he accomplished them. After describing the condition of surgery at the time of Hunter's birth as "composed of a vast unwieldy mass of observation and experience balanced on a single point, the study of anatomy," the orator narrated how, in the year 1748, a young man arrived in London from the North, who had spent most of his time in country sports, and it is probable that no person at that time would have ventured to predict that this same young man—"Jack Hunter"—would not only display a life-long industry, but would leave behind him a reputation which, as the College celebrations of yesterday proved, "is born of our conviction of his value to the art of surgery, and, as a natural corollary, the human race."

The history of Hunter's life affords an excellent example of the moulding of a man's character. Anatomy itself attracted him, and he threw himself into the study of it with much success. Many a young man, said the lecturer, may have gone thus far and their remained, content with the occupation for a livelihood and for the pleasure it gave him. Happily, Hunter's ambition urged him to become a surgeon, and he began to attend the Chelsea Hospital, and, subsequently, at St. Bartholomew's and St. George's Hospitals. Failing health, however, forced him to leave London, and he became a military surgeon. His duties in this latter capacity impressed him with an interest in the maladies in human beings which never left him, and which directed his scientific investigations to the elucidation of the problems of health and disease.

About the period of middle life he returned to London and began to build up what was destined to be a unique collection of specimens, dissected and prepared by himself. This formed the nucleus of the collection which was purchased, after Hunter's death, by Parliament for a sum of £15,000. The collection was offered to the College predecessors, the Corporation of Surgeons, and was accepted by them. And, said the lecturer, in conclusion, "to the glory of the college be it said, that one of the chief objects of generation after generation of our Councils has been, not merely to maintain the Hunterian Museum, but to enlarge and perfect it, until at this moment the Council of the College can exhibit it as the best museum of its kind in the world."

HUNTERIAN DINNER.

Among the guests entertained by the President (Mr. Henry Morris) and Vice-Presidents (Mr. Edmund Owen and Mr. Rickman J. Godlee) were: Prince Francis of Teck, the Earl of Onslow, Lord Reay, Lord Cheylesmore, Sir Schomberg McDonnell, Sir Herbert Maxwell, the deputy master of the Mint, Sir Edward Carson, Mr. Justice Bargrave Deane, the President of the Royal College of Physicians, the Vice-Chancellor of Cambridge University, the principal of London University, Archdeacon Sinclair, the President of the Institution of Civil Engineers, Sir William Church, Sir James Reid, Vice-Admiral Neville-Rolfe, Sir William Collins, Mr. Alderman and Sheriff Crosby, Mr. Sheriff Dunn, the Director-General of the Medical Department of the Royal Navy, the Director-General of the Army Medical Service, Sir John Wolfe Barry, Sir Charles Stanford, the Provost of University College, the treasurer of the Inner Temple, the treasurer of Gray's Inn, Sir Squire Bancroft, Sir Frederick Bridge, Mr. J. W. Waterhouse, the Masters of the Mercers, Grocers, Drapers, Clothworkers, Apothecaries and Barbers Companies, Sir Douglas Straight, Sir John Macfadyean, Sir Edward Henry, Sir Thomas Smith, Mr. Jonathan Hutchinson, Mr. Thomas Bryant, Dr. J. Kingston Fowler, Professor Clifford Allbutt, Mr. Ernest Page, Dr. Dawson Williams, and Mr. T. H. Wakley, together with sixteen members of the Council and the following officials: Professor Stewart, Conservator; Mr. Plarr, Librarian; and Mr. Cowell, Secretary.

After the usual Royal Toasts had been duly honoured, the Vice-President, Mr. Edmund Owen, proposed the Visitors, which was responded to by the Earl of Onslow, Sir Herbert Maxwell, and Mr. Justice Bargrave Deane. Sir Martin Rucker proposed the toast of the Hunterian Orator, which was responded to by Mr. Henry T. Butlin.

Vaccination Exemptions.—Important Government Action.

ON behalf of the Government the following statement was made in the House of Commons on the 15th instant:—

Dr. Macnamara (Camberwell, N.) said he rose to speak on behalf of the Government for the first time upon one of the most controversial questions in the whole range of public affairs. The expert anti-vaccinator had got up and bombarded the House with absolutely irrefutable figures, proving that vaccination was a barbarous and silly operation, fraught with real danger to the health of the person undergoing it. Directly he sat down up got the expert pro-vaccinator, and quoted equally reliable figures, showing vaccination was a vital necessity to the health of the community. No statistics were, in his opinion, more perplexing, unless they were tariff reform statistics. In his infancy his parents in their wisdom had him vaccinated. But neither side were entitled to claim him on account of that, because he was not consulted in the matter beforehand. In consequence of that operation, according to the view of the hon. member for Sleaford, he ought now to have died a hundred horrible deaths. On the other hand, he was comforted by the hon. and learned member for Kingston, who really convinced him that it was due to the fact of his having been been vaccinated that he was alive now to tell the tale. Be that as it may, the solid fact remained that from 1853 onwards there had been an increasing agitation against compulsory vaccination. His own view of that was that what ultimately became an objection to the operation itself originated in an objection to the manner in which it was carried out. As a result of the prolonged labours of the Vaccination Commission, the Act of 1898 once and for all gave up compulsion. But it could not be denied that a great many of our magistrates, challenging the wisdom of this Act, deliberately set themselves to make the obtaining of a certificate of exemption as onerous as possible. They frequently went out of their way to pour ridicule and contumely upon people who were availing themselves of the benefit of the law, and they inconvenienced them in every possible way. In some cases magistrates made a most contemptible discrimination between a rich man on the one side and a poor man applying for this relief on the other. This was not consonant with the spirit, to say nothing of the letter, of the Act. On behalf of the President of the Local Government Board, he had to say that it was proposed to substitute for the present system, under which a parent must obtain a certificate of conscientious objection, a new system, which would enable a conscientious objector to secure exemption upon making an ordinary statutory declaration. The Government desired to make general what was obviously a practice with the Kingston Bench. The President of the Local Government Board was not in a position to indicate more definitely the nature of his proposal, but it was intended to make the new procedure as little onerous as possible.

NOTICES TO CORRESPONDENTS, &c.

☛ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

HAIR-GROWING BY MACHINERY.

DEAR SIR,—We should be obliged if you will inform us your lowest charges for the insertion, next to reading matter, of the enclosed advertisement in your publications once a week for a period of one year, we to provide you with a block. A NOTICE TO BE WRITTEN BY YOU ON THE ADVANTAGES OF THE CAP TO APPEAR ONCE EVERY THREE MONTHS; we to be at liberty to vary the advertisement once every three months. A copy of your publications with advertisement to be sent to us each week.

Yours faithfully,
The Evans Vacuum Cap Co., Ltd.,
J. R. HANBURY, Manager.

P.S.—We will furnish you with the material necessary for the notice above referred to.

[The foregoing letter refers to a kind of vacuum apparatus to be affixed to the head with a view to inducing a growth of hair. The impertinent assurance of the proprietors, who ask for advertisement and notice of their specious quackery in a medical journal speaks for itself.—ED., "M. P. AND C."]

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 20th.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—8 p.m.: Exhibition of Slides of Marine Zoological Objects lent by Mr. Flatters. Papers:—Mr. J. W. Gordon; An Early Criticism of the Abbé Theory. Mr. J. Murray: Some Tardigrada of the Sikkim Himalaya. Dr. E. Penard: On Some Rhizopods from the Sikkim Himalaya.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m.: Mr. H. Williams: Cold Storage and Food Supply.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. C. Ryall: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. P. Horrocks: The Uterine Curette and its Uses.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Dermatological (Dr. Meachen), Ophthalmological (Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, FEBRUARY 21st.

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8.30 p.m.: Annual General Meeting. Election of Officers. Presidential Address:—Dr. C. E. Beevor: The Distribution of the Arteries supplying the Human Brain.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. G. N. Pitt: Associated Abdominal and Thoracic Disease.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Clinique:—Medical In-patient (Dr. Chappel). 4.30 p.m.: Lecture:—Dr. Corner: Mental Disorders associated with Pregnancy and Parturition.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Fungous Diseases of the Skin: I., Tinea Circinata; II., Inbricata, Versicolor; III., Erythrasma; IV., Actinomycosis; V., Madura Foot.

FRIDAY, FEBRUARY 22nd.

BRITISH ELECTROTHERAPEUTIC SOCIETY (11 Chandos Street, Cavendish Square W.).—8 p.m.: Council. 8.30 p.m.: Paper:—Dr. S. Sloan: Some Physiological Effects of High Frequency Currents in Disease (illustrated by lantern slides and apparatus.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m.: Mr. R. Johnson and Mr. C. E. Reynolds: Case of Spinal Meningocele in an Adult Successfully Treated by Operation after Spontaneous Rupture had occurred. Mr. C. H. Fagge: Resection of the Jejunum and Colon for Carcinoma of the former.—Mr. T. H. Kellock: A New Method of Excising the shoulder-joint.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. L. Lack: Clinique. (Throat).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Ophthalmological (Mr. Brooks). p.m.: Clinique:—Medical In-patient (Dr. Leslie).

Vacancies.

Leicester Infirmary.—House Surgeon. Salary £100 per annum, with board, apartments, and washing. Applications to Harry Johnson, House Governor and Secretary.

West Riding Asylum, Wakefield.—Assistant Medical Officer. Salary £150 per annum, with apartments, board, washing, and attendance. Applications to the Medical Director at the Asylum.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Medical Officer for the Casualty Department. Salary £100 per annum. Luncheon provided. Applications to W. M. Wilcox, Secretary.

Worcester County and City Asylum, Powick, near Worcester.—Third Assistant Medical Officer. Salary £140 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

London Open-Air Sanatorium, Pinewood, Wokingham, Berks.—Assistant Resident Medical Officer. Salary £100 per annum, all found. Applications to the Secretary, London Open-Air Sanatorium, 20 Hanover Square, London.

Royal Free Hospital, Gray's Inn Road, W.C.—Radiographer and Medical Electrician. Salary £100 per annum. Applications to the Secretary.

York County Hospital.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to Frederick Neden, Secretary and Manager, York.

Middlesex Hospital, W.—Resident Medical Officer. Salary £200 per annum, with residence and board in the Hospital. Applications to F. Clare Melhado, Secretary Superintendent.

Male Third Assistant Medical Officer.—Salary £150 per annum, with lodging, attendance, and washing. Applications to the Office of the Board, Embankment, London, E.C.

Leicestershire and Rutland Asylum, Leicester.—Second Assistant Medical Officer. Salary £120 per annum, with apartments, board, and washing. Applications to W. J. Freer, Esq., New Street, Leicester.

Shillelagh Union.—Medical Officer. Salary £130 per annum and £15 a year as Medical Officer of Health. Applications to J. Hopkins, Clerk of the Union. (See advt.)

Appointments.

BROWN, W. H, F.R.C.S.Irel., Consulting Surgeon to the General Infirmary, Leeds.

CARNELL, EDWARD, M.R.C.S., L.R.C.P.Irel., D.P.H.Irel., L.S.A., Medical Superintendent of the Newton Abbot (Devon) Joint Hospital District.

COLLINSON, HAROLD, F.R.C.S.Eng., Honorary Assistant Surgeon in Charge of the Patients at the Ida and Robert Arthington Semi-Convalescent Hospitals of the Leeds General Infirmary.

DOBSON, J. F., M.S.Lond., F.R.C.S.Eng., Honorary Assistant Surgeon to the General Infirmary, Leeds.

FORSYTH, R., M.D.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Birstal District of the county of York.

GUBB, FLORENCE ERIN, M.B., B.S.Lond., L.S.A., House Surgeon at the Children's Hospital (East-End Branch), Sheffield.

HORSFORD, CYRIL, M.D.Edin., Laryngologist and Aural Surgeon to the London College of Music, Great Marlborough Street, W.

LANGMEAD, FREDERICK, M.D.Lond., M.R.C.P. Lond., Physician to Out-patients at Paddington Green Children's Hospital.

LEACH, J. C., M.D.Dub., Certifying Surgeon under the Factory and and Workshop Act for the Sturminster Newton District of the county of Dorset.

LORD, JOHN R., M.B.Edin., Medical Superintendent, London County Asylum, Horton, Epsom.

MACNAMARA, E. D., MB., B.Ch.Cantab., Physician to Out-patients at Paddington Green Children's Hospital.

OGG, THEODORE A. W., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer for the Parish of Rothes, Morayshire.

PEGLER, L. HEMINGTON, M.D.Edin., Laryngologist and Aural Surgeon to the London College of Music, Great Marlborough Street, W.

Births.

COSTELLO.—On Feb. 14th, at 76 Lower Mount Street, Dublin, the wife of T. B. Costello, M.D., Tuam, co. Galway, of a daughter.

PRINGLE.—On Feb. 14th, to Dr. and Mrs. Seton Pringle, 27 Lower Baggot Street, a son.

Marriage.

PITTS—COCHRANE-BROWN.—On Feb. 14th, at Christchurch, New Zealand, Arthur Gentry Pitts, F.R.C.S.Eng., eldest son of Robert Pitts, Merlewood, Sanderstead, to Dr. Edith Cochrane-Brown, only daughter of Thomas Brown, Esq., of Strathmere, Christchurch, New Zealand (late of Dundee).

Deaths.

NEEDHAM.—On Feb. 15th, at 19 Campden Hill Square, London, Charlotte, the dearly loved wife of Frederick Needham, M.D., in her 67th year.

PEAKE.—On Feb. 16th, at 228 Goldhawk Road, London, Rowland Mabbatt, only son of Solomon Peake, M.R.C.S., aged 21.

WARD.—On Feb. 17th, at Bournemouth, Austin George Ward, M.R.C.S.Eng., late of the Charity Organisation Society, aged 54.

THE CHILDREN'S HOSPITAL,
TEMPLE STREET, DUBLIN.

Applications for the position of Visiting Physician to this Hospital will be received by the Hon. Secretary, Medical Board, up to Feb. 28th, 1907.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, FEBRUARY 27, 1907. No. 9

NOTES AND COMMENTS.

L.C.C. Election. THE approaching election of members of the London County Council is exciting far greater interest than any previous one, and though it is encouraging to think that Londoners are beginning to concern themselves about the management of the wonderful city in which they live, it is much to be regretted that the polemics of the occasion should be so much embittered. The charges made against opponents are in many cases of the most invidious kind—even for municipal warfare—and when decisions of great pith and moment have to be taken, it is a thousand pities that the issues at stake should be overlaid with unworthy details. The County Council is the supreme health authority for London, and as the controlling and co-ordinating instrument of the policy of the Borough Councils, its importance is immense, so that medical men cannot but feel the responsibility of casting their lot in with one side or the other. From the hygienic point of view, the problem that overshadows all others at the moment is the housing question. The ground rents in the central parts of London make cheap and decent house accommodation impossible for the working-classes, and the only alternative is the erection of cottages in convenient situations in the outskirts, together with a rapid, cheap system of locomotion. Block dwellings in the inner ring are suitable only for the better-paid artizans, with no families or only one or two children, so that the question of traction—odd though it may seem—stands out as the most pressing sanitary question. The Council has already shown a strong sense of its responsibilities in this direction, and whatever may happen at the election nothing should be allowed to divert its energies from it in the future.

Education Pitfalls. THEN, too, the Council, as the Education Authority for the metropolis, has onerous duties to the rising generation, and it must realise the danger that it runs of centralising its authority on the Embankment. Few systems need more flexibility than educational ones, for the healthy child is the most variable factor in a world where change is the sign of life, and if under the Council administration becomes bureaucratic, the best intentions in the world will not suffice to atone for the certain disaster that will follow. So far the Council has taken some admirable steps with regard to providing medical inspection and nursing care for its pupils, and in this respect sets a wholesome example to the other public school authorities. An enterprising contemporary that feeds its readers largely on hollow sensations alighted on a pretty mare's nest the other day. The parents of a child under treatment for its eyes at a London hospital were advised, it was said, by the ophthalmic surgeon to keep the child from school, but through some bungling the child was compelled by the attendance officer to return to work, with the result that its eyes suffered much damage. This incident was placarded over London under the cheerful heading "Blind by order of the L.C.C.," and it was made the text from which to excite political prejudice against the Council. The *dénouement* was not long in coming, for a rival journal discovered that the child in question lived at Edmonton, a district which is not in the L.C.C. area !

"Deaf by Order of the L.C.C." THIS sort of stupid criticism of the work of the Council can only do harm, as it excites other people to indulge in equally wild accusations. At the last meeting of the Education Committee attention was called to a letter from a firm of employers who complained that six boys who came to them from the Council's schools, were deaf as the result of the swimming lessons now given them as part of their educational course. One of the Council's medical officers went down and examined three of the boys, and reported that there was no evidence that they were deaf even temporarily as the result of their swimming instruction; and that nothing of the kind had been heard of elsewhere. What an opportunity someone missed of getting up an agitation—"Deaf by order of the L.C.C." ! No, the policy of the Council wants much watching on the side of physical education and much encouragement. It can do nothing but harm to stir up blind animosity over imaginary grievances.

Bone-Setters' Ethics. WITH pomp and circumstance it is announced that Arthur Birch, the unfortunate jockey who was seriously injured at Gatwick last December, and who has been lying there ill ever since, has decided to fly in the teeth of the advice of Sir Victor Horsley, Mr. Lane, and his local medical attendant, Dr. Matthews, and to have himself transferred to London, that he may enjoy the advantage of the services of one Raby, a bone-setter. Birch is said to have been highly delighted when he knew he was to be moved, and "laughed at the grave fears of the doctors." We have no information as to the nature of the patient's injury, and, for all we know, his present condition may be represented in black colours in order that his subsequent cure may shine the brighter, but on the face of it the announcement strikes us as being in execrably bad taste, by whomever it was made. It has, however, had the effect of stirring up our friend, Mr. H. A. Barker, who fearing doubtless that he may be eclipsed by the new star, writes to the Press Association: "From the accounts I have of Birch's condition, I am of opinion that a manipulative or bloodless operation might be of the greatest service. The Hon. George Lambton was operated on by my predecessor, Mr. Atkinson, for a similar injury quite successfully some years ago." Mr. Barker's opinion is doubtless most valuable, but we do not follow his reasoning with regard to his "predecessor" and Mr. Lambton. Is it a necessary sequence that because his "predecessor" cured Mr. Lambton, whom he had seen, that Mr. Barker could cure Birch, whom he has not? It reminds us rather of the man who said he could not speak French himself, but that his cousin could play the German flute.

"Help."

RESEARCH and observation bring to light new diseases with disconcerting rapidity, and yet we appear to be far from having reached finality. For instance, a malady, new at any rate to ourselves and the inspectors of the Local Government Board, has arisen in our midst. Its name is "Help," but its clinical phenomena, its signs, symptoms, and portents, have so far not been described. Then only thing certainly known about it is the treatment, which consists entirely, so it seems, in the prescription of alcoholic stimulant. The disease was unearthed during the recent researches of an inspector of the Local Government Board into the books of the workhouse at Kedington (Suffolk), in the course of which he struck this remarkable entry frequently recurring in the column, headed "Nature of Disease," in which the illness for which alcohol was necessary for the inmates was inserted. The inspector, in his report, remarks that he is not sure whether "Help" is a disease or not. We can only say that if it is, in its usual manifestations it is not markedly contagious.

Union at Wimborne.

AT Wimborne recently the medical officer to the Guardians applied for a rise of salary. Considering that he enjoyed the princely emolument of £30 a year, out of which appliances and medicines had to be found, it is not surprising that the local Guardians should have stood as aghast as their predecessors when Oliver Twist proffered a similar outrageous request. The rise being refused, the medical officer resigned, and the post was advertised at a salary of £25, exclusive of appliances and medicines. The medical men in the town met together, discussed the situation, and decided that none of them would apply. So the Guardians have no candidates for the appointment. It is good to hear of such loyalty among members of the profession, for when the medical interests are not divergent they are irresistible. We shall be interested to notice the next step of the Wimborne bumbles.

LEADING ARTICLE.

THE MEDICAL INSPECTION OF SCHOOL CHILDREN.

THE progress of the Parliamentary coach, year in and year out, is to onlookers a spasmodic, an uncertain, and, at times, even a hopeless affair. Here it creaks and rumbles as if the whole structure were about to collapse in ruins, after the fashion of the wonderful "one 'oss shay." There it sinks to its axles in a slough of despond, or pauses for a prolonged period of renovation and repair. Yet on the whole its course is onward; and sometimes, when least expected, it speeds forward at a rapid rate, regardless of any difficulties of the road to be traversed. This metaphor might be applied with interest and advantage to the chequered career of public health legislation. From the outset of its scientific birth, almost, if not quite, within the memory of living man, it has had to struggle against enormously powerful vested interests of various kinds. Indeed, it may safely be asserted that not a few of the rocks ahead in practical sanitation depend upon obstacles of this kind. The medical officer of health, for instance, will never become a power in the land until his tenure of office is made independent of the local authorities, composed as the latter are of individuals whose interests in trade and in property are often opposed to the rights of the public as regards sanitation. Another cogent illustration is the vast capital sunk in farming and in dairies, which is vitally disturbed by the recent authoritative declaration of the Royal Commission that tuberculosis can be conveyed to mankind by infected meat and milk. Happily, however, many public health reforms do not involve any obvious interference with vested interests, although they involve necessarily some amount of sacrifice on the part of the ratepayers who have to foot the bill. Among the more hopeful of this sort of measure is the medical inspection of school children. There appears to be a fair prospect that a Bill for the furtherance of that object may be presented to the House of Commons by Mr. Walter Rea. Clearly it is a matter that deeply affects the medical profession as well as the nation. The principle of medical inspection was adopted in the Government Education Bill of last session by Mr. Tennant's amendment to clause 24, inserting a sub-clause providing for such inspection. There is little need here to enumerate the overwhelming case in favour of the systematic medical supervision of school children who will form the backbone of the next generation of our countrymen. If ever the problem of physical deterioration is to be strenuously handled, the first stages of the campaign must be carried out in our schools. The ultimate prevention of communicable disease, notably diphtheria, measles, scarlatina, and tuberculosis, hinges around this question. Incidentally the proper feeding, the physical culture, and the moral training of the rising generation are all woven into the warp and woof of this matter of medical inspection. So far as the general practitioner is concerned, more especially in the smaller towns and the rural districts, there are various points of practical administration upon which it is desirable that his mind should be made up and his attitude clearly defined without loss of time. In the large towns, it may be taken for granted that a whole time officer will, in most cases, be appointed. In other instances, where the school medical officer is permitted to engage in private practice, the situation becomes at once complicated with many possibilities of friction which need not be particularised. It may be as well to note, however, that the school medical officer is often called upon to examine teachers as to their health generally, and in case of sickness; further, to remind the medical profession that the proposal that is shortly to come before Parliament deals with the treatment as well as the medical inspection of school children. Indeed, so deeply are the interests of the medical profession concerned, that the whole matter is worthy of extended discussion. The General Medical Council is not likely, either by constitution or by inclination, to raise a voice in the protection of the profession. Almost the only body to whom medical men can turn with any hope of practical guidance and help is the Medico-Political Committee of the British Medical Association, and we learn with profound satisfaction that they are giving close attention to the subject. Under present circumstances, school boards all over the country contrive to secure a great amount of gratuitous medical service by way of certificates obtained without fee from general practitioners and from the honorary and paid medical staffs of medical charities.

CURRENT TOPICS.

Cerebro-Spinal Fever—A Warning Note.

THE epidemic of cerebro-spinal meningitis is rapidly spreading in various parts of the Kingdom. Especially alarming is the multiplication of cases in London, which, by reason of its unwieldy population, is apt to become the ready prey of any malignant infectious outbreak of the kind. The recent circular issued by the Local Government Board warns sanitary authorities to be on the alert, while at the same time it expresses the opinion that there is not at present any ground for apprehension. We fear that there is no strong foundation for such happy official optimism, and that the position is full of the gravest omen. Judging from the history of acute infectious maladies in general and still more from that of cerebro-spinal meningitis in particular, we are forced to the conclusion that the cases recorded in London and other parts of England are simply precursors of a widespread epidemic like those that are already occurring in Ireland, Scotland, and various parts of the Continent. Unfortunately our knowledge of the life-history of the specific micro-organism of the disease is inadequate to enable us to frame any trustworthy scheme of prevention. The first and last word of the medical profession in that direction, so far, is to insist upon the necessity of absolute attention to ventilation, cleanliness, and other details of domestic and personal hygiene. The fact that the malady, like typhus fever, specially attacks poor and overcrowded quarters, points to the first line of defence against its invasion. Londoners will do well to avoid the error of imagining with the ostrich that danger un-seen is danger averted.

A Chemist's Knowledge of Poison Regulations.

A CHEMIST named William Howell, of High Street, Peckham, has recently had the unpleasant experience of a prosecution by the Pharmaceutical Society of Great Britain, and the infliction of a mitigated penalty of 40s. and costs. Under the circumstances he may regard himself as fortunate for escaping so lightly from a serious position. The attention of the prosecuting society was very properly drawn to the case by the City of London coroner. A woman died of corrosive sublimate poisoning, and it was shown she had bought the drug from defendant, who was "a person unknown to him and not introduced to him." As a matter of fact, the unfortunate lady was an inmate of Bethlem Hospital, and had been let out for a day in charge of her father. In a fit of temporary insanity she purchased the corrosive sublimate and signed the poison book. The defendant chemist said the lady, although not actually known to him, was a customer. He was careful to ascertain that she knew all about the drug, and she mentioned the text-book she used in the study of photography. He was not aware that it was necessary for him to know or to be introduced to the buyer. The Pharmaceutical Society will surely have something further to say to a holder of their qualification who is so grossly ignorant upon a fundamental law of daily application in his business relations with the public.

Hospital Nurses and the Employers' Liability Act.

THE Employers' Liability Act apparently applies to hospital nurses, which means a simple revolution in the position of nurses, both in public and in private service. Should a nurse in the execution of her duties contract any illness or sustain any accident, she will be entitled, if we read the Act correctly, to indemnity. The responsibilities of medical charities will, in that event, be enormously multiplied, and will undoubtedly have to be covered by insurance. Recently, at Bangor Workhouse Infirmary Board, a nurse was reported to have contracted tuberculosis in the hospital. The question was raised by a guardian as to whether it was really tuberculosis, and, if so, whether it was "taken" in the Infirmary. These points suggest that in future medical practitioners will have to be extremely careful as to their grounds before publishing a diagnosis, and also in granting certificates or in making verbal statements about any given cases. Another curious result will be the possible effect of compensation upon existing nurses' insurance and pension funds, the contracts of which may require modification in view of compensation contingencies.

"Viewing" the Body and Parliament.

THE ancient ceremony of "viewing" the body at coroners' inquests, like many other legal customs, has long since lost its justification in expedience and necessity. The feeling of aversion to the practice is universal, and there should be little difficulty in passing into law the Bill to abolish compulsory "viewing" recently introduced into the Commons by Mr. Luke White. Himself a coroner, that gentleman represents the general feeling among his brother officials in urging this most desirable reform. There is no need to remind readers of the terrible nature of the ordeal that is thrust upon jurors by insisting upon this custom of feudal times. It is somewhat to be regretted, however, that the proposal is fragmentary, and does not form part of a wider scheme of reform in this ancient court. The present system works, on the whole, fairly well, but few even of its most ardent supporters would venture to assert it is incapable of improvement in the direction of suiting modern views and modern requirements.

Illegal Practice in France.

IN spite of an outward air of levity, our volatile neighbours on the other side of the Channel are wont to treat vital issues in the most logical and serious of fashions. The crusade against quackery is carried on in Great Britain by the medical journals, aided by the fitful and capricious action of the police. In France, however, the lot of the unlicensed practitioner is apt to be far from a happy one. A gentleman of that kidney named Thomas Xambo has recently been convicted in the Tenth Correctional Chamber of the Department of the Seine for illegal practice. The prisoner was charged with having treated a relative of the plaintiff for a trouble of the ankle, making several incisions, with the result that the leg had to be amputated by a duly qualified surgeon. The prisoner, once a student in pharmacy, was sentenced to eight months in prison, also to pay a 2,000 fr. fine and 1,000 fr. to the Société des Médicins de Paris. This short shrift to a dangerous class of social parasites might be copied with advantage on our own side of the Channel.

The English Royal Colleges and Diplomas for Women.

IT is now many years since women stormed the portals of the medical profession in the Royal College of Surgeons of Edinburgh. Some years later the Irish Colleges threw open their qualifications to women. The English Colleges, both of Surgeons and Physicians, however, have always adopted an unfavourable attitude towards the admission of women to their examinations and diplomæ. In the year 1895 they seriously discussed a petition praying for the abolition of the sex distinction in the candidates for the diplomas of the Colleges. The petition was rejected both by the Surgeons and by the Physicians, but not by large majorities, and there the matter has rested until lately. The subject has recently been brought to the front, however, by the appointment of a committee of the Surgeons to consider the question afresh. From all that we can gather, it seems to be within the bounds of probability that the women may carry this as they have previous positions. Moreover, there is some rumour that even so highly conservative a body as the London College of Physicians may surrender in a similar fashion. Indeed, as the two institutions examine by means of a conjoint board, the consent of both would be necessary to enable women candidates to sit for the ordinary diplomas, and it is hardly likely that the College of Surgeons would admit candidates for the F.R.C.S., whom the College of Physicians would decline to allow to sit for the M.R.C.P. However, the mere fact that such changes come within the range of practical college politics throws a gleam of hopefulness upon the situation as regards much-needed reform in other directions.

The Royal Society of Medicine.

THE amalgamation of London Societies has now settled upon a name, which is both dignified and imposing. As "The Royal Society of Medicine" we wish the new body a long and distinguished career. It is interesting to recall the fact that similar proposals to join forces were put forward nearly forty years ago. There are twenty-five societies in the Metropolis that would be eligible for inclusion, and of these twelve have agreed to join, four are willing to join conditionally, and of the remainder five have definitely declined the invitation. It is interesting to note that one reason urged against the selection of the title of "The Royal Academy of Medicine" was that the abbreviation R.A.M. is already popularly allotted to the Royal Academy of Music.

The Health of Belfast.

As has been expected for some time, the Government has appointed a Commission to inquire into the health of Belfast. The terms of reference are of the widest possible character, including "any subject that bears directly or indirectly on the health of Belfast." Much interest has been roused on sanitary matters in Belfast during the last few months, and several candidates were returned to the Corporation on the "Public Health Ticket" at the recent elections. The proceedings of the Commission will therefore be watched with close interest by the citizens at large, an interest greatly increased by the events of the past few weeks. As is well known, the city is at present being visited by epidemic cerebro-spinal meningitis of a virulent type, the disease showing no signs of diminution. At the same time, typhoid fever has broken out and the infection has been traced by Professor Symmers to the water supply. While the Commission, therefore, is likely to have many serious questions to decide, we cannot help expressing wonder at its *personnel*. Only three of its five members are medical men, and distinguished as the other gentlemen may be in their individual spheres, we cannot but think that an inquiry into the health of a community is for the most part a

matter for medical men. The Commission should, we think, have been mainly constituted of active working medical officers of health; only one of the members, Dr. Chalmers, of Glasgow, is a medical officer of health. Moreover, for the present condition of affairs two bodies are responsible, the Corporation of Belfast and the Local Government Board of Ireland. It seems strange, therefore, that two of the five commissioners should be officials of the latter body.

Carlyle and Women.

AN unpublished letter from Carlyle is always likely to be more or less of an event, and such a letter of his, written in 1871, was published in the *Scotsman* last week. For the medical profession it possesses particular interest from the views therein expressed by the sage on women and medicine. After expressing his opinion that the "true and noble function" of a woman was to be a good wife, housewife, and mother, he goes on to say that "If a woman miss this destiny, or have renounced it, she has every right before God and man to take up whatever honest employment she can find open to her;" also that medicine is not intrinsically unfit for women, because they have virtually practised medicine and surgery, to say nothing of nursing, on their relatives and friends since the world began; "in much more sound and earnest ages than ours," as he characteristically puts it. Then he continues: "Two things are not doubtful to me in this matter. First, that women —any woman who deliberately so determines— have a right to study medicine, and that it might be profitable and serviceable to have facilities, or at least possibilities, offered to them for so doing; and second, that, for obvious reasons, female students of medicine should have female teachers, or else an extremely select kind of men, and, in particular, that to have young women present among young men at anatomical classes, clinical lectures, or generally studying medicine in concert is an incongruity of the first magnitude, and shocking to think of to every pure and modest mind." Yet in thirty-five years this "incongruity of the first magnitude" is a commonplace, or nearly so. Is it because there has been difficulty in finding "the extremely select kind of men," or that the selection has proceeded on the usual Darwinian lines?

Burial Law Reform.

WHEN, we wonder, is the question of reform in the law relating to the certification of deaths and to burials going to be taken up seriously? There is no sort of mention of it in the King's Speech this session, and no indication that the necessity for it is recognised. Yet every year the bodies of numbers of persons are buried without certificate, and the law still requires no burial order for still-born children, or children alleged to be still-born. In other words, every year numbers of children are murdered soon after birth and buried as "still-born." Only last month at Walsall an inquest was held on a child who had died four hours after birth. The midwife put the body in a dry-soap box with a view to burial, and would have actually buried it, if the police had not had information which caused them to seize the box. The mother denied knowing anything about the manner of the child's death, and the medical witness testified to there being some marks on the face. The jury found eventually that the child had been suffocated in bed by a hand being placed over the mouth, but by whom there was no evidence to show. The midwife was censured. The jury were horrified to find out that any number of still-born children could be buried in a cemetery by the bearer of the body merely answering a few questions, and they registered their view that the law needed alteration. So, indeed, it does, but as there is no political capital to be made out of dead babies in England, the question is likely to have to take a back seat for a great many sessions yet to come.

PERSONAL.

DR. GEORGE CARPENTER lectured on February 20th at the Institute of Hygiene on "The Rearing of Children."

DR. A. J. RICE-OXLEY has been appointed a Physician in Ordinary to her Royal Highness Princess Henry of Battenberg.

ON February 20th, at a meeting of the Elective Committee of Chester Infirmary, Mr. W. Henry Dobie, M.B., C.M.Edin., M.R.C.S.Eng., was appointed to the position of honorary surgeon, vacated by the resignation of Mr. James Taylor. Mr. Dobie has been for ten years honorary assistant surgeon to the infirmary.

DR. R. G. ALEXANDER has intimated his resignation as honorary physician to the Halifax Royal Infirmary, to which post he was elected in 1886 as successor to his father, the late Dr. William Alexander, who had held that position since 1840.

AT the meetings of the Poor Law Commission held last week the following medical witnesses were examined:—Dr. James Allan, medical superintendent, Leeds Union Infirmary, Dr. Spottiswoode Cameron, medical officer of health, Leeds, and Dr. Scurfield, medical officer of health, Sheffield.

PROFESSOR RONALD ROSS, F.R.S., will lecture at the Royal Sanitary Institute on Friday, March 1st, on "Points of Interest connected with Tropical Sanitation."

DR. F. S. TOOGOOD will give an address at the annual general meeting of the Association of Certified Dispensers on Thursday, February 28th.

Sir JOHN MOORE, M.D., visiting physician to the Meath Hospital, has been elected president of the Irish Medical Schools' and Graduates' Association.

THE Gillson Scholarship in Pathology of the Society of Apothecaries of London has been awarded this year to Francis Arthur Bainbridge, M.A., M.D.Camb., D.Sc.Lond., M.R.C.P.Lond., of Guy's Hospital.

MR. LUKE WHITE, M.P., who recently introduced into Parliament a Bill to abolish "viewing" of the body at inquests, is the only coroner who couples that office with a seat in the Commons.

MR. HERBERT SAMUEL, M.P., Under-Secretary for the Home Department, intends to re-introduce at an early date, with some modifications, the Poisons and Pharmacy Bill, which will ultimately settle the vexed question as to the use of the title of chemist and druggist by trading companies.

A Clinical Lecture

ON

THE TREATMENT OF CONCOMITANT CONVERGENT STRABISMUS.

By J. B. STORY, M.D., F.R.C.S.I.,

Surgeon to the Royal Victoria Eye and Ear Hospital; Ophthalmic Surgeon to Dr. Steeven's Hospital, Dublin.

The subject of Strabismus is one upon which it is very desirable that the student should have correct views, as when established in practice, no matter what his or her speciality may be, advice will be sought by anxious parents for the treatment of this deformity in children's eyes.

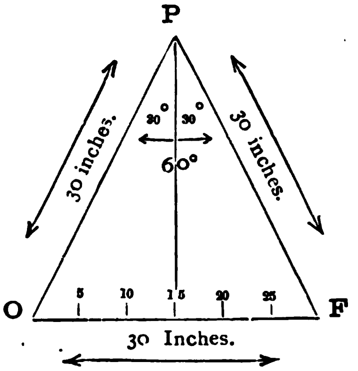
The questions asked by the parents will probably be (1) Is there a cast? (2) Can it be cured? (3) When should it be treated, or, perhaps, will the child grow out of it? Now, the answer to the last question is the most important of all, and that answer is, that *the deformity should be treated at once, and the earlier the better.* That the child may grow out of it is not impossible, but is so far from being probable that it should never be entertained by any reasonable person, for theory and experience are at one in maintaining that these deviations do not get better, but for a time grow worse, and then remain permanent.

Until a few years ago it was very usually held that surgical interference in Strabismus should be postponed till the child was five or seven years of age, and this opinion you will find in many text-books, and it is acted on by many medical men all over the country. Nothing can be more harmful than that cases of Strabismus should be left to nature, as this opinion leaves them, during the first six or seven years of life. Treatment should be commenced as soon as the cast is observed, and as regards operation it should be performed as soon as the effect of treatment shows that operation is necessary.

I have already answered the second question inferentially. The deformity can be cured, and now we come to the first: "Is there a cast in the child's eyes?" This is ascertained by getting the child to fix some object (a bright object like the ophthalmoscope mirror in the case of a very young child) and observing if the two eyes appear to be directed at the object. If one eye appears crooked, slip your hand before the straight eye, and if a movement of the crooked eye occurs, Strabismus is present. This diagnosis is substantiated by observing at the same time that the originally straight eye has turned crooked behind your covering hand. The deviation of the usually crooked eye is termed the Primary Angle, and that of the usually straight eye, when you have excluded it from fixing the object and the crooked eye is fixing, is termed the Secondary Angle.

As a matter of clinical experience these two angles are equal in all cases of Strabismus properly so-called, and it is in the equality of these angles that Strabismus differs from Paralysis.

When making this examination you may find that the crooked eye does not fix at all, or looks to the side of the object when you cover the good eye. You then conclude that it must be more or less Amblyopic. This, however, is no bar to treatment, and in sufficiently young children no bar to cure. Before commencing treatment you must note the amount of the squint—in more technical terms the size of the angle of deviation—and this is a quantity that none of you will have any difficulty in measuring if you adopt the simple plan that has been proposed by Priestly Smith. The only instrument required is a tape measure. The one I use is thirty inches in length, and of course only determines the angle of squint for a fixation distance of thirty inches. This is the method. I seat myself in front of the patient thirty inches between his eyes and my own right eye and reflect light by an opthalmoscope mirror into his eyes. One of these eyes is straight, and I see the reflex of the ophthalmoscope in the centre of the pupil of that eye. The other eye is crooked, and the reflex is seen to the outer side of the pupil, perhaps close to the periphery of the cornea. I now move my finger towards the side of the crooked eye, keeping my own eye still thirty inches distant from the child's eye, and also keeping my finger the same distance from it, and persuade the child to look at my finger. As the good eye follows my finger towards the side of the crooked eye, the latter moves also in the same direction, and a time comes when the crooked eye arrives at the point from which the good eye started—viz., pointing straight at my eye and the ophthalmoscope, and I know this by observing the reflex of the mirror in the centre of the pupil. I then measure the distance my finger has travelled from my eye along the tape, and I record one degree of strabismus for each half-inch of that distance.



In the triangle I have drawn on the board, the patient's eye is at P. the observer's eye at O, and the observer's finger has moved along the line from O to F.

You will say at once that I have not measured either the primary angle of squint in this case, or the secondary. And I admit that you are correct. What I have measured is the angle through which the good eye has happened to rotate during the time that the crooked eye rotated from some unknown position to the point at which the good eye was originally fixed. This angle, however, is equal to the other angles, so that in measuring it I have measured both the primary and secondary angles. I am speaking from a purely clinical "practical" point of view, for neither the ophthalmologist nor the mathematician can accept the method as perfect.

You will understand why I say that each half-inch measured corresponds to one degree of strabismus from the following considerations:—If my finger has travelled, let us suppose, the distance of thirty inches along the tape measure before I perceive the reflex of my mirror in the centre of the pupil of the crooked eye, then you see I have obtained an equilateral triangle, one of the angles being at the patient's eye. There are thirty inches between my eye and the patient's eye, and between my finger and the patient's eye. Each angle of such a triangle is two-thirds of a right angle, or sixty degrees. If my finger is but half that distance from my eye, the angle at the patient's eye is halved; it is then thirty degrees, or if the distance is but one-sixtieth of the original thirty inches the angle is just one-sixtieth of the original angle—viz., one degree.

It is obvious that, mathematically, this calculation is not quite correct, but the errors of calculation are so very much smaller than the unavoidable errors of observation that they may be neglected. There are other methods of measurement that are more perfect from a mathematical point of view, but they are all subject to much the same errors of observation, and no method gives accurate results unless the crooked eye has such good power of fixation that the observation can be corrected by an exact knowledge of the true position of that eye.

There are defects also in the method from a purely ophthalmological point of view, some of which are probably familiar to you. First, the centre of the pupil does not always coincide with the line of fixation. This can be observed in the straight eye. It is seldom the reflex of the mirror is seen in the centre of its pupil when it is actually looking at the ophthalmoscope. What we attempt to do in such a case is to get the mirror reflex in a corresponding position in the pupil of the crooked eye, and then assume that this eye is directed straight at the mirror.

In another respect you will also observe that my examination is incomplete, for I have only measured the angle of squint for a fixation distance of thirty inches. Who knows that it is not greater or less at other distances? As a matter of fact, it usually is, and in cases where the child is old enough to permit these measurements to be made with any approach to accuracy, further examination should be undertaken.

This would take up too much time at present, and we shall proceed to the matter of treatment.

Now the method of treatment depends upon the theory we hold of the etiology of strabismus. Is it a purely "mechanical" deformity caused, for instance, by a congenital shortness of a muscle? All theories of this description are now quite abandoned. Is the deformity due to defective vision in the crooked eye? Although defective vision is admitted as one of the factors, this theory is also abandoned, as it seems to be pretty well established that the strabismus is more to be regarded as the cause of the amblyopia than the converse.

The theory that is most widely held at present is that CONVERGENT STRABISMUS IS "A DISEASE OF INNERVATION." The visual centres fail to control the act of convergence, and the act becomes excessive, just because it is uncontrolled. This failure of control depends upon some derangement of the visual apparatus, central or peripheral, which need not concern us just at present. Hypermetropia is a predisposing cause, and once a squint occurs the disorder is confirmed by the suppression of the retinal impressions in the squinting eye.

FUSION FACULTY.

The normal man possesses, as you all know, a faculty for fusing the two images formed upon his two separate retinæ into a single image. Otherwise, we would see all objects double. A defective development of this faculty is present in every case of strabismus, and is to be regarded as essentially the cause of the deformity. Without this faculty, what we call binocular vision cannot exist, and if it is present and a deviation, a squint, exists, diplopia must be present too. Diplopia is never complained of by squinting children, though possibly it exists when the squint first appears. At that early age the child cannot tell us. Or, again, the squint may come on before there is any definite fusion faculty in existence. The fusion faculty has, unlike the poet, to be made, for it is certainly not born with us. That the new-born baby does not possess it is obvious to the most casual observer. Other faculties, other centres, are also imperfect, undeveloped, at birth, and the eye itself is even anatomically an incompletely developed organ.

As regards the fusion faculty, Worth holds that it normally attains its full development before the age of six. Up till that age there is, then, some chance of improving an imperfect faculty, or even of developing one apparently non-existent, but after that age the attempt is probably hopeless, and a perfect cure—that is, the establishment of binocular vision—is impossible. No cure is really perfect unless binocular vision is attained, and this cannot be attained in many cases. But a cosmetically perfect cure is always possible, even when the crooked eye is practically blind.

There are many points that ought to be determined before making a prognosis or undertaking the treatment of a case. In very young children all of these cannot be determined, but we should deal with as many as we can:—

(1) Is the squint unilateral or alternating?

(2) Is it continuous or periodic, and if the former, constant or varying in amount?

(3) What is the physical condition of each eye? Perhaps there may be a patch of central atrophy in the retina.

(4) What is the functional condition of each eye—viz., vision, field of vision, refraction, fixation power of crooked eye, which has been already mentioned, the possibility of eliciting diplopia by prisms or coloured glasses, &c. A good fixation power and the possibility of seeing double are favourable prognostic signs.

(5) What power have the muscles to rotate the

eyes in different directions—that is specially their lateral movements.

TREATMENT.

Having established as many of the above points as the case permits, or as we think necessary, the next thing to do is to try what change in the condition can be produced by paralysing the accommodation. This is done, of course, by the use of atropine, but if the squint is unilateral and more especially if the crooked eye has no proper power of fixing, the atropine must be used only in the good eye. This is most important, as by doing this we diminish the sharpness of vision in this good eye, and induce the child to make use of the crooked eye in preference. We still further throw the crooked eye into use by getting the nurse or mother to put a pad or bandage over the good eye for some definite period two or three times every day. The most satisfactory result you can have from the above treatment is when the mother reports to you in the course of one or two weeks that " the bad eye is cured, but, unfortunately, the cast has gone into the good eye." This proves that there is good power of sight and fixation in the originally crooked eye. We now put atropine into the good eye also, and expect, what does not always happen, that the two eyes will become straight. If they do, the wearing of glasses (to correct the hypermetropia or astigmatism that is nearly universally present) will probably effect a permanent cure. Or atropine may have to be used for some weeks longer, along with the correcting glasses. If the child is quite too young to wear glasses at all, we can only continue to use atropine in moderation until we can put on the glasses.

The immediate cure effected by atropine and glasses is not always permanent—by which I mean that the cast returns when the atropine is discontinued. In these cases atropine may be used for several months without danger, and glasses worn that over-correct the hypermetropia—in fact, render the eyes artificially myopic.

The solution of atropine I employ is usually the liquor atropiæ sulph. of the Pharmacopœia, but in very young children I use only half the strength. One drop in the eye twice a day is as much as is ever required, and in cases where a long continuance of the mydriatic is indicated, one drop every second day may be sufficient. You should be careful to avoid toxic symptoms in young children. They mostly come from the solution passing down the nasal ducts into the nose and pharynx. You will prevent this happening if you have the eye dried with a handkerchief immediately after the drop has been instilled.

STEREOSCOPIC EXERCISES.

When we have got the eyes straight by the treatment already described, or, indeed, before this happy result is obtained, we attempt to develop and improve the dormant power of fusion by stereoscopic exercises. There are many instruments devised for this purpose. The one I employ habitually, and which I get my patients to use at home, is the stereoscope of Hallwach. It is so cheap that persons of moderate means can afford to buy it. It differs from the ordinary stereoscope in being capable of adaptation to any degree of squint. In the ordinary stereoscope only those who have no squint can fuse the two pictures. In Hallwach's, fusion can be effected even if there is a squint of fifty degrees. Different pictures are employed according to the amount of binocular vision present in the case. In the first type, where only what is termed simultaneous macular perception is present (that is, where the child perceives that there is a picture before each eye—viz., can see the two pictures at the same time; for in consequence of the suppression of the image formed in the crooked eye, many cases cannot see the picture formed in that eye so long as the good eye is open), pictures are used like this of a bird in one picture, and a cage in the other. We try then to get the child to see the bird and the cage at the same time, and then to get him or her to see the bird actually in the cage. Other types of pictures are like this : a dog trying to jump up a pillar in one picture and a cat standing on the top of a pillar in the other. The child should see the two pillars as one, with a cat on the top and a dog trying to jump up. None of the pictures of this type elicit true binocular vision—that is, the perception of depth, solidity, distance. When this is attained the cure is perfect, but we have to use pictures of another type to demonstrate the existence of perfect binocular vision. When the child fuses any of these pictures, we try to increase his or her range of fusion by altering the angle of the stereoscope, so that the eyes have to be more converged or diverged to keep up the fusion.

There are other instruments devised for the purpose of developing and exercising the fusion faculty, of which the amblyoscope of Worth is perhaps the most perfect. It is an instrument which is employed by the surgeon himself, and not suitable for home use in consequence of its relatively high price.

The treatment described can be carried out by any medical man, and does not require the attention of a specialist in ophthalmology, though naturally the family doctor will procure the collaboration of an oculist when possible. When, however, this treatment has been given a sufficiently long trial without producing a cure, a specialist is, in my opinion required in order to determine if an operation is necessary, and if so what operation.

I shall not enter into this matter in the present lecture, not alone on account of want of time, but also on account of the impossibility of laying down definite rules either as to the length of time treatment should be carried on before having recourse to operation, or as to the particular operation to be done in a given case.

Each case must be judged according to its own special idiosyncracies.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Patrick Dempsy, F.R.C.S.I., M.R.C.S.Eng., Surgeon for Diseases of the Throat, Nose and Ear, Mater Misericordiæ Hospital, Dublin, on " Empyema of the Maxillary Antrum."*

MEDICAL MEN AND THE POOR LAWS.—At the meetings of the Royal Commission on the Poor Laws on January 28th and 29th, evidence was submitted by Dr. James Niven, Dr. Barlow, Dr. Meredith Young, and Dr. J. Milson Rhodes; and by the following witnesses representing the British Medical Association : Dr. J. Macdonald, Taunton ; Dr. H. Langley Browne, West Bromwich ; Dr. Ford Anderson, Hampstead ; and Mr. J. Smith Whitaker, medical secretary.

ORIGINAL PAPERS.

THE GYNÆCOLOGY OF TO-DAY AND FIFTY YEARS AGO. (*a*)

By W. D. SPANTON, F.R.C.S.

The tendency of recent years has been to specialize in every department of science. Hence it comes to pass that the modern gynæcologist is acknowledged to be one devoted rather to the special maladies of women than to obstetrics. More often than not, indeed, the gynæcologist does not practise obstetrics at all, any more than the pure physician does surgery. He finds, in fact, quite enough to do in his own department, which is mainly surgical. The general practitioner, especially in remote districts, must necessarily combine both offices, so perhaps a few remarks on this practical side of the question may not be out of place.

Mr. B. Jessett told us recently, in his interesting story of the history of ovariotomy, some of the difficulties which were encountered by ovariotomists in its early days. I recollect seeing Spencer Wells and Baker Brown operate in the early sixties, and at that time the operation was looked upon as quite an event, especially in a general hospital. This is hardly to be wondered at, with the mortality which then prevailed. It requires a considerable amount of courage to perform an operation which has been denounced from the medical pulpits as unjustifiable and murderous. The same denunciations have been made concerning many surgical procedures, notably those for the radical cure of hernia, and it is a significant fact that opposition came chiefly from those metropolitan teachers whose knowledge of anatomy and the principles of surgery ought to have availed to prevent them With the exception of John Wood in London, all the early successful work in this direction was done by provincial surgeons, notably by that sound surgeon, Sir W. Mitchell Banks. But this is a digression.

Let us consider for a moment the attitude of the profession half a century ago, with regard to some other affections of women which are matters now of everyday occurrence.

Take, for example, the excision of the cervix uteri for various forms of cancer. We are told that this operation, which had been performed repeatedly on the Continent, had been very rarely done in this country. Lisfranc was at this period its foremost advocate, and his results may be gathered from the fact that out of 19 private cases, four died within 24 hours, and 12 had an immediate relapse. In another series we find, out of 9 patients operated on, 6 had frightful hæmorrhage, three of whom died within 24 hours. "Such facts were held to deter the most hardy from attempting this fearful operation." (*b*) Another writer, Dr. Montgomery, declared his "conviction of its almost universal impracticability, and of its utter inutility." Dr. Robert Lee also stated "it must appear unnecessary to pass a sentence of condemnation upon the practice of removing the uterus, either wholly or partially, when afflicted with malignant disease. The operation appears to be equally cruel and unscientific." This was the leading text-book of that period. But, in spite of these pronouncements, Professor (afterwards Sir) James Simpson had then operated on eight cases, only one of whom had died, and a few single cases of success are recorded by other operators.

One can hardly be astonished at the dread of this operation when we read of the methods of procedure. Dupuytren used a kind of spoon with a cutting edge, "cullier tranchante," by which the cervix was gouged out. Various other mechanical contrivances of an elaborate character were employed by other Continental surgeons, but in none of them was any attempt made apparently to amputate in what we now consider a surgical manner—by making flaps and properly securing the vessels. To restrain hæmorrhage plugging alone seems to have been resorted to, which failed more often than not. Here, as in so many other matters, it was not until the true principles of clean surgery were adopted that any real success was attained. No one now ever anticipates a fatal result from a properly conducted operation for excision of the cervix uteri.

Then we come to extirpation of the whole uterus. In the presence of so many who have had far larger experience of this operation than I have had, I wish to speak cautiously; but certainly the immediate results of the operation as practised now are abundantly conclusive as to its safety. How far it is curative when performed for malignant disease may be still an open question. At the date I am referring to, however, it was proscribed even more rigorously than the operation limited to the cervix.

Vaginal hysterectomy for prolapsed uterus, associated with many conditions, such as inversion, polypus, and so on, had been successfully practised by many obstetricians then, some being done in a very crude fashion. But the deliberate removal of the uterus when *in situ*, for uterine tumours, had been only then just begun, mostly in single instances, among which we find one by our esteemed Hon. President, Dr. Barnes. At that date there is a record of only 19 cases, 6 of which belong to British surgeons. "Of these no less than 16 died in consequence of the operation, one only as late as the fourteenth day, the others mostly on the following or third day at the latest; some in a few hours or even a few moments after the operation."(*a*) Velpeau stated that this operation had been performed 21 times in 20 years, not one of which had been permanently cured. It was about this time, when the fatality of vaginal hysterectomy was so alarming that Dr. Clay, of Manchester, and Dr. Köberle, of Strasburg, ventured upon abdominal hysterectomy. Dr. Clay's first patient, where he also removed both ovaries, recovered.

When we remember that the usual method employed then was either to use the ecraseur or one or more ligatures which were left to slough away, the time occupied being from three weeks to two months, no surprise need be experienced at the extremely large proportion of fatal cases. With modern methods, in which the ordinary principles of surgery are fully carried out, the operation has been rendered, as we are all aware, a comparatively safe one, and of immense advantage to those unfortunate women who are, without it, doomed to a most pitiable, lingering condition of intense suffering and certain death.

Now we come to abdominal hysterectomy, which, as I have said, was first done successfully by Dr. Clay in this country. Dr. Blundell, with his usual sagacity, wrote about this time:—"Might not the womb be taken out above the symphysis pubis? . . . . The effects of these malignant ulcerations are so deplorable that I think the propriety of extirpating the womb in these cases ought certainly not to be lost sight of." But up to the period of his writing this most valuable suggestion, I can find a record of only four cases, the first being in 1825. Even the bold and sagacious Sir James (then Dr.) Simpson says in 1860:—"Judging of the operation *a priori*, we should regard the operation as unjustifiable, and experience seems only to confirm the judgment. . . . I have no hesitation in saying extirpation of the uninverted uterus is such a hazardous operation that it should be rejected as an utterly unjustifiable operation in surgery."(*b*) Dr. Churchill tells us he finds "it is really difficult to find adequate reasons in its favour, except the repugnance which everyone must feel to give up entirely the hope of affording relief from the most agonised sufferings to which the female sex is exposed." This sentiment, so eloquently expressed, is, I venture to believe, the one which animates us to-day, and is the mainspring of the endeavours which have been made in succeeding years to render such operations so safe, and bring them to such perfection, as to warrant us in not only ad-

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(*a*) Presidential Address, British Gynæcological Society, Feb. 14th 1907.

(*b*) Churchill, "Diseases of Women," 1856.

(*a*) Boivin and Dugès. "Diseases of the Uterus," p. 248.

(*b*) "Lectures by Sir J. Y. Simpson," vol. iii., p. 169.

vising, but persuading our patients to submit to them.

Concerning inflammatory affections of the ovaries, I will quote some extracts from a leading text-book of the period I am referring to:—"Inflammation (of the ovaries) may spread to the broad ligaments and the peritoneum. . . ." And the author naïvely adds:—"It is scarcely necessary to mention that this complication compromises the safety of the patient. . . . The formation of matter is a frequent termination of both acute and chronic ovaritis. . . . The abscess may burst into the peritoneum and cause fatal peritonitis, or it may terminate in gangrene, which will not be discovered until after death," and so on. Then follows the treatment—*secundum artem* of that period, including "antiseptics and chlorides internally, with blisters and camphorated frictions externally," where gangrene is feared. Then it concludes:—"Failing in all these remedies, it has been proposed to cut down upon and extirpate the ovary, but no one has been foolhardy enough to reduce this suggestion to practice." (*a*)

It is quite evident that many of the cases referred to as abscess of the ovary were salpingitis, a subject dismissed in a few lines without any hint of surgical interference. What a change has taken place since that was written! The dread of meddling with the peritoneum which prevailed was, no doubt, one chief reason for the teaching of that day, and those who have taught us not to fear but to utilise the peritoneum have done more, perhaps, to advance abdominal surgery than any other workers. What would be said now of a surgeon who knowingly left an ovary, or Fallopian tube, to set up fatal peritonitis or gangrene without an attempt to relieve it by surgical means?

In looking through the records of early gynæcology. one cannot help being impressed by the fact that, for a long period, most of the pioneer work was done by the Continental obstetricians and surgeons, and in most of the instances I have referred to previously we find ourselves following rather than leading. This is not so now, I quite believe, and our backwardness may be attributed in some measure, perhaps, to the innate modesty of Englishmen—and English gynæcologists in particular—for I can see no other reason to explain it.

In connection with this part of my subject, it is only just to refer to the very important work accomplished by the women obstetricians and gynæcologists of that time. If we take, for instance, the practical records of Madame Bovin, we shall find there information of the most valuable kind, which had an important influence on subsequent practice during the evolutionary stage of modern gynæcology. That indebtedness to women gynæcologists has not diminished as time has progressed, and we are rejoiced to find among our Fellows some whose knowledge and technical skill has never been surpassed.

The time has surely arrived when the scientific teaching of the department of gynæcology, which has been long recognised and carried out in the provinces and in special hospitals, should be adopted in a whole-hearted manner by all the Metropolitan Hospital Schools.

I hope the time will come when more liberal ideas will prevail, and a sort of extramural practice will occupy its proper place, to be recognised on its merits by the examining boards. It is much to be desired that attendance on such a special course should be made compulsory, concurrently with that of obstetrics. Diseases of children might very well be kept apart

To return to my text. I remember the time when fistulæ, rectovaginal and vesicovaginal, were common enough, and the brilliant efforts of gynæcological surgeons at home and abroad were beginning to be recognised. Now such affections, thanks to the better teaching of obstetrics, with the scientific use of forceps, are becoming rare, and there is happily less scope for the surgeon in that direction. On the other hand, we meet more frequently with cases of ruptured perineum since the use of forceps has become general, and it is due largely to the teaching and practice of Lawson Tait that this misfortune has lost its terrors. The general practitioner who meets with a case of ruptured perineum now (and I pity the man who tells you he never had a case), if he be at the same time conscientious and capable, sets to work to repair the damage immediately. Hence it is that only more severe cases come under the care of the operating gynæcologist. This is a thing to be thankful for, and is, I believe, the direct result of the teaching of modern gynæcologists. Happily it has now become a well-recognised rule that no surgeon can be held liable for accidents, such as the rupture of a perineum, especially in primiparæ; while he is liable, both legally and morally, for pecuniary compensation on the one hand, and just opprobrium on the other, if he fails to recognise, and does not at once adopt, the necessary measures to cure such a condition.

Take as another illustration of the enlightenment of the ordinary medical attendant by the advanced teaching of the gynæcologists those varied conditions of endometritis set up by fœtal remains left behind after abortions especially. I remember many years ago a case of this kind, at the time I was assistant to the late Sir W. Priestley, when such conditions were rarely recognised. A patient suffering from a putrid discharge, with general septic condition, was admitted into the cancer wards under one of his colleagues as a well-marked case of cancer. Sir W. Priestley was asked to see her, dilated the cervix, found a small piece of old placenta, removed it, and the patient was soon well—rather to the chagrin of the surgeon who failed to recognise it. Now I venture to think most men are so much better informed that a mistake of this kind is far less likely to happen.

There are some points in this relation which are worth a moment's consideration, notably the difference in the results in private and hospital practice. This is an old story, and I know that opinions differ with regard to it, but no one has ventured yet to assert that the results, both as to fatality and speedy recovery, are not vastly better in private than in hospital. There are many reasons for this, especially the personal element. In hospital work, the after-treatment of cases must necessarily fall upon those who have had less experience than the operator himself—there are many loopholes for the introduction of adventitious elements of danger. The surroundings of the patient are less restful to the nervous system, and, with many, this is a matter of vital moment. On the other hand, in private, the surgeon usually sees the case through himself, superintends each dressing, directs personally every detail, chooses his own experienced nurses, and, above all, is enabled to ensure for his patient that quiet and seclusion which tend so greatly to speedy recovery. The results, so far as my practice is concerned, differ greatly in the two classes of patients—so much so that, with regard to some operations, such as breast excisions, I have never had a fatal case in private among a total of about 350 operations. After laparotomy especially, as we all know, a woman needs absolute repose, and this can hardly be secured in a large ward where something or other is constantly going on. And the reason, I imagine, why the difference is not more marked, lies in the fact that so many hospital patients feel quite at home among, and suffer no harm from, the sights and sounds by which they are surrounded. It is fortunate for them it is so, and fortunate also for the general success of hospital work. When so much is attributed to septicity in its multifarious forms, it behoves us not to lose sight of those emotional psychical elements which are, in their way, equally important in the attainment of surgical success. We all know, too, that a prolonged operation, even if intended to impress on students attention to minute details, or a too rapid and ill-finished one, may mean subsequent excessive shock, which is one of those submerged surgical sandbanks which usually have no lighthouse placed there to warn us. *Festina lente* is not a bad motto for the operating gynæcologist.

Now one word concerning our Society's work. Free discussion tends, above all things, to elicit scientific

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(*a*) "Churchill, "Diseases of Women," 1856.

truth and to promote our best interests. Let us encourage it by all means, so that—

> "We may hold converse with all forms
> Of the many-sided mind.
> And those whom passion hath not blinded,
> Subtle-thoughted, myriad-minded."
> (Tennyson.)

We must remember that life is made up largely of the multitude of small things, and although the great ones may appeal most, it is in the details of our work that we can best utilise our efforts. Nothing need be too trivial to bring forward if it elucidates some practical point, and enables us to render our methods more perfect. It often happens that some of the simplest everyday subjects elicit the most valuable contributions, and most useful discussions. After all, what we desire to attain is the utmost perfection in our scientific work. If everyone will take his or her part, however small and insignificant it may seem, it will be of great value in the aggregate, and make our Society what we all desire it to be—a brilliant success.

FOUR CASES OF MEMBRANOUS DYSMENORRHŒA WITH CASTS. (a)

BY S. JERVOIS AARONS, M.D.EDIN., M.R.C.P.LOND.

TRUE membranous dysmenorrhœa is by no means so common as some authorities would have us believe, though it has been described more frequently than any other form; indeed, Champneys (1) gives a formidable list of references which show the amount of attention bestowed on the subject. It will, I think, be found that cases of dysmenorrhœa with the passage of a cast from the uterus are, in comparison with the number of other forms of dysmenorrhœa, rare, so I need offer no apology for showing these four specimens.

CASE 1.—Mrs. E. M., æt. 31. Married six years. Commenced to menstruate at 14 years, 30-day type, periods last six days. Always had pain, which became much worse during the past four years. She frequently passed shreds, but never a complete cast as in the present instance; this was passed at the last period on the third day. Patient was sterile, and wished to have a family, and sought advice for this as well as for the dysmenorrhœa. On examination, uterus slightly enlarged, lying in normal position. Length of cast, 4.5 cm.; width, 4 cm. Curettage advised and carried out, November, 1905.

CASE 2.—Miss L. J., æt. 15, commenced to menstruate at æt. 13, 28-day type, periods very profuse, and last eight days. The cast was passed on the second day, and she had not previously noticed any shreds or membrane. Her periods have always been painful. Has never missed a period. The mother of the patient was anxious about the child. On examination, the hymen was found intact, and, per rectum, the uterus was felt to be of normal size and anteflexed. Length of cast, 3.5 cm.; thickness, 5 cm.; width, 3 cm. I am indebted to Dr. Dauber for permission to record this case.

CASE 3.—Mrs. M. S., æt. 35. Married eleven years, four children. Commenced to menstruate at æt. 14, 28-day type, periods last from two to six days. The pain is premenstrual, with no history of previous casts or shreds. This was passed on the third day of the period. Menorrhagia. On examination, uterus enlarged and in the middle line. Patient states that the periods have only been painful since the birth of last child. Length of cast, 4 cm.; width, 2.5 cm.; thickness, .6 cm. I am indebted to Dr. James Oliver for permission to publish this case.

CASE 4.—Miss S. L., æt. 45. Commenced to menstruate at æt. 18; last period on December 5th. Cast was passed on December 11th. Passed a cast previously (last October), and also shreds at different periods. Menorrhagia. Length of cast, 7 cm.; width at top (corresponding to fundus uteri), 4.5 cm.; at middle, 2.5 cm.; thickness, .3 cm. I have to thank Dr. Heywood Smith for this cast and for his permission to publish the case.

It is generally stated that the cast of membranous dysmenorrhœa is in the nature of a sac, but that this is not always so reference to the specimens from cases 2, 3, and 4 will prove. You will notice that all three are practically solid. In cases 2 and 4 there are no openings at the angles which would correspond to the openings of the Fallopian tubes and cervical canal; instead they taper off into points. In Case 3 these openings are imperfectly seen. I have cut sections from all except the first, and in all no cavity in the true sense of the word can be found. Case 1 is much more typical of those usually described. I have split it open to show the inside of the cast.

The cast from Case 4 is unusually long, viz., 7 cm. Champneys (2) states "that they never exceed 5 cm., and that a length decidedly greater than this, unless there is evidence that the additional length is due to the extension of the membrane to the cervix or vagina, points strongly to enlargement of the uterus, and is in favour of the diagnosis of abortion." Microscopically, the specimen proves to be a typical membranous cast, and shows no sign of the products of conception.

With regard to treatment, Case 1 was curetted and is now seven month's pregnant; in the interval between the curettage and her becoming pregnant she had no recurrence of her dysmenorrhœa. Sir Halliday Croom (3) states that patients who suffer from membranous dysmenorrhœa are sterile, and this patient certainly was prior to treatment. It will be interesting to see if, after the birth of her child, she has a recurrence of membranous dysmenorrhœa, because Champneys (4) says "not even pregnancy going to full time cures it."

Microscopically they all present much the same appearance. The substance of the cast showing connective tissue with a delicate fibrous stroma with masses of round cells irregularly distributed. In one or two can be seen an aggregation of cells in an oval-shaped envelope, suggestive of broken-down glandular elements.

For the sake of comparison, I show a cast from a case of ectopic gestation, which was passed a few days prior to operation, also one of a six weeks abortion. It will be seen at once how much these differ from those casts of membranous dysmenorrhœa which I have passed round to-night.

Since writing the above, I have received another cast, which I show, from the patient described under Case 2. It exactly resembles the first one passed except that it is perhaps a little smaller.

(a) Read before the British Gynæcological Society, February 14th 1907.

REFERENCES.
(1) Champneys, "Painful Menstruation."
(2) *Ibid*, page 54.
(3) "System of Gynæcology," Allbutt and Playfair, page 101.
(4) Champneys, "Painful Menstruation," page 56.

CLINICAL RECORDS.

LARGE FIBROMYOMA OF THE UTERUS.

By JOHN H. DAUBER, M.B., B.Ch., M.R.C.P.

MRS. H., æt. 57, a multipara, had suffered from a large fibroid tumour for the last 12 or 14 years. Ten years ago, when it reached the umbilicus, she was advised that it was not a case suitable either for hysterectomy or oöphorectomy, and that at the menopause the fibroid would begin to shrink.

The patient was a small, pale, hollow-cheeked, emaciated woman, with the abdomen enormously distended with a hard tumour reaching to the diaphragm and embarrassing respiration and the action of the heart, and the pulse rate was 120-130. In walking the patient had to lean back in order to maintain her balance.

Operation, Friday, February 8th, 1907, Mr. Ogle giving gas and ether, and Dr. Mansell Moullin assisting.

The abdomen was so distended that as the patient lay on her back the sub-umbilical incision was perpendicular instead of horizontal. As soon as the peritoneal cavity was opened a gallon or more of ascitic fluid escaped. The incision was carried to within half an inch of the ensiform cartilage. On the left the tumour burrowed beneath the broad ligament, which was pushed up as far as the costal margin. Above, the transverse colon and omentum were intimately adherent to it. The adhesions could not be broken down, and had to be clamped, cut, and tied. There were extensive adhesions on the right side to the ascending colon, and below the tumour seemed intimately incorporated with the bladder by an attachment as thick as one's wrist. This was cut off the bladder, which bled freely, but the muscular coat only being laid open was stitched together again with fine silk. The uterine arteries were tied in the usual manner, the broad ligament on the left side being incised and the left portion of the tumour shelled out by stripping the peritoneum off it. The cervix uteri, which was small and high up, was then cut across and the tumour removed. It weighed about 28 lbs. Both ovaries were left. The broad ligaments and stump were sewn over in the usual manner, and the long wound sewn up in three layers with silk, the assistant and operator both sewing at the same time. A pint of saline injection was administered per rectum, and the patient put to bed. She had been previously wrapped up in cotton wool from head to foot, with the exception of the field of operation. There was practically no shock, and the patient has made up to the present a good recovery.

The operation lasted a little over an hour.

The principal object he had in showing this specimen was to demonstrate the futility of waiting for the menopause in cases of fibroid disease. He had seen many lives ruined by this advice having been followed. He himself advised the removal of all fibroids as soon as discovered, and in no single instance had he ever regretted having given such advice.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

A CASE OF BRANCHIAL CYST.—Mr. JOSEPH CUNNING operated on a patient, æt. 18. Before beginning, he pointed out that the patient had a swelling in the left anterior triangle reaching from the parotid region to the level of the upper border of the thyroid cartilage, and about the size of an orange.

The swelling was first noticed five years ago, and had gradually reached its present size, though at times it had varied, sometimes getting larger, sometimes smaller. It had never been painful or tender.

The lump was fluid in consistence and not tense, while the tissues covering it were not adherent to it. The sterno-mastoid muscle could be demonstrated to be lying superficial to the outer part of the tumour.

There were no other lumps to be felt on either side of the neck.

Mr. Cunning remarked that this swelling was undoubtedly a branchial cyst, and that the only thing which could be mistaken for it was a chronic tuberculous abscess. But the long history of five years was decidedly against the latter, while the fact that there was no trace of infiltration of the surrounding tissues, and still more that there were no enlarged glands to be felt apart from this swelling, completely put out of court the possibility of it being a tuberculous abscess.

Mr. Cunning then made an incision three inches in length along the upper part of the anterior border of the sterno-mastoid, and after dividing the platysma, came upon the wall of the cyst. The tissues were easily peeled off it, and on its outer aspect, it was found going well out under the sterno-mastoid. The spinal accessory nerve had here to be separated very carefully from the cyst wall. Then, working round to the inner side, the cyst was found to go deeply in the neck between the branches of the carotid artery, and here the descendens noni had to be peeled carefully off the tumour. Working up higher, the hypoglossal nerve and the posterior belly of the digastric muscle were in turn exposed, and under this muscle the upper part of the sac dipped. A little careful dissection here soon freed the uppermost limit, which was running to the neighbourhood of the tonsil, and the cyst was removed whole.

Bleeding vessels were tied, and the cut edges of the platysma sutured; the skin wound was then closed. Mr. Cunning remarked that there were two very important points to be considered in connection with a branchial cyst. The first was that it should never be mistaken for an abscess and merely drained. It was easy enough sometimes to mistake the fluid contained in these cysts for pus, for it varied in character from clear serous to thicker yellow fluid, and finally to whitish stuff of the consistence of porridge. The nature of the fluid depended upon whether the lining was skin or mucous membrane. If the mistake were made of merely opening a branchial cyst, it would be found that a constantly or intermittently leaking fistula remained.

The other point of importance was that no one should operate upon these cases unless he was prepared to make a deep dissection of the neck, going between the branches of the carotid down to the wall of the pharynx, and following the cyst up under the digastric, for if any portion should be left, the cyst would soon reform.

These cysts were interesting morphologically, and were of the nature of sequestration dermoids, *i.e.*, a portion of a branchial cleft remained unobliterated, and as time went on the glands in the epithelial wall secreted and so dilated the space more and more till at last quite a big cyst resulted.

A curious feature in the last three cases of this kind he had operated upon was that they gave a history of alternating increase and diminution in size. That, he supposed, was due either to some excess in secretion or to inflammatory exudation. In the latter case it was easy to understand that traumatic causes might play a part, as these patients were usually young, and therefore subject to rougher usage than older people.

The situation of the cyst he had just removed was that of the most common type, and there was no doubt it belonged to the second branchial cleft.

Mr. Cunning called attention to the fact that he had stitched together the cut edges of the platysma. That was a precaution often neglected, but was important from the point of view of obtaining an unnoticeable scar. He had adopted that method since he first watched his colleague, Mr. James Berry, carefully stitching together the infra-hyoid muscles and subcutaneous tissue in goitre operations and observed what beautiful scars resulted.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

Meeting held February 22nd, 1907.

Dr. Hale White in the Chair.

Mr. Raymond Johnson and Mr. C. E. Reynolds described a case in which

A MENINGOCELE IN THE SACRAL REGION WAS SUCCESSFULLY TREATED BY OPERATION IN AN ADULT, AFTER THE SAC HAD RUPTURED SPONTANEOUSLY.

The patient was a woman, æt. 22, in whom the tumour of the back had only been noticed for about two years. The tumour was of the size of a large orange, and after spontaneous rupture of the thin skin covering its summit large quantities of cerebro-spinal fluid continued to escape. An operation was performed on the second day, and the small opening by which the sac of the meningocele communicated with the theca was treated like the neck of a hernial sac and ligatured; the rest of the sac was removed. On the sixth day after the operation cerebro-spinal fluid again began to escape from a small opening in the otherwise healed wound. For thirty-seven days the free discharge continued; a second operation was then undertaken, and a very small opening which led into the theca was closed by suture. From this date no further leakage occurred, and the wound remained soundly healed. Several months later the woman was reported to be in perfect health. A point of interest in this case was that the tumour formed by the spinal meningocele was not noticeable until adult life had been reached, although a small dimple in the skin over the coccyx had been present from birth. It was further of interest that during the period of more than a month, when cerebro-spinal fluid was constantly escaping in large quantities, the patient presented no symptoms directly attributable to the loss.

Dr. **Hale White** referred to Dr. St. Clair Thomson's celebrated case in which large quantities of cerebro-spinal fluid dripped from the nose. The patient lost three times as much fluid that way as by the kidneys, and yet was in perfect health.

Mr. W. G. **Spencer** had operated on a similar case which was leaking and suppurating at the time. There was a dermoid cyst in the wall of the meningocele, and that was probably the source of irritation that had promoted rapid growth. In the present case the amount of fluid might have been due to local sepsis, and so caused no general symptoms, because it was derived merely from a local area. He detailed two operations he had performed in infants suffering from a like condition.

Mr. C. H. **Fagge** said that with a view to the prevention of leakage he was in the habit of first suturing the dura transversely, then dissecting up elliptical flaps from the deep fascia of the erector spinae, and suturing this longitudinally over the dura.

Mr. **Raymond Johnson**, in reply to Dr. Alexander Morison, said that no changes in the pulse rate had been noted as the result of the loss of fluid. Indeed, the only change noted anywhere was relief of the headache. He disagreed from Mr. Spencer's explanation of the source of the fluid in the present case, because cultures were sterile till quite late, and then the appearance of staphylococcus albus did not coincide with any increase in the amount of fluid poured out.

Mr. C. H. **Fagge** read the notes of a case of

RESECTION OF THE JEJUNUM AND COLON FOR CARCINOMA OF THE FORMER.

The patient, a woman, æt. 33, had had attacks of abdominal pain, relieved by sickness, for three months; sickness more severe for past three weeks. A hard lump was felt in right iliac fossa. To the left of this were seen peristaltic waves in a large coil passing from left to right. The patient looked ill. Temperature 96° F., pulse 120; she was sick several times.

The abdomen was opened on the day of admission to Guy's Hospital, December 11th, 1905. A malignant mass was found in the jejunum 18 inches from the duodenum, involving the hepatic flexure. An area of the jejunum and colon was resected and closed; double lateral anastomosis of jejunum to jejunum, and ascending to transverse colon was performed with small and large Murphy's buttons; the former was passed about six weeks, latter four weeks, after operation. Microscopically the growth was a spheroidal cell carcinoma.

Dr. **Hale White** commented on the youth of the cases recorded. He shortly described a case occurring in a man of 32. Duodenal ulcer had been diagnosed, but at the operation a jejunal growth was found and short circuited. The patient died later with secondary deposits.

Mr. T. H. **Kellock** inquired whether any symptoms of stricture had appeared as the result of the use of Murphy's button. He agreed as to the difficulty of decision in the matter of the treatment of such cases, as one was practically deprived of the two-stage method of procedure.

Mr. C. H. **Fagge** said that no symptoms at all were present in January. As a general rule, he thought that the use of Murphy's button was not good surgery, but it certainly saved time in many cases.

Mr. T. H. **Kellock** read a paper on

EXCISION OF JOINTS: A NEW METHOD OF OPERATING AT THE SHOULDER.

Attention was first drawn to the fact that comparatively little change had taken place in the technique of the operation on the various joints. Comparison was made between the operation of excision as performed at the hip and shoulder; in the former the section of bone was made within the capsule, and no muscular attachments to the femur disturbed, whereas at the shoulder the humerus was divided through the surgical neck and the insertions of the important muscles into the tuberosities sacrificed as well as, in the case of a child, the most important seat of growth of the humerus. The operation now described was an endeavour to save these muscles and the epiphyseal line, whilst still preserving a movable joint; it was carried out by removing the necessary amount of bone from the scapular instead of the humeral side of the joint. The operation as performed on the dead body was comparatively easy. After opening the joint by a long anterior incision, the muscles attached to the upper end of the humerus were retracted, the coracoid process broken, but not completely separated, and turned a little downwards with the origins of the biceps and coracobrachialis muscles. The neck of the scapula was then sawn through, and the glenoid cavity completely removed, sacrificing only the long tendon of the biceps and a part of the middle head of the triceps and structures of comparatively little importance.

The patient on whom the operation had been performed was a man, æt. 41, who had sustained a dislocation of the left shoulder, complicated by fracture at the surgical neck of the humerus eleven weeks previously. The fracture had united firmly in good position, but the subcoracoid dislocation remained unreduced. At the operation the glenoid cavity and part of the neck of the scapula were removed by gouge forceps, and the head of the humerus fell back easily into the cavity. Passive movements were commenced early. The result had been very fairly satisfactory;

flexion and extension were quite good, abduction fair, but rotation of the humerus on its own axis; all these movements were improved by exercise and rubbing.

It was pointed out that should the operation be performed again for a similar pathological condition, it might be advisable to add a posterior incision to the anterior one, and so, possibly, divide the neck of the scapula from behind, and also to remove a little more bone from the neck of the scapula than was done in this case.

Mr. W. G. **SPENCER** said it was difficult to define such a laxly used term as excision. At the shoulder joint the posterior incision had been long recommended, the circumflex nerve had, of course, to be avoided.

Mr. **RAYMOND JOHNSON** asked as to the nature of the passive movements used. He suspected that sometimes too vigorous early movement defeated its object by causing more cicatricial tissue to form.

Mr. **KELLOCK**, in reply to a question by Mr. Watson, said that he sacrificed the upper part of the long head of the triceps as well as the long head of the biceps, these were less important than the muscles inserted into the upper end of the humerus, because they had other attachments. As to the passive movements, he agreed with Mr. Johnson. In the present case he had, for special reasons, begun them on the tenth day, but, as a rule, he waited later. He recognised that the operation he now proposed was rarely applicable to cases of disease such as tuberculosis, for they usually affected the humerus more than the scapula.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD FEBRUARY 14TH, 1907.

Mr. W. D. **SPANTON**, F.R.C.S., Consulting Surgeon to the North Staffordshire Infirmary, President, in the Chair.

THE PRESIDENT: Ladies and Gentlemen,—It is sad that my first official duty should be to refer to the tragic death of Dr. Thomas Savage, one of our foundation Fellows, in the earthquake in Jamaica. He was President here thirteen years ago, and many of you will remember the admirable manner in which he carried out his duties, his geniality, his professional work, which he understood so well, and his delightful personality. He was indeed a typical illustration of what a gynæcologist should be.

Dr. H. **MACNAUGHTON-JONES** moved :—"The Fellows of the British Gynæcological Society have heard with deep sorrow of the tragic death of Dr. Thomas Savage under peculiarly sad circumstances. He was a valued original Fellow of this Society, and held the office of President with much distinction, contributing in various ways to its progress for many years. The Society deplore his loss, and would convey to his relations their sincere sympathy in the bereavement they have sustained." Dr. Savage began life as an ophthalmic surgeon, was a lecturer in natural history and botany, as well as a distinguished anatomist, and after filling these various offices, he followed the line of gynæcology. Not only did he occupy the position of President of the British Gynæcological Society, but he was also President of almost every important society and public body in the Midlands. He held the position of President of the Obstetrical and Gynæcological Section of the British Medical Association when it met in Birmingham.

Dr. A. E. **GILES**: I willingly second this proposition. Nothing that we can say will lessen the feeling of loss to his family, but we hope that it will be some comfort to them to have an assurance of the high regard in which he was held by the Fellows of this Society.

Dr. **FURNEAUX JORDAN**, in supporting the resolution, said :—I can only express to you the feeling that at our hospital we have lost one of our best friends. He was known amongst us always as a most genial, kindly, and friendly man. His kindness to everybody was absolutely unbounded, his hospitality was almost unique. He never hesitated to sacrifice himself for the sake of those for whom he cared. I think one of the saddest features of his loss is that he felt he was getting younger every year. Since he lost his arm and was compelled to give up work he told me he became younger as the years went by. Only two days before he sailed I met him on the street running along like a boy of fifteen, and he remarked, "Jordan, in a few years' time I shall be younger than you are—I get younger as the years go by."

The vote of condolence was passed in silence.

SPECIMENS.

Dr. S. **JERVOIS AARONS** showed specimens of

NOTES ON FOUR CASES OF MEMBRANOUS DYSMENORRHŒA WITH CASTS.

(which will be found on page 227 of present issue.)

Mrs. **SCHARLIEB** had seen a good many cases of membranous dysmenorrhœa. In one case she would have mistaken it for an abortion if she had not noticed the orifices of the tubes. She entirely agreed that the casts which were sometimes obtained in a case of extra-uterine gestation were much coarser and stronger.

Dr. **MANSELL MOULLIN** remarked that treatment of these cases had very little result. Curetting appeared to be a quite useless procedure. In his experience nearly all such cases occurred in sterile women. He had seen a second membrane was sometimes passed within a period of four days after the first, which showed how rapidly the membrane may form.

Dr. **HEYWOOD SMITH** asked whether any transverse sections of the casts had been made in order to ascertain if there were any indication of cavities when they were first formed, and, if so, whether they had been closed by pressure. He could hardly imagine a dysmenorrhœal membrane not to be an open sac.

Dr. **GILES** said he was interested to see that some of the casts were solid. The teaching one had was that these casts were hollow. He had only seen three cases of membranous dysmenorrhœa. As casts were formed by a kind of exudation in the cavity of the uterus, it was not surprising, perhaps, that from time to time the exudation should appear entirely solid. If the uterine cavity was distended and the exudation passed to the surface of the endometrium, becoming solidified before the surfaces came together, then they would expect a cavity. It would be interesting to hear in future cases whether it was common to have solid casts in membranous dysmenorrhœa.

Dr. H. **MACNAUGHTON-JONES** expressed the opinion that the etiology of cases of membranous dysmenorrhœa was the main point in connection with them. The old idea that they were associated with pregnancy had been long ago discarded, and it was well known that the disease very frequently occurred in sterile women. Many years ago he published a case of membranous dysmenorrhœa where he treated a patient shortly before marriage by curettage and application of chromic acid. The woman married, and shortly after became pregnant, and had no return of membranous dysmenorrhœa. He did not think that any light whatever had yet been thrown on the exact etiology of membranous dysmenorrhœa. Moreover, there were cases which were sometimes mistaken for membranous dysmenorrhœa, where a certain amount of exudation was thrown out in endometritis. Independently altogether of the treatment of membranous dysmenorrhœa, their object in curetting was to get rid of the endometritis. He did not think that the treatment of membranous dysmenorrhœa was so hopeless as some appeared to think. By the application of pure carbolic acid to the uterus, he certainly had cured such cases, and he thought that arsenic given internally was also a valuable aid in treatment. He thought that curettage did good.

The **PRESIDENT** remarked that the specimens illustrated a difficult problem. One always had the idea that the passage of membranous casts in dysmenorrhœa was part of a vicious cycle, and the cases of which they had heard that night seemed to emphasize that point.

Dr. **AARONS**, in reply, remarked that in the second case of the series an unfounded suggestion of pregnancy was made. None of the smaller casts showed a cavity. One of them showed a slight opening suggesting that it was closed by pressure. The best treatment was curettage followed by the application of nitric acid.

Dr. DAUBER showed a specimen of

FIBROMA OF OVARY FIXED IN PELVIS, CAUSING COMPLETE EXTRUSION OF UTERUS.

The patient from whom the tumour was removed stated her age as 77, but looked older. The tumour was removed by the abdomen. The operation was easily borne, and the patient made a rapid recovery without an untoward symptom of any kind. The object Dr. Dauber had in view in exhibiting this specimen was to illustrate the fact that aged patients bore abdominal and other operations remarkably well. He had lately operated on some patients between 70 and 80 years of age, performing hysterectomy or other major operations, and in every case recovery was speedy and complete.

Dr. Dauber read notes of a case of "Fibromyomata of the Uterus," and showed a specimen, which will be found under "Clinical Records," on page 228).

Dr. MANSELL MOULLIN remarked that in the second case the density of the adhesions to the bowel and bladder with the presence of ascitic fluid suggested that sarcomatous changes had already taken place, but he understood that this was not so.

Dr. H. MACNAUGHTON-JONES thought that people in advanced life, unless they were suffering from some other disease, such as disease of the kidney or liver, bore operations practically as well as young people. The other day he had a letter from a lady aged 83 from whom he removed the uterus when she was 71 years of age.

Dr. FURNEAUX JORDAN said that if a fibroid, however small, gave rise to symptoms, it should be removed. The more he saw of these cases the more he came to the conclusion that myomata should be treated in the same way as ovarian cysts.

Dr. ETHEL VAUGHAN said she thought it was important to consider the situation of a fibroid. It might be subperitoneal, and cause such severe pain, and perhaps retroversion or retroflexion of the uterus, as to require removal. In some cases, however, where the tumour was large, it did not cause any symptoms at all. She thought that operations in the case of fibroids should be limited to tumours as large as a uterus of three months' pregnancy. At any rate, the patient should be given the option of an operation, because it caused symptoms which seriously interfered with the patient's pleasure in life and her usefulness. One drawback in making an abdominal incision was that of a scar, especially in a young woman. It depended, she added, more on the position of the fibroid than on its actual size as to whether an operation should be performed or not

Mr. F. B. BOWREMAN JESSETT said he would have regarded the specimen as a rapidly-growing fibroid had he not been informed that it was of about 14 years' duration. He quite agreed that early operation was most desirable for all cases of fibroid. The operation of removing a fibroid from the uterus was so simple that he thought many women suffering from tumours of the kind might be saved a great deal of trouble and risk if they had them removed early.

Dr. HEYWOOD SMITH corroborated what had been said about the question of age and operations.

The PRESIDENT remarked that there was no age limit for surgical operations, and very often older people came through operations better than younger ones. There was no question about removing a fibroid so large as the specimen before them. He would be sorry indeed to have it advanced as a dictum from the Society that every small fibroid should be removed. He quite agreed that many small uterine tumours ought to be removed as possible sources of trouble. But if one was removed, how were they to insure the patient against others coming afterwards? What had struck him very much amongst better-class patients had been the number of cases where one had been tempted to suggest removal of the fibroid, and yet the patients were now perfectly well without any operation whatever, and leading useful lives in society. The removal of some of those fibroids might have resulted in the loss of very valuable lives.

Dr. DAUBER, in his reply, said he thought that every fibroid should be removed. He did not say that the uterus should in every case be removed. He would deal with small fibroids, not by removing the uterus at all, but only in cases of multiple or large fibroids he would do a hysterectomy. The mortality was now so slight in doing an operation of the kind under modern aseptic precautions, that it hardly needed to be considered.

Dr. MACNAUGHTON-JONES said he could not personally protest too strongly, and he would join in hoping that no opinion should go forth from that Society that merely because a woman had a myoma of the uterus the size of a walnut, or some myoma which was giving her practically no trouble, therefore one was justified in removing the tumour. The greatest and most skilled operators in the world did not operate unless some symptom arose which justified an operation. He had always advocated hysterectomy under justifiable circumstances.

The PRESIDENT then gave his introductory address (which will be found on page 225).

Mr. F. B. JESSETT, in presenting a vote of thanks to the President, said he thought they would agree with him that the address to which they had just listened was one of the most interesting addresses that had ever emanated from the Society

Mrs. SCHARLIEB, in seconding the vote of thanks, referred to the complimentary way in which the President had mentioned the services rendered to obstetrics and gynæcology by women as representing one branch of their great profession.

The PRESIDENT gracefully responded to the vote of thanks.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, FEBRUARY 1ST, 1907.

The President, Dr. R. D. PUREFOY, in the Chair.

DR. THOMAS NEIL exhibited a chart showing a convenient methods of keeping a record of obstetrical cases.

Dr. HASTINGS TWEEDY, Sir A. V. MACAN and the PRESIDENT referred to the importance and value of being able to refer to previous records in obstetrical cases.

Dr. HENRY JELLETT exhibited apparatus for sterilising ureteral or other forms of gum-elastic catheters by means of formaline vapour. The exhibit consisted of two instruments—one of which had been brought from Germany by Dr. Gunn, who thought that it had been originally devised by a Japanese; the other Dr. Jellett had made for himself from particulars given by Dr. Gunn. Sterilisation was effected by the constant passage of coal gas, impregnated with formaline vapour through the catheter, which gas was subsequently burnt off in the Bunsen burner, which supplied the necessary heat for generating the formaline. A series of experiments were undertaken by Dr. Rowlette to determine the efficacy of the steriliser, and he reported as follows:—"I have tested the steriliser with cultures of the following organisms—(1) *B. coli communis*, the most common bladder infection; (2) *Staphylococcus aureus*, another common infection; (3) *B. anthracis*, an organism extremely resistent to disinfectants. Experiments were in each case conducted as follows:—An active fluid culture of a couple of days' standing was employed. In this culture an elastic catheter was allowed to stand for ten minutes. The catheter was then placed in the sterilisers for half an hour. It was then dipped and rinsed in melted agar, which was immediately poured out into a Petri dish and incubated at blood heat. In no case did any colonies appear. Controls were employed to establish the vitality of the cultures. The method of sterilsation seems very thorough and satisfactory."

Dr. **Hastings Tweedy** recalled that when the disinfecting properties of formaline were first discussed opinion was strongly against it when vaporised from the solid. If the dry formaline had no sterilising power it must be the coal gas in the apparatus exhibited which acted as the disinfectant.

Sir A. V. **Macan** said that anything that made a catheter quite safe after using in an infected case was a most important matter.

Dr. **Kirkpatrick** said that in experiments on the subject of room disinfection formaline was found to have slight penetrating power. Bacteria could be killed close to the opening of culture tubes, but quite a short way down the disinfection ceased abruptly at a definite line. It was not likely, therefore, to penetrate effectively into the catheters for any considerable distance. Dr. Rowlette's experiments were to a certain extent vitiated by the fact that he probably carried formaline on the catheter into the agar solution, and this formaline naturally prevented growth.

Dr. **Donnelly** drew attention to the possible action of ordinary coal gas on metallic instruments, and suggested that experiments be made to find out whether they would be injured nor not.

Dr. **Jellett** in reply said he was not disposed to take the view that formaline in the dry state would not cause sterilisation. The larger apparatus would take in a cystoscope, but he had not tried it on metallic instruments. The same objection would, however, stand in regard to them as to the use of the apparatus in disinfecting dressings and sponges—viz., that there would be a certain amount of deposit of formaline left on them which would leave sponges and the like in a too irritating state. This objection did not apply to catheters, as they could be washed in sterilised water and the formaline thus removed. He quite appreciated Dr. Kirkpatrick's objection, but did not see how it was to be overcome.

A CONTRIBUTION TO THE TECHNIQUE OF OPERATIONS ON THE APPENDAGES.

Dr. **Henry Jellett** read a paper on the above subject. He said the paper could be divided into two parts. The first part dealt with the methods, which he approved of, and adopted of performing salpingectomy, oöphorectomy, and salpingo-oöphorectomy, as well as plastic operations on the ovaries and tubes. After discussing various practical points connected with the performance of these operations he then suggested that the following principles might be laid down :—(1) Never tie the broad ligament with interlocking sutures or with a Staffordshire knot. The objections to both methods are that—first, they pull the top of the ligament together and so shorten it, and the contracted ligament in turn tends to drag the uterus backwards; secondly, they necessitate the use of silk, as it is difficult or impossible to include so great a mass tightly in a catgut ligature; thirdly that there is always a certain amount of risk of the slipping of ligatures so applied unless a considerable amount of tissue is left beyond them, and as this tissue is deprived of blood, and possibly bacteria-laden, it may subsequently slough and give rise to the formation of adhesions or even to general infection. (2) Never use silk in the presence of inflammation, as it tends to become a permanent depository of infection. (3) Never remove more of the appendages than is necessary. The retention of even a portion of the ovary adds greatly to the future comfort of the patient, and if to this is added even the stump of a patent Fallopian tube, there is present at any rate the possibility of a future pregnancy, instead of the certainty of sterility. (4) Always conclude the operation by performing ventro-suspension of the uterus, otherwise the uterus is almost certain to fall back and contract fresh adhesions, thus often causing the persistence of pain. The second part of the paper dealt with the statistics of thirty cases of adnexal disease on which the speaker had operated according to the methods and principles mentioned in the first part of the paper. It also contained a table showing the exact nature of the operations in each case, the extent of the lesion, the immediate result, and the condition of the patient when she was last seen.

Sir A. V. **Macan** said the paper opened up the whole question of operations on the appendages. The feeling on the Continent was, he said, in favour of the vaginal route as against the abdominal. The question of infection was of great importance. There were four possible infections, and the deciding of which was present was a very important question. Another question was whether it was better to remove the uterus or hang it up to the abdominal wall. The rule for choice should be—No operation if possible; next, the least operation possible, and above all, the retention of function where possible. The possibility of a woman having children in the future had an enormous effect in obviating depression of the mind; and the retention of a sufficiency of ovarian tissue to enable menstruation to continue could not be too highly praised. The feeling abroad in connection with the danger of silk as a focus of infection was that it was impossible to prevent it; hence catgut was favoured for everything except the abdominal wall and intestines. The speaker criticised the paper from the point of view of Professor Martin's latest edition, and indicated the latter's method of dealing with cases of infection and tubercular disease.

Dr. **Hastings Tweedy** said that Dr. Jellett's treatment in the cases he had cited was almost identical with his own, and they were agreed on the point of saving as much as possible. There were some points of detail, however, on which they were not in agreement, but probably they did not make much difference either way. For instance, Dr. Jellett objected to the Staffordshire knot; still it had been used successfully for many years, and he (Dr. Tweedy) considered it a quicker method of tying off the broad ligament than any of the methods suggested, and it was less liable to cause subsequent adhesions. There was not, he thought, any second opinion in regard to the use of silk in an infected case; the burying of it in the midst of septic matter must end in disaster. But it had enormous advantages in other cases. If *fine* silk was used, and was boiled in corrosive sublimate, it was capable of resisting germs for five or six days; and he had absolute proof that silk was absorbed. In regard to the question of drainage, its value lay in the causing of irritation and the exudation of serum that might possibly wash out some of the germs and do good; but drainage after twenty-four hours was seldom of any use.

Dr. **Thomas Neil** said that silk, being an animal substance, should be absorbable, but it was necessary that it should be unmixed with vegetable fibre.

The **President** said he was fully in accord with the value of preserving as much of the organs as they could where there was the least possibility of function continuing afterwards. He had been accustomed to tying the broad ligaments *en masse*, and he shared the view that, however more artistic Dr. Jellett's method might be, he was not sure that it had any great advantage over the other. He had no doubt that silk was absorbable. In operations for the removal of the appendages, where a large extent of raw surface was left on the face of the rectum, he had been content to allow the uterus to fall back, hoping thereby to prevent contact with intestines; and he thought that in some cases that was better than lifting the uterus above the appendages and leaving a raw surface as a possible source of subsequent adhesions.

Dr. **Jellett**, in reply, said he knew there was a tendency in favour of the vaginal route, and he brought forward his cases as going a certain way to show that there were no bad results attributable to the abdominal operation. The predominant feature of his series of cases was not so much the accumulation of large quantities of pus in the tubes and ovaries as extensive intestinal adhesions. That being so, he could not have got as good after-results by the vaginal route, nor could he have left the genital organs in as satisfactory a condition as appeared on subsequent examination. He had started with the view that in tubercular cases the entire pelvis should be cleared out; but in view of two of the cases he recorded he could not help thinking that removal of the diseased portions alone was sufficient. Moreover, primary ovarian infection was very rare. He thought that those speakers who advocated ligature of the broad ligament *en masse* must use silk, and there had been a general consensus of opinion that this was inadvisable.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD ON FRIDAY, FEBRUARY 15TH, 1907.

Mr. Sydney Stephenson in the Chair.

The following cases were shown and discussed.

A case of buthalmus was shown by the Chairman affecting a syphilitic infant, æt. 10 months. The condition had been observed immediately after birth. The corneæ, which had been extremely cloudy, had cleared under treatment by physostigmine and mercury internally. Moreover, the operation of anterior sclerotomy had been performed upon the left eye. The child retained fair sight.

A case of cretinism was shown by Drs. Spriggs and Higgs.

The child, æt. 2 years and 7 months, had always been backward. She was 26 inches long, circumference of head 17½ inches. She could not walk nor stand and was a typical cretin physically. The mind was about equal to that of a normal infant of 8 months. The complexion had already improved markedly since thyroid treatment was began only three weeks ago. One grain of the extract is given three times a day. The weight fell half a pound and there was considerable restlessness and fretting, which ceased when the dose of thyroid was lessened.

Dr. Leonard Guthrie always thought breast-fed children escaped myxœdematous symptoms, but had recently two cases which disproved this.

Dr. Fletcher Beach believed the result depended upon the age at which thyroid treatment began.

Dr. Poynton mentioned a case of a mother suffering from four ophthalmic goitu who nursed her child which was a cretin. This child responded well to thyroid treatment.

Dr. Porter Parkinson believed that mental improvement did not always correspond with the physical improvement by thyroid treatment.

Dr. Sutherland alluded to diarrhœa as a symptom when too large doses of thyroid were given.

A case of cerebral tumour was shown by Dr. Cantley in a boy æt. 10. For six weeks he had had attacks of headache lasting 12 hours, terminating in vomiting about once a week. For two weeks he squinted, due to paralysis of the left external rectus. He had optic neuritis and exaggerated knee-jerks, but no other abdominal signs on examination. Dr. Cantley suggested a small quiescent tuberculous focus in the superficial portion of the pores.

Dr. Hardthorne pointed out the likelihood of such cases becoming quiescent through blindness was a frequent consequence.

A case was also shown by Dr. Cantley of an infant six weeks old with a large inguinal hernia in conjunction with basal meningitis. The condition of rigidity of the abdominal muscles made it doubtful if an operation should be done at present for the cure of the very large inguinal hernia.

Mr. Mummery thought the child should be strung to a cross-bar to facilitate return of the hernia; that failing, he would operate.

Lymphangeioma or lymphatic nævus of the left side of the tongue was shown by Mr. Lockhart Mummery.

The patient was a boy, æt. 5. The surface of the tumour showed small clear walled cysts. It caused no inconvenience. Three cases of aortic regurgitation were shown by Dr. J. Porter Parkinson. They were all in girls and of rheumatic origin. In one patient, æt. 9, there were crostic diastolic and mitral systolic murmurs. In case two, æt. 12, there was only an aortic regurgitant murmur with enlargement of the left ventricle, water-hammer pulse and well marked extensive visible arterial pulsation and capillary pulse. In case three, æt. 14, similar signs were present, but in addition there was a presystolic thrill at the apex of the heart and presystolic and systolic murmurs in the same situation, the pulse was of moderate size, indicating there could be little, if any, mitral stenosis.

Dr. Spriggs considered there was no mitral stenosis. One of the cases showed the delay between the venticular contraction and the pulse due to the elasticity of the arteries.

A case of cerebral abscess after operation was shown by Mr. P. Turner. The patient, a girl, æt. 7, was operated on for an acute mastoid abscess following disease of the right middle ear on December 4th, 1906. Attacks of petitmal had been observed for a year. After operation drowsiness supervened and a left-sided convulsion occurred followed by hemiparesis. There was no headache, vomiting or optic neuritis. Granulations were found blocking the opening from the antrum into the tympanum and removed, but the dura mater was found healthy; the drowsiness and headache disappeared; ten days later headache and drowsiness came on, and a needle inserted into the tempero-sphencidal lobe showed pus, the abscess was drained and recovery was then uneventful.

A girl, æt. 3 years, with undue mobility of the knee joint was shown by Dr. Poynton. If semiflexed she could voluntarily move the tibia outwards and slightly forwards over the femur and back again into position. This movement was apparently due to the popliteus muscle. There was considerable laxity of the lateral terminal ligaments. The movement was accompanied by a clicking sound. When the limb was extended there was no lateral movement and walking was not interfered with. The articulations of the wrist and fingers were to a lesser degree more mobile than natural.

A case of "Punch"-like intonation in a syphilitic infant was shown by Dr. G. H. Sutherland. The child, æt. 3, had been blind since birth from post neuritic atrophy and general choroidal atrophy. He could not sit nor stand and was small and flabby and markedly ricketty. There was syphilitic scarring round the mouth. The speech was unintelligible and squealing or "Punch"-like. The larynx appeared normal. The exhibitor had seen a similar case in a hydrocephalic infant.

A case of infantilism was shown by Dr. L. A. Clutterbuck. The patient was a girl, æt. 13¾. Height 3 feet 4½ inches. Weight 2 stones 6¾ lbs. She was intelligent, but did not know her letters. She was only at school for a year up to about eight years of age. Breasts quite undeveloped. No history of syphilis or consanguinity in the parents. Dr. Fletcher Beach said these cases were rare in this country, but Dr. Bourneville, of Paris, had described several cases and showed that the children did grow to a certain extent, but not very much.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Feb. 24th, 1907.

Treatment of Typhoid Fever.

The mortality of typhoid fever, says Professor Robin, has considerably diminished It has fallen to 8 or 9 per cent. in the civilian population, and to 5 per cent. in the army, where the treatment is begun at the outset.

Three great facts predominate the therapeutical indications: organic destruction is increased, oxidation is diminished, and the waste of nutrition is retained in the organism. The causes which produce this retention are that of diminished vitality of the cells, insolubility of the nutritive waste, and an inferiority in the functional capacity of the emunctories.

The tissues are encumbered with this organic waste, which exceeds by 25 or 30 per cent. the quantity contained in the healthy tissues. The period known as the crisis is accompanied by a larger elimination of the waste, and precedes by 24 or 48 hours the improvement in the condition of the patient.

The first indication in the treatment is to diminish the organic disintegration. The patient must be nourished, but by milk and beef tea only. A quart and a half of milk and one quart of beef tea are sufficient. Coffee, champagne, or wine in small quantities, and largely diluted, are useful in aiding oxidation and the elimination of the waste of nutrition.

As to medicine, small doses of quinine (6 grains of hydrochlorate morning and evening) can be prescribed. Cinchona extract may replace the quinine.

Ext. of cinchona, dr. 2.
Benzoate of soda, dr. 1.
Rum, oz. 2.
Syrup of gum, oz. 3.
Water, oz. 5.

A tablespoonful every two hours.

Antipyrine should not be given, as it diminishes the oxidation and reduces the quantity of urine. However, at the outset of the malady one dose (6 grs.) of pyramidon might be given, and rarely repeated, as it has a depressing action on the patient. Cold bathing should be prescribed where the temperature exceeds 102 degrees. The first bath might be given relatively warm, so as not to produce too great a shock to the patient. It might be given at 89 degrees, and lowered gradually to 77, 71, or 68 degrees. Ten minutes in the bath will be sufficient at first, and as the patient gets accustomed to it, 15 minutes. The bath will be renewed night and day every three hours as long as the rectal temperature shows 102 degrees. Ten minutes after each bath the temperature should be taken, and the fall invoiced. While the patient is in the bath he may be given a little champagne, while his shoulders and legs should be rubbed, but care should be taken not to touch the abdomen. A jug of water 6 or 8 degrees colder than the bath should be poured on his head, or in the case of a woman a cold compress.

The only counter indications to cold bathing are intestinal hæmorrhage and cardiac weakness.

To encourage elimination of tissue waste, the energy of the circulation should be maintained; hence the utility of dry cupping, which diminishes the cardiac labour by relieving the congestion of the lungs and favouring the absorption of oxygen. The heart should be strengthened by sparteine, digitalis, and especially by cinchona and alcoholic drinks. Elimination by the intestines is assured by the employment of enemas. If all these precautions are taken, it is rare, says Prof. Robin, that the patient does not get well.

As to dietetic regime in the period of convalescence from typhoid fever, it should be prescribed with intelligence and caution. No solids should be allowed for a week after the temperature has become normal, and until all trace of albumen has disappeared, and here the density of the urine is of primary importance to guide the attendant. If the density is found to be 10.18, for instance, the two last figures (18) will be multiplied by the invariable number 2.33; the result is 41.94. If this figure exceeds 50, the consumption of solids must be retarded, in spite of the entreaties of the patient. But in every case the patient will be led very gradually to usual diet.

Certain complications may have to be treated in the course of typhoid fever, amongst which may be mentioned vomiting, pulmonary congestion, tonsillitis, perforation, and intestinal hæmorrhage.

The vomiting may be treated with Vichy water and a small blister over the epigastrium. The blister is left on seven hours, and replaced by a linseed poultice for an hour, when the raised blister is cut and 2 grains of powdered opium inserted under the skin. This is an active remedy, and without danger. Inhalations of oxygen gas arrest also the vomiting, and may be ordered.

The pulmonary congestion is best treated by the cold baths, dry or wet cupping, and alcoholic mixtures.

For tonsillitis the following gargle:—

Naphthol, gr. 4.
Perborate of soda, dr. 4.
Peppermint water, 1 quart.

Perforation requires laparotomy, and many successful operations have been recorded. After perforation, hæmorrhage is the most dreaded complication.

Here the enemas must be stopped as well as the cold bathing. Iced milk in small quantities, complete rest, and every hour alternatively a tablespoonful of each of the following mixtures:—

Ergoline, dr. 1.
Gallic acid, gr. 10.
Syrup of turpentine, oz. 1.
Water, oz. 4.

Chloride of calcium, dr. 1.
Syrup of opium, oz. 1.
Water, oz. 4.

GERMANY.

Berlin, Feb. 24th, 1907.

INFECTIOUS DISEASE IN BERLIN.

In December, 1906, 606 deaths took place in Berlin from infectious diseases. There were 13 deaths from measles, 21 from scarlatina, 35 from diphtheria and croup, 22 from whooping cough, 55 from influenza, 12 from puerperal fever, 315 from pulmonary and laryngeal phthisis, 51 from tuberculosis of other organs. Other causes named are cancer 190 deaths, diseases of the heart 295, inflammation of the lungs 231, intestinal catarrh 90 and amongst these 85 of children under 1 year of age; 7 from vomiting and diarrhœa, 6 of them under one year of age. The number of deaths of children under 1 year of age was 639=22.71 per cent. As a set off against this mortality it may be noticed that typhoid and typhus fevers as causes of death are conspicuous by their complete absence.

There were 3,310 patients in the city hospital at the end of the month, the total accommodation at these places being 3,966 beds. There were 121 female patients in the institution for sexual diseases. In the various lunatic asylums and institutions for epileptics there were on January 1st, 1907, 4,919 inmates and 2,641 persons were under private care.

Complaint was made of the inadequacy of the provision for convalescents and it is claimed that if there were further accommodation in this direction patients need not be detained so long in hospital. For various reasons they may be unfit to be sent home, whilst on the other hand they are no longer in need of hospital treatment. If each hospital had its own convalescent home much would be gained, particularly on the part of the patients themselves.

It is announced that the Deutsche Gesellschaft for the Combating of Sexual Diseases will be held at Mannheim on May 24th and 25th. A special discussion will take place on Sexual "Pädagogik," this will include the duty of the mother, the home, the common school, instruction on sexual matters in higher schools for those about to leave school, seminarists, continuation schools in the country, literature for youth and sexual dietetics.

At the Medical Society, Hr. H. Neumann introduced the subject of the

NATURAL FEEDING OF INFANTS IN PRACTICE.

He pointed out how the practice, especially in the better class families, had fallen off. From statistics it appeared that the number of unsuckled infants had increased by two-thirds between the years 1885 and 1900, and he asked the question whether scientific knowledge of the artificial feeding of infants had advanced so far that we as physicians could quietly look on. It was true that the generalisation of the Soxhlet principle of preparation of food had been of great service, and especially since the overheating of milk had been given up, and the view had become more widespread of the great importance of the good and unobjectionable milk supply. The consequence of this was that the acute intestinal disease of infants scarcely occurred at all now in families who were well off, but they were still very frequent amongst those without means. But as regarded the chronic intestinal nutritional disturbances the infants of well-to-do families were not so much better off, as the advances made in the feeding of infants were not the common property of the general profession. The idea still seemed to prevail that the more food the infant took the better; they very often had to try different kinds before hitting upon the right one for the case, which when once found they were so enamoured of it that they ordered it for every one without distinction. But in artificial feeding we always ran a great risk, and the younger the infant the greater this was. It was true that we often did well enough when the infants were not of low class physically, *i.e.*, when they were not premature or twins. In particular one must not be deceived by rapid increase of weight; for instance, one may find great increase of weight, but convulsions are apt to occur. Great increase was often followed by rapid loss from intestinal disturbance and moreover rickets was liable to come on with its associated convulsions and spasms of various kinds. Rickets did not come on if the food was proper. The disease depended principally on heredity; it showed itself by certain signs in the new-born, particularly in the skull. This must be borne in mind in the feeding of infants. The physician must examine the other members of the family as to signs of former disease and on any signs of heredity showing he must insist on the natural feeding of the child. The time of the birth was also of importance as regarded rickets. If the birth was in August or September we often saw rickets develop later on with artificial feeding from insufficiency of fresh air as the infant was kept more in the house; it was the same with the tetanoid irritability. Rich and poor were affected alike in regard to this. Congenital rickets was often arrested by breast milk, but if nothing were done until the rachetic symptoms were developed, it was difficult to get the child to take the breast. Breast children were as a rule not so fat as artificially fed ones, but they were more muscular and lively. Then for a time we saw Barlow's disease amongst infants from over-heating of the milk; since the cause became known the disease had disappeared.

The decline in suckling, both in the well-to-do and among the poor, was not due to either social or physical causes, but solely to fashion. In well-to-do families less than 30 per cent. of the infants were breast-fed. When the milk came early and freely suckling came easier. But when it did not come so, but with pain, the mother made up her mind to it less readily and the attendant did not press for it enough, often out of regard to the mother herself. The fault of not suckling often lay with the doctor.

Grave chronic diseases, especially phthisis, were objections to suckling, but according to recent observations, especially those of Schlossmann, the milder form was not harmful either for mother or child. Again, suckling was often refrained from as it caused too much exhaustion for the mother, but really it only very rarely had such an effect. If the mother was weakly, anæmic and nervous from suckling, things could generally be put right with proper treatment. Public opinion had to be acted upon and this duty of enlightening the public, which fell on the physician, should not be neglected.

On putting the infant to the breast the mistake was often made of thinking that it should have food at once, and that if there was not enough milk artificially prepared food must be given. This was a mistake, for it took time for the milk to come after the birth of the child, and during the first few hours the infant required no food. With very weakly children a little Soxhlet milk might be given to make it strong to suck. A wet nurse with her child might also be procured and the nurse's child put to the breast to help bring the milk. The infant must not be put to at stated hours, but only when it shows signs of wanting something. Otherwise digestive disturbances might easily be set up by overfeeding.

AUSTRIA.

Vienna, Feb. 24th, 1907.

OSTITIS FIBROSA.

HABERER presented a boy, æt. 13, to the "Gesellschaft der Aerzte," with the skeleton bent and tumefied. The Röntgen rays showed the bony tumours to be large cysts in the bones. Excisions for microscopical examinations proved the growths to be largely composed of giant cells with a fibrous transition of the marrow which had transformed the bony substance and medulla into sarcomatous tumours with narrow isthmi between, and forming a kind of multiple giant cell sarcoma of a benignant character, as the disease, according to history, had existed for ten years, having commenced when the boy was three years of age.

DYSENTERIC TOXIN.

Doerr gave a short history of dysentery in the army, and the various theories in literature. He next recounted his experiments with guinea-pigs and the toxin obtained from the dysenteric with anatomical and histological specimens to show the changes were those caused by the Shiga-Kruse bacilli, which he cultivated and injected as an antitoxin with marked success. He also showed the effects of Paltauf's experiments in the Sero-therapeutic Institute of Vienna, which justified his own belief in a powerful antitoxin.

RONTGEN APPARATUS.

Stein showed the members a novel construction of this instrument to take radiographs, ortho-diagraphs, ortho-photographs, and to act as a radioscope in the lying, sitting and standing postures. This, he contends, will be of immense advantage on the field of battle or open air, where all luxuries are absent.

Freund thought the instrument was an excellent universal one, but was afraid that its very portability was a blemish in its stability which would seriously affect the ortho-diagraphs. The centering of the tubes would be another grave matter for correction in such a light instrument. Otherwise the idea was a good one. Stein's method obviated the tedious operation of exchanging tubes or producing a clearer light when desirous of taking an orthograph with the radioscope Stein admitted these defects, but thought they were compensated for by the information afforded the economy in case of injury in transit and the changes of temperature.

Ranzi thought there were a number of similar instruments put on the market during the year, all claiming superiority.

LEPROSY.

Deyke and Bey, from Constantinople, have prepared a bacterial fat which they affirm is a protective, but not a cure, for leprosy. This substance is obtained from the cultivation of the streptothrix leproides, which forms a thick gluey fluid, and from this property has been named "Nastin," which is injected into patients where the disease is moderate or mild, when the morbid process seems to receive a check and recede in many cases. In several cases the disease disappeared entirely, and no trace of the morbid products could be found. Severe cases were very little affected, and no beneficial effects could be observed. The explanation offered is that the true bacillus or genuine parasite is not exactly known, although the "Nastin" may be similar as a biological product, though not the exact counterpart, of the exciting changes. They consider the "Nastin" injection, however, an active immunising agent, and therefore a preventive, but not a curative product. "Nastin" seems to be a glycerine ester of the tubercular bacillus, and therefore a biological fat.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

BRITISH MEDICAL ASSOCIATION.—A most successful joint meeting of the Scottish branches took place in Edinburgh on February 22nd, at which a large number of interesting cases were shown, and several demonstrations of special methods of treatment, etc., given. Much interest was taken in the museum which had been got together for the occasion, the feature of which was a large series of most beautiful and lifelike wax casts of diseases of the skin prepared by Dr. Cranston Low, who has recently been appointed dermatologist to the Infirmary. The fidelity with which these depict the conditions they are intended to represent was a matter of admiring comment among all who saw them. Among a great many other exhibits. Professor Annandale's series of preparations illustrating various surgical diseases calls for mention on account of the large field it covered. Mr. Henry Wade, curator of the Museum of the College of Surgeons, showed a number of pathological specimens mounted in a novel manner which should be very convenient for teaching and demonstration purposes. Coming into the same category was Mr. Richard Muir's exhibit of a permanent method of mounting bacterial cultures as museum specimens. Demonstrations of the pathological and clinical features of cerebro-spinal meningitis were given by Drs. John Thomson, Fowler, and Stuart McDonald, by Drs. Shennan and Ritchie, and by Dr. R. W. Philip. Dr. Haig Ferguson showed a new form of obstetric bag, with steriliser attached, and an extensive series of surgical and gynæcological specimens were shown by Messrs. Brewis, Stuart, Caird, Dowden, Shulters, Miles and others. Drs. Malcolm Campbell, Gardiner, and Watson showed photographs and microscopic preparations illustrating the effect of varying diets on animals, and Dr. Nicholson exhibited a series of photographs and tracings of cases of myxœdema, eclampsia, and Graves' disease illustrating the action of the thyroid gland. The clinical meeting was well attended, and among cases shown were several of exceptional clinical interest. Drs. Ford Robertson and McRae showed two cases of general paralysis undergoing special serum treatment. Dr. J. V. Paterson showed the unusual condition of orbital aneurism following fracture of the base of the skull; Mr. C. W. Cathcart, a patient after removal of the Gasserian ganglion; Dr. Byrom Bramwell a case of hemiplegia with crossed plantar reflex; the plantar reflex on the non-paralysed side was flexor, on the left (paralysed) side extensor. On stimulation of the right sole a crossed flexor reflex—flexion of the left big toe—was obtained. Mr. Alexis Thomson showed a patient with supposed fracture dislocation of the lower cervical spine, with symptoms of complete destruction of the first dorsal segment of the cord. After an accident motion and sensation were abolished below the third rib; there was anæsthesia in both arms along the region of the ulnar nerve, paralysis of most of the small muscles of the hand, paralysis of the sympathetic, retention of urine, and priapism. He was not expected to live more than a month. At the end of three weeks improvement began, and has steadily continued, so that at the end of a year he could walk with a stick, and had only slight spasticity and abolition of sensation in the legs. Other exhibitors of cases were Dr. Farquharson, Dr. Edwin Bramwell, Dr. Norman Walker, Mr. Miles, Dr. Caverhill, Mr. Cotterill, Dr. James, Dr. Haig Ferguson, Dr. Gardiner, Mr. Stiles, Dr. Gilson, Mr. Caird, Dr. Fleming, and Mr. McGillivray. Dr. Dawson Turner gave an electrical demonstration, including the method of estimating the hæmorenal index; Mr. Miles demonstrated the ambulant treatment of fractures and ulcers of the leg; Dr. Caverhill gave a lantern demonstration of British and Continental sanatoria; and Professor Schäfer a demonstration of his method of artificial respiration. In the evening the members of the Association dined together in the North British Station Hotel.

MEDICAL OFFICERSHIP OF THE EDINBURGH SCHOOL BOARD.—On the 18th inst., Dr. John Hally Meikle, M.D., B.Sc., was appointed Medical Officer to the Edinburgh School Board at a salary of £400. Dr. Meikle is at present senior assistant and bacteriologist at the City Hospital.

CRICHTON ROYAL ASYLUM.—Dr. Rutherford, the superintendent, takes the occasion which his annual report affords of making some reply to Lord Rosebery's remarks on the enormous increase of lunacy, which excited considerable interest and comment at the time of their utterance some months ago. Dr. Rutherford asserts that there is no increase of insanity among the wealthier classes—*i.e.*, those who pay £60 per annum and upwards as patients in asylums. The same may be said of the well-to-do artisan classes. From a return made by the clergy of Dumfries and Galloway in 1831 there was then in the counties 333 insane persons. In the asylums to-day there are 325. A striking feature is that, of the 333 seventy-four years ago, only 143 claimed parochial relief, while 190 did not claim charity. The great increase in the population of our asylums is entirely from the lowest class of society, a class which is increasing in all our large towns. It is a class which displays little mental activity, lives under insanitary conditions, abuses stimulants, and is exposed to exhausting labour and contagious disease. The tendency of those whose brains are abnormally constituted is to sink step by step, through the various grades of society, until they reach the final sedimentary deposit of pauper lunacy. In London the increase of asylum inmates has been very fast, and it is the same in all large towns. The chief increase in the pauper lunacy of Dr. Rutherford's district has been from the urban districts—from the rural parishes the numbers are even less than they appear in the return of 1831. A great impetus was given to pauper lunacy by the giving of the 4s. grant in aid of local taxation in 1875. From that time a change took place in our asylum inmates. Persons who are weak-minded and senile, or otherwise troublesome, many of whom used to be accommodated in poor-houses, are now sent to asylums. To a large extent the alleged great increase in lunacy is therefore due to—(1) an extension of the area of pauper lunacy; (2) to the accumulation in asylums of persons for whose detention there is no urgent necessity, and who do not materially benefit by asylum treatment; (3) to the artificial stimulus given by modern legislation to that accumulation. As regards Lord Rosebery's objection to the expenditure on the insane, Dr. Rutherford urges the desire among civilised communities to do all that can be done to alleviate suffering. Far from being "tombs of the intellectually dead," asylums are largely curative. It is a comfort to think that no curable person can enter an asylum and not be cured. As it is, even with the drawback that more than half the cases are incurable on admission, statistics show a recovery rate of 40 per cent. The Scottish asylums are far from being tombs. Good work is being done in them as regards the recovery and care of the patients, and in the laboratory of the Scottish asylums as regards investigation into the causes of insanity and the best means for its prevention.

BELFAST.

THE HEALTH OF BELFAST.—It will be remembered that last autumn at the time of the appointment of a new Medical Officer of Health for the city, an effort was made to obtain a Royal Commission to inquire into the unsatisfactory health of the city. It was said to be owing to difficulties with the Treasury that the Commission was not granted, but the matter was not allowed to drop, and it has now been announced that we are to have a Commission of Inquiry, appointed by the Local Government Board. The members are: Colonel Harding, of Leeds (Chairman); Dr. Chalmers (Medical Officer of Health for Glasgow); Dr. Mair (Medical Inspector, Local Government Board, England); and Mr. P. C. Cowan and Surgeon-Colonel Flinn (of the Irish Local Government Board). The reference is an exceedingly wide one, and will bring every question connected with the health of the city into the scope of the inquiry.

THE WATER SUPPLY AND TYPHOID.—Following on the reported discovery of the typhoid bacillus in the Belfast water, as noted in this column last week, a searching inquiry is now in progress, three experts having been brought over by the Water Commissioners. These are Professor Percy Frankland, of Birmingham; Dr. A. C. Houston, Bacteriologist to the Metropolitan Water Board, London; and Dr. Mervyn Gordon, of St. Bartholomew's Hospital. For years past the Belfast Corporation has blamed the water supply for our constant epidemics of typhoid, and the Water Commissioners, in reply, have asked for evidence of contamination, and have blamed the general sanitary conditions of the city. Now at last we may hope to have an authoritative pronouncement on the subject.

CEREBRO-SPINAL MENINGITIS.—There have now been about 110 cases of this infection in Belfast, with about 58 deaths, and there are still 36 cases under treatment at the Purdysburn Fever Hospital. The serum treatment is being tested, but the medical men in charge refuse to express any opinion as yet on its efficacy.

LETTERS TO THE EDITOR.

LAW FOR LAWYERS AND LAW FOR DOCTORS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR;—You will do a service to the profession if you will continue to keep to the front a record of the anomalous condition of the law. The profession are not by any means fully informed on the subject, whilst the people of all classes are almost entirely ignorant. Everyone must agree with you that if the story were once made fully public a demand for reform would arise outside as well as inside the profession. The case to which I would now draw attention occurred at a London Police Court last week. A man who had been struck off the Rolls was fined £10 and £5 costs for using the title of solicitor. There are a large number of medical men whose names have been removed from the register for infamous conduct who still go on practising and using titles, sometimes with a prefix before the letters, as ex-M.D.Edin., etc. In some cases these men have become advertising quacks of a low fraudulent type, and yet in the present state of the law no attempt can be made to interfere with them either by medical authorities or the police.

I am, sir, yours truly,
AN OBSCURE PRACTITIONER.

OBITUARY.

JOHN BOURNE, M.R.C.S., L.S.A., OF WEARDALE.

DR. JOHN BOURNE, of St. John's Chapel, has just passed away at the ripe age of 85. He qualified as a member of the Royal College of Surgeons as far back as 1844. For over sixty years he was a medical man, resident in Weardale, and for nearly half a century acted as medical officer to the Weardale Board of Guardians. As a matter of fact, he was the first medical officer ever appointed, and his salary was £28 per annum. He was much esteemed locally, not only for his skill as a surgeon, but for his many social excellencies. His personality is an interesting link with the past, inasmuch as he was nominally associated with the prototype of Mr. Wackford Squeers, of Dotheboys Hall, immortal sed in "Nicholas Nickleby." He went to London University College with a son of the reputed Squeers. In relating his remembrances, Dr. Bourne never failed to emphasise that in his opinion Dickens's story, so far as Dotheboys Hall was concerned, was exaggerated, and would not admit that exceptionally cruel treatment was ever meted out to the pupils of that now noted academy.

FRANCIS RICHARD CARTER, M.R.C.S., L.S.A.; OF CHAPEL-ALLERTON, LEEDS.

WE regret to announce the death of Mr. Francis Richard Carter, of Chapel-Allerton, which took place suddenly at his residence on the 21st inst. He was the son of the late Dr. J. B. Carter, who was in practice at Chapel-Allerton for nearly fifty years, and his grandfather and great-grandfather were also medical men. He received his professional training at the Leeds Medical School. He qualified as a surgeon at the age of 21, joined his father in partnership, and had been in practice for the last thirty-five years. His elder son, following the professional tradition, is a student of medicine at the University of Leeds.

SIR WILLIAM HINGSTON, OF MONTREAL.

WE regret to announce the death of Sir William Hingston, one of Canada's greatest surgeons, on the 19th inst., at Montreal, aged 78. Sir William, who was the son of the late Lieutenant-Colonel S. J. Hingston, was born in Quebec, and after graduating at McGill University he visited Europe, and obtained diplomas in Scotland, France, Prussia, Austria, and Bavaria. Upon his return to Canada he began practice in Montreal, which henceforth became his home. He was the first secretary and afterwards president of the Canadian Medical Association; he organized the first Board of Health in the Dominion, and when Bishop's College Medical School was founded he became professor of surgery and afterwards dean of the faculty. In 1895, he was knighted for his distinguished services to medical science, and in the following year was called to the Senate by Lord Aberdeen. Sir William Hingston married in 1875 Margaret Josephine, daughter of the late Hon. D. A. Macdonald, formerly Lieutenant-Governor of Ontario.

SURGEON-MAJOR WILLIAM CAMPBELL SEAMAN, R.A.M.C.

SURGEON-MAJOR SEAMAN, who died on February 14th at North Kensington after a long illness, at the age of 88, received his first appointment as assistant surgeon in 1841, and was promoted surgeon in 1851. He served with the 72nd Highlanders in the Crimea, and was present with the expedition to Kertch and at the siege and fall of Sevastopol, including the attack on June 18th. He also served through the Sepoy revolt, and was present at the siege and fall of Kotah and the subsequent campaign in Central India. He retired in 1866 with the honorary rank of deputy-inspector-general.

DR. WRIGHT, OF BOTTESFORD.

WE regret to announce that Dr. James Wright, of Bottesford, died last week from bronchitis. The deceased was in his 85th year, and was for many years a notable figure in Bottesford and district. His grandfather was a medical practitioner in the place a century ago, and his father practised as a surgeon at East Bridgford. Dr. Wright himself came to Bottesford more than half a century ago, and established a medical practice. A few years ago Dr. and Mrs. Wright received the congratulations of a wide circle of relatives and friends on the occasion of their golden wedding. Dr. Wright suffered a great blow by the death of his youngest son, Dr. Frank M. Wright, who was killed at Bottesford railway station in August, 1895.

AT a meeting of the Harveian Society of London on Thursday, March 7th, Mr. Watson Cheyne, F.R.S., F.R.C.S., will open a discussion on the Diagnosis and Treatment of Fractures in the neighbourhood of a Joint, and will illustrate his remarks with skiagrams. The following have promised to speak:—Prof. Howard Marsh, Mr. Edmund Owen, Mr. Pearce Gould, Mr. Arbuthnot Lane, Mr. Robert Jones, of Liverpool, Mr. Lynn Thomas, of Cardiff. Members of the medical profession are invited to attend.

SPECIAL ARTICLE

UNIVERSITY EDUCATION IN IRELAND.

WITHOUT doubt the most important event within the past week in regard to the University question has been the meeting of the Senate of the Royal University of Ireland. It will be remembered that shortly before the late Commission met the Senate passed unanimously the following resolution :—" That in the judgment of the Senate of the Royal University it would be disastrous to the interests of education in Ireland, and gravely injurious to the welfare of the country, to concentrate the control of higher education in one University."

Now, however, its attitude has changed and at a special meeting held on Wednesday the following resolutions were proposed by Sir Christopher Nixon, M.D., Vice-Chancellor of the University and seconded by the Rev. Dr. Hamilton, President of Queen's College, Belfast :—

(1) " That while the Senate feels that it was its right and duty, as long as the various plans for the settlement of the question of University Education in Ireland were under consideration, to express its views clearly and strongly on the undesirability of establishing a single rigid system of University Education, shaping the whole intellectual culture of the country in one mould, now that the outlines of a scheme have been put forward in the name of the Government, with whom the responsibility rests, the Senate does not deem it proper to take any course which might prevent or obstruct the immediate removal of one of the greatest and most crying grievances under which the Irish people labour. The Senate by its own action in asking for a Royal Commission had already shown how keenly alive it was to the urgent need of having this question dealt with ; and they therefore cordially welcomed the announcement that the Government will take it in hand during the present session of Parliament.

(2) " That whilst the Senate is prepared to give the most careful and friendly consideration to the scheme of the Government when published in full detail, it submits the expression of its conviction that in any scheme which would involve the establishment of one or more federal universities, it is essential in order to avoid the evils of one stereotyped system of higher education that there should be granted to the federal colleges the largest possible amounts of autonomy on the lines recommended unanimously by the Robertson Commission, and with practical unanimity by the recent Commission."

A further resolution was proposed by Dr. Leslie and seconded by Dr. Windle, as follows :—" That the following statement be adopted :—' That, in justice to this University, the Senate feels it a duty to enter a protest against certain statements regarding it which Mr. Bryce is reported to have made in his speech on January 25th.'

" The Senate believe that if he had been correctly informed of the actual working of the University and if he had borne in mind the limitations imposed on it by its Constitution, Mr. Bryce could not have said, as he is reported that ' the Royal University has not been so far a success,' that ' it has in no sense prospered,' seeing that in the twenty-five years of its existence the number of candidates presenting themselves yearly at its Examinations has been steadily growing larger, until in the last Session (1906) it reached the huge number of close upon 4,000, or nearly four times the number of students on the rolls of the University of Dublin, and that it has many of its students holding distinguished positions in all parts of the British Empire.

" Nor was it accurate to describe the Royal University as a ' mere Examining Board,' unless it be understood that the University of Dublin, which also gives its degrees to non-resident students on mere examination, may also on that account be called a mere examining Board ' ; especially bearing in mind (1) the fact that independently of the large number of students on the rolls of the Royal University, who present themselves from teaching Colleges like Maynooth, Blackrock, Clongowes, and Clonliffe, and from Women's Colleges like the Alexandra, Victoria, Loretto, and Dominican Colleges, independently of all these— the six teaching colleges, which are officially connected with the Royal University more closely in regard to some of them than any colleges at Oxford or Cambridge are connected with their respective Universities— have on their joint rolls a larger number of students receiving Collegiate instruction than can be counted on the rolls of Trinity College.

" And (2) the fact which is generally overlooked, that unlike the University of Dublin or Queen's University, which are spoken of as teaching Universities, though neither of them ever spent a pound of its income for teaching purposes, the Royal University has from the very first spent a considerable portion of its yearly income in paying the salaries of its Fellows, whom it charges expressly with the duty of teaching in one of its recognised colleges."

The first of these resolutions is a remarkably one, inasmuch as whilst the Senate " cordially welcomes the announcement that the Government will take it (the question of university education) in hand during the present Session of Parliament " it again places on record " its views clearly and strongly on the undesirability of establishing a single rigid system of University Education, shaping the whole intellectual culture of the country in one mould." Apparently, then, the Senate has decided to bless what it clearly and strongly considers to be undesirable. To the casual observer this seems rank opportunism, but of course it also may be high diplomacy.

In this connection the evidence given by the Rev. Dr. Hamilton, President of the Queen's College, Belfast, before the Commission is very interesting reading. Dr. Hamilton had been asked whether the resolution of the Senate of the Royal University (which we quote at the commencement of this article) had been passed at a large meeting of that body, and his reply was as follows :—

" Yes. And when your lordship recollects the constitution of that Senate, that we have upon it Protestants, Roman Catholics, representatives of all churches, heads of colleges, teachers in colleges, and members of all professions, clerical, medical, and legal, you have a body which, I think, speaks with exceptional authority ; and when you recollect that that Senate has been dealing with Irish higher education now for twenty-six years, and has had full experience of all the difficulties under which it has to be carried on in Ireland, I think that a very large amount of value ought to be attached to the deliverance of such a body of men.

" I should like to say, again, that Queen's College, Belfast, is entirely opposed to the solution which your lordship has mentioned to me, I thought it right before coming to give evidence here to convene a meeting of the professors, because I felt certain that their views would be of very much greater weight than mine. That meeting was held on the 2nd of this month, and the following resolution was passed unanimously :—' That the corporate body of Queen's College, Belfast, does not think it desirable that this College should be introduced into the University of Dublin, or be connected in any way with that University ; and it requests the President to lay this, its unanimous opinion, before the Royal Commission.' "

In answer to further questions he replied :—" In the next place, it is always equally unfortunate, I think, to have a forced marriage between two people who do not want to be married. Now, as far as I understand, Trinity College, Dublin, as represented by its governing body, does not want this connection with us, and the resolution I have placed before the Commission shows that Queen's College Belfast, does not want it. It would be an unhappy kind of marriage if the two were brought together against their will. . . . Really, can see no solid argument for this solution either as regards Trinity College, Dublin, or Queen's College, Belfast, and I am afraid that its adoption would be attended by serious dangers, not only to these two Colleges, but to learning and to Ireland—dangers so serious and so great that for my part I cannot view them without dred."

Dr. Anderson, President Queen's College, Galway, said :—" To unite in any way in the same University two Colleges of so different types as Trinity College, Dublin, and Queen's College, Galway, would, I submit, be profitable to neither."

Dr. B. C. A. Windle, President Queen's College, Cork, said :—" In Ireland a common University would bring together a group of Colleges differing in age, in wealth, in religion, and in ideals. What would be the result ? In my opinion such a scheme would convert the National University into a cockpit—a cockpit, too, into which all the birds would go spoiling for a fight."

Rev. Dr. Delany, J.S., President of University College, Dublin, said :—" I do not see any advantage in bringing anybody against their will into any system. As a rule, if you bring men into a system against their will, you put their backs up to go the other way, and you alienate outside feeling in the country. . . . I believe all the people would be alienated, and that they would look upon it as an act of tyranny to force them together in that way. I do not see that it would lead to their liking one another afterwards ; on the contrary, I am led to believe from recent information which I have received from several of my students in Germany, that there, far from having brought together Protestants and Catholics, there is a deeper antagonism between Protestant and Catholic students attending the same University than has ever been found in Ireland."

All these gentlemen are members of the Senate of the Royal University and were present at the meeting on Wednesday last.

A meeting of the Catholic Young Men's Association was also held during the past week. It was addressed by several influential Catholic laymen, amongst whom was Mr. McArdle, F.R.C.S.I., and it passed a resolution expressing satisfaction with the scheme proposed by the Government.

REVIEWS OF BOOKS.

MASSAGE AND ELECTRICITY (*a*).

Dr. Stretch Dowse's " Lectures on Massage and Electricity " have now attained the dignity of a sixth edition, so that we are called upon to do little beyond congratulating the author on his well-deserved success. Medical books unless they really meet and fulfil a demand do not run into edition after edition, and it may safely be concluded from the vogue of Dr. Stretch Dowse's work that it is highly esteemed. The full, painstaking account that is given not only of the physiological action of massage and electricity on the tissues, but also of the practical manipulations which are most advantageous in various conditions, enables readers who are not thoroughly *au fait* with the subject to render themselves so, and it is a mere platitude to-day to say that a knowledge of massage and passive movements is as necessary to the practitioner as a knowledge of drugs. In fact the case may be put more strongly. There seems little reason to doubt that therapeutical measures will largely supplant drug treatment in the medicine of the future, and among such therapeutical measures movements active and passive are likely to bulk largely. Much that is evanescent undoubtedly exists in hygienic fashions just as in drug fashions, but massage and electricity have come to stay, and acquaintance with their potentialities and with their limitations is an essential part of a modern practitioner's mental outfit. Such an acquaintance can be satisfactorily made through this book.

EXPERIMENTS ON ANIMALS (*a*).

We venture to hope that Mr. Stephen Paget's " Experiments on Animals " is too well known to need much description from us in this, its third, edition. Mr. Paget was for many years secretary to the Association for the Advancement of Medicine by Research, and it occurred to him that it might serve a useful purpose if he employed the knowledge he gained in that capacity by writing a popular book, showing what experimental research really had done for medicine. The anti-vivisectionists for years had being going up and down the country disseminating foul and calumnious falsehoods about scientific investigators, and it was a happy idea that prompted Mr. Paget thus to show a little of what research had done for modern medicine, and what sort of men investigators were. An accomplished writer and a vigorous opponent, Mr. Paget has many qualifications for the task, and on the whole he has carried it out well. We are delighted to see the book in its third edition ; we only wish it were the thirtieth. To those medical men who at present take no interest in the controversy it becomes almost a duty to make themselves acquainted with its chief features, and we say without fear of contradiction that if they read this book their eyes will be opened. The portrait often drawn of the anti-vivisectionist as an enthusiastic humanitarian with a certain want of discrimination, will be found to reflect but little the professional anti-vivisectionist. No lie is too base, no slander too outrageous, no insinuation too revolting for them to use of scientific investigators. Mr. Paget gives quotations from their speeches and writings which reveal human nature at its lowest and at its vilest, and we can only say that it is inconceivable that persons in a civilised country can so far be blinded by passion and prejudice as to adopt the methods and make the statements that are here recorded. The book is one that cannot be too widely circulated.

SAVAGE ON WATER EXAMINATION (*b*).

A perusal of this book satisfies us that the author has succeeded in his aim " to demonstrate the facts which are now established, and to bring the varied data into some sort of ordered relationship." He deals in turn with bacteria occurring in soil, sewage, and water, with the methods of examination, and the interpretation of the results, in a satisfactory manner. The atypical coli bacilli, which are the cause of so many differences of opinion, receive an amount of attention that shows a determination on the part of the author to leave no stone unturned to render his book as helpful as possible. The portions devoted to the bacteria in the excreta of different animals are particularly interesting, and the author has collated and compressed a vast amount of information on this subject, which soon reveals to the reader the present state of our knowledge in this direction.

As an adjunct to laboratory teaching this work will be found useful, and it will be of great service to bacteriologists desiring the latest information on the subject. Unfortunately the author appears to have a very small appreciation of the value of the chemical analysis of waters, which is to be regretted. Apart from this, however, the work is characterised by a broadness in tone and a just appreciation of the work of other men, while the author's researches on the bacteriological examination of water allow an amply justified assumption that the book is the outcome of a wide personal experience.

(*a*) "Lectures on Massage and Electricity in the Treatment of Disease." By Thomas Stretch Dowse, M.D., F.R.C.P.Ed., formerly Physician-Superintendent London Sick Asylum, &c. Sixth Edition. Revised. Bristol : John Wright and Co., 1906. 7s. 6d. net.

(*a*) " Experiments on Animals." By Stephen Paget. With an introduction by Lord Lister. Third and Revised Edition. London : James Nisbet and Co., Ltd. 1906. 4s. 6d. net.

(*b*) "The Bacteriological Examination of Water Supplies." By William G. Savage, B.Sc., M.D., D.P.H., Medical Officer of Health and Public Analyst. Colchester. 1906. London : H. K. Lewis Pp, 297, xxi. 8vo. Price 6s. 6d. net.

LITERARY NOTES.

DR. ELIE METCHNIKOFF has done well to republish his Harben Lectures in book form. "The New Hygiene," as he names the little volume, is one that will supply many stimulating thoughts to those who have only looked at the questions dealt with from the British point of view. These questions are chiefly those of personal hygiene—the hygiene of the tissues and of the alimentary canal and the hygienic precautions against syphilis—and they are treated with the grace and skill that one has learned to expect from the distinguished school to which the author belongs. If his views seem unduly optimistic on some points, enthusiasm is perhaps the best fault one can have.

WE have to welcome yet another new contemporary, and we do so very cordially. "Folia Therapeutica," as its name implies, will deal chiefly with new preparations and methods of treatment, and if the future numbers keep up to the level of the first one which has lately appeared, there should be a wide demand for it. Good original communications such as the editor has secured are always of value to the practitioner, and as the printing and get-up of the journal are particularly well done, this new literary recruit has everything in its favour.

THE prize of seventy-five guineas, with bronze medal of the Parkes' Memorial Fund for 1906, have been awarded to Surgeon-Major F. Smith, D.S.O., R.A.M.C., for his essay on the "Sanitary Requirements of Naval and Military Units in Peace and War : with suggestions for Complete Schemes of Sanitary Organisation suitable for both the Navy and Army.' The subject for the next competition is : "The Part Played by Blood-Sucking Insects in the Causation and Spread of Disease in Man, and the Measures to be recommended for the Prevention of such Diseases."

THAT extremely practical little book by Mr. Frederick F. Maccabe entitled "War with Disease," has already reached a second edition. It is one of the best publications on military hygiene that has ever been issued, and the warm thanks of many general officers have been accorded to the author, supplemented by purchases of large numbers of copies for distribution among the rank and file.

Since the efforts recently made to stem the tide of infant mortality, almost every manufacturer of children's food has issued a booklet descriptive of its composition and proper method of use ; and there can be little doubt that if these were instructions intelligently carried out a large proportion of the deaths which now occur from improper feeding would certainly be avoided.

The latest essay before us is entitled "Healthy Children make Happy Homes," issued by the Angier Chemical Co., and written naturally in support of Angier's Emulsion, which has been chiefly instrumental in bringing about the restoration to health of many a little one. It is a remedy for long approved by medical men in suitable cases and as the little book is essentially one for mothers, any of whom may have a copy free by writing for it direct to the Angier Chemical Co., Ltd., Snow Hill London, it affords us pleasure to mention the fact.

DR. T. N. KELYNACK, hon. secretary of the Society for the Study of Inebriety, and editor of the new quarterly *Journal of Tuberculosis*, has just passed for press a work on "The Drink Problem in its Medico-Sociological Aspects."

WE understand that Sir Almroth Wright, Professor of Pathology in the Army Medical School, Netley, is engaged on a work on "Therapeutic Inoculation."

MEDICAL NEWS IN BRIEF.

Inquest on a Medical Man.

An inquiry was held at Lutterworth, on February 19th, on the body of Dr. J. R. Ogle (55), who died on Monday morning.

The Coroner stated that it was a painful case, and although there was nothing doubtful as to the cause of death, it was advisable to hold a public inquiry.

Carrie Hippenstall (trained nurse), stated that she had been in attendance on deceased. He told her he had pricked his finger while out shooting.

Dr. H. E. Davies said he was called to see deceased, who complained of pain in the middle finger of his left hand. There was a slight redness and a slight swelling of the second joint, and in the centre a slight black mark, which witness thought at first was a thorn. On examining it with a magnifying glass, he found a small black puncture, but no thorn there Deceased stated that he had pricked his finger the previous Friday—he thought it was with a thorn—while out shooting. On Wednesday the swelling had increased all over the hand. and he opened the hand back and front. Witness continued to attend him to his death. The cause of death was blood-poisoning, caused by septic absorption from the accidental wound of the finger.

The Coroner said the deceased was a personal friend of his, and it was a sad occasion for him to have to hold that inquiry.

The jury returned a verdict of death from blood-poisoning, and the foreman said the jury endorsed all that had been said by the Coroner.

Sale of a Practice.

At the Manchester Assizes on February 5th, before Mr. Justice Lawrence and a jury, Dr. Henry L. Smith sued Dr. Haslewood, late of Slaidburn, Yorkshire, for damages for alleged misrepresentation in regard to the value of a medical practice. Mr. Byrne was for the plaintiff, and Mr. Langdon, K.C., and Mr. Greaves Lord were for the defence.

Counsel explained that for some ten years Dr. Smith was in practice in South Africa. In December, 1905, he got in communication with Dr. Haslewood, and subsequently an agreement was entered into in respect of the Slaidburn practice, which was said to be worth £400. After entering on the practice Dr. Smith ascertained that it did not correspond with the representation made to him ; that the receipts were much less than £400 a year, and that instead of it being an exclusive one, other medical men who resided at a distance came into the district.

In evidence the plaintiff stated that the purchase price was £400 for the practice, with an additional £60 for drugs. He found that the extent of the midwifery and vaccination practice had been exaggerated. The whole of the takings for last year, including public appointments, amounted only to £244.

In cross-examination, Dr. Smith admitted having written friendly letters to Dr. Haslewood after taking over the practice, but he did not complain, he said, because, having, as he supposed, no redress, he resolved to try and work up the practice.

When the case was part heard a consultation took place between the parties, and in the result Mr. Byrne stated that opportunity having been offered of examining the visiting lists, his client was satisfied that they provided an answer to the allegation of fraud. He was instructed to withdraw that charge unreservedly. Terms had been arranged, which would be endorsed on counsels' briefs.

Mr. Langdon said he accepted the withdrawal, accompanied as it would be by a judgment in the defendant's favour.

THE Royal London Ophthalmic Hospital (Moorfields Eye Hospital) has received a donation of £50 from the Grocers' Company.

Apothecaries' Hall of Ireland.

THE annual dinner of the Worshipful Company of Apothecaries of Ireland took place on Saturday evening at the Gresham Hotel. The Governor (Colonel Adye Curran) occupied the chair. The health of the King having been duly drunk, the Governor, in giving the toast of the Visitors, said that the qualification granted by the Hall was a most comprehensive one, and one which was in every way up-to-date, fully qualifying the holder in Medicine, Surgery, and Midwifery, and accepted alike by all the service. They were on the eve of a great revolution in University Education in Ireland, and he sincerely hoped and trusted that, whatever might be the outcome of it, the interests of the Apothecaries' Hall of Ireland may be safeguarded, and in the grand shuffle of cards about to take place, theirs, although, perhaps, the least card to be played, might prove to be a trump. The Very Rev. L. Healy, Sir Lambert Ormsby, and Mr. Gerald Byrne responded. The toast of the Apothecaries' Hall was given by Sir Charles Cameron, and responded to by Dr. Seymour Stritch.

Annual Meeting of the Leinster Branch B.M.A.

ON Saturday last the annual meeting of the Leinster Branch of the British Medical Association was held in the hall of the Royal College of Physicians, Kildare Street. The chair was taken by Dr. J. Craig, and was subsequently occupied by Dr. John Lentaigne.

The annual report stated that the Council had met four times during the year, and elected 13 new members. The branch membership on December 31st, 1906, was 341, as compared with 340 on December 31st, 1905. The Council regretted the death of Dr. Laffan, of Tara. The credit balance in the hands of the treasurer amounted to £28.

A resolution protesting against the proposed reduction of representatives on the Central Council of the United Kingdom was adopted on the motion of Dr. Poyse, seconded by Dr. Mortley.

Dr. J. Lentaigne, who was appointed President of the Branch for the forthcoming year, read a paper dealing with the Viceregal Commission Report on the Poor Law Reform in Ireland. In the course of an interesting address he said no event of greater interest or importance to the profession in Ireland had ever occurred than the appearance of the report of the Viceregal Commission on Poor Law Reform in Ireland.

The following officers were elected for the ensuing year:—President, John Lentaigne, F.R.C.S.,; President-Elect, J. Wallace Boyce, M.B.; Vice-Presidents, F. W. Kidd, M.D., Sir William Smyly, M.D.; Country Representative of Branch on Irish Committee, J. M. Kenny, M.B., Granard; Hon. Secretary and Treasurer, Professor White, Royal College of Surgeons, Dublin. Votes of thanks to the outgoing chairman and to Dr. Lentaigne for his address brought the meeting to a conclusion.

The Jamaica Earthquake.

Mr. W. Ralph Hall Caine has received, on behalf of the passengers of the steamship "Port Kingston" at a meeting held on board the ship and presided over by Lord Dudley, the following letter:—

"Board of Trade, Marine Department,
"7, Whitehall Gardens, London, S.W.,
"February 22nd, 1907.

"Sir,—I am directed by the Board of Trade to advert to your letter of the 1st inst., addressed to the President, forwarding copies of six resolutions passed at a meeting on board the Royal Mail steamship "Port Kingston," respecting the services rendered by Sir Alfred Jones, K.C.M.G., Doctors Arthur Evans and Neville Williams, Nurse Sarah Cross, and the master, officers and crew of the "Port Kingston" on the occasion of the earthquake at Kingston, Jamaica, on the 14th ult. In thanking you for forwarding copies of the resolutions in question to this department, the Board desire me to say that they very highly appreciate, not only the self-denying labours of those who so readily assisted in the work of succouring the unfortunate sufferers from the catastrophe, but also the courage and devotion displayed in rendering those services under most trying and difficult circumstances.—I am, sir, your obedient servant, WALTER J. HOWELL."

Birmingham Health Conference.

AN important conference of representatives of the Birmingham Health Committee and the Boards of Guardians of Birmingham, Aston, and King's Norton, took place on February 8th. There were present the Lord Mayor (Councillor H. J. Sayer), Alderman Sir William Cook, and the Medical Officer of Health (Dr. Robertson), representing Birmingham; Mr. J. W. Turner and Mr. C. Fletcher (Birmingham Board of Guardians); Messrs. T. O. Williams and J. North (Aston Board of Guardians), and Messrs. T. A. Bayley, F. Barlow, and Curtis (King's Norton). The point under consideration was the clause of the Act which makes it imperative for a midwife in certain circumstances to call in the assistance of a registered medical practitioner. The object of the meeting was to agree upon a plan by which midwives having charge of necessitous cases might secure the attendance of parish doctors in cases of urgency. Hitherto it has not been the general practice of medical men to act in such cases merely on the statement of a midwife that a patient cannot afford to pay a professional fee. It is hoped that in the near future arrangements may be made by which parish doctors will honour the request of the midwives just as they have done that of relieving officers.

Cerebro-Spinal Meningitis.

The Public Health Committee of the Stepney Borough Council report that a case of cerebro-spinal fever has occurred in that borough. The case was taken to hospital where the patient died three hours after admission. Every step is being taken to isolate any further cases that may occur. The Committee think the disease should be made a notifiable one, but that there should be uniformity of action throughout the metropolis in this direction.

Three additional cases of cerebro-spinal fever and two deaths were reported at Belfast on Saturday, making a total of 113 cases, of which 61 have proved fatal. Another death occurred in the city yesterday.

Last week's deaths from spotted fever in Glasgow numbered 20. There were 42 new cases during the week.

University Intelligence—London.

THE Treasurer of Guy's Hospital has received a bequest of £1,000, under the will of the late Dr. Charles James Oldham, of Brighton, for the purpose of endowing an annual prize in Ophthalmology at the Medical School. A further anonymous donation of £200 has also been received for the Fund of the Endowment of Medical Education and Research.

The following candidates have gained the Diploma in Public Health:—Major E. G. Browne, L.R.C.P. F.S.I., R.A.M.C., John G. Devane, M.B.R.U.I., Capt. A. Leventon, F.R.C.S.I., I.M.S., with honours, T. Nicol, M.B.Edin., with honours, M. J. Russell, F.R.C.S.I., Major G. W. Tate M.B.Dub. Univ., R.A.M.C., A. A. Woods, L.C.R.P. & S.I.

IN connection with the recent rejection by the Grimsby Immigration Board of three Russian labourers suffering from trachoma, the chairman of the Board has issued a notification that German shipping agents must be made to understand that all cases of trachoma which their officers refuse to pass for America must be likewise refused for England, and that the Home Secretary will be asked to take drastic action if after this warning cases continue to be sent merely with the object of securing the passage money.

THE Friedenheim Hospital (Home for the Dying), Swiss Cottage, has received a grant of £300 from the executors of Mr. Alfred Beit.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Infection of Man with the Bovine Tubercle Bacillus.—Weber (*Deut. Med. Woch.*, December, 1906) reports some interesting and important observations on tuberculosis from the Berlin Board of Health. In 20 cases the bovine variety of tubercle bacillus was found, 15 times in the mesenteric glands, 5 times in the cervical glands. The bovine type of infection is found almost exclusively among children, and is usually a primary infection of the intestine or mesenterie glands, never giving rise to the anatomical picture of phthisis, and possessing a marked tendency towards spontaneous cure. Infection seldom occurs during the first year, during which the milk is usually boiled; 90 per cent. of the cases were in children under seven. No instances have been observed in which infection with the bovine variety was transmitted from one human being to another. Only a single case has been reported among adults. Weber concludes that the danger of infection of man with bovine tuberculosis is a real one, though insignificant compared with that from the human variety. D.

Air Massage.—Klapp (*Mun. Med. Woch.*, January, 1907) describes a new method of physical treatment which he calls air massage. It consists of a strong current of air which is directed against the desired part of the body by means of a nozzle. It has much the same effect as manual massage, but differs from it in that there is no friction. If a current of cold air be followed by one of hot air active hyperæmia is also produced. Good results are claimed. D.

Epidemic Cerebro-spinal Meningitis.—Westenhoeffer (*Berlin Klin. Woch.*, 1906), as the result of his researches in the recent epidemic of cerebro-spinal meningitis in Silesia, announces that there is constantly in the early stages a pharyngitis, due to the meningococcus. The adenoid tissue at the vault of the pharynx is chiefly affected; the meningococcus may be cultivated from the pharyngeal secretion and from the tissue. This pharyngitis is always present from the beginning, preceding the involvement of the meninges, and passes off in the course of a week or so. Westenhoeffer regards this as undoubtedly the port of entry of the meningococcus. The nose is only secondarily affected. The infection of the meninges takes place by way of the blood current, rather than directly by way of the lymph channels; for this route speak the cultivation of the cocci from the blood, and the presence of endocarditis, arthitis, encephalitis, etc. The meningococcus is also found in the pharynx of healthy persons, but only in those who have been exposed to the disease. Such cocci bearers are an important means of spreading infection, and should be isolated. The reason that children form the majority of those affected (90 per cent. in this epidemic) is that the adenoid tissue is more developed, and pharyngeal infections more common at this age. Moreover, the majority of adults sectioned by Westenhoeffer showed hyperplasia of the lymphatic tissue, so that in this respect they resembled children. D.

Treatment of Asthma.—Zuelzer (*Therapie d. Gegenwart, Berlin*) ascribes the asthmatic paroxysm to expansion of lung through irritation of the vagus nerve. That swelling of the mucous membrane of the bronchi and possibly bronchial spasm, contribute to the clinical picture, is not to be denied. That such an expansion of the lung can be produced by irritation of the vagus is easily proved by experiment. This experimental expansion of the lung can be cut short by the administration of atropin. Zuelzer, therefore, advises the administration of atropin by hypodermic injection for attacks of asthma. A dose of 1 mg., he states, causes a reduction in the limits of the lung within from 10 to 15 minutes, with marked improvement in the subjective condition. D.

Treatment of Nephritis.—Alberto Rovighi writes on this subject in the *International Clinics* (Vol. II., Sixteenth Series, p. 198). He reviews briefly the development of the treatment by decapsulation, and then reports the result of some experiments which he had made on animals, with a view to determining whether such treatment was of any value or not. Several rabbits were treated with cantharides and with diphtheria toxin, until the typical signs of nephritis had been produced. Some of these were then subjected to scarification of the renal capsule, some to unilateral, and some to bilateral decortication, while control animals were left unoperated on in each case. Out of the rabbits treated with the diphtheria toxin, all of the control rabbits, 10 in number, died, while five out of seven operated on recovered. Slightly better results were also obtained in the rabbits treated by cantharides, and later scarification, than in those left untouched after the poison had been administered. In the animals that recovered after operation, it was noticed at the autopsy a month later (the animals were killed by chloroform) that a new fibrous capsule had been formed, which contained numerous new blood vessels, and that these vessels anastomosed freely with the stellate veins on the surface of the kidney. Immediately after decortication there is an increase in the amount of urine passed, and a gradual disappearance of albumin and casts. Unilateral decortication seems to be attended by better results than the double operation, and this is attributed by the author to a renorenal reflex. The author also ascribes the beneficial results that he has noted to a modification of the renal circulation, leading to a better irrigation of the diseased organ with blood, and feels justified in recommending decapsulation in (1) cases of acute nephritis; (2) cases in which anuria and subsequent uræmia supervene in the course of chronic nephritis; (3) cases in which all medical measures have been tried and without success. M.

The Prophylaxis of Scarlatinal Nephritis.—Dr. Thompson has analysed the records of 300 cases of scarlatina with a view to determine whether drugs have any influence in preventing the onset or diminishing the severity of scarlatinal nephritis (*Edin. Med. Jour.*, February, 1907, p. 103). The drugs employed were urotropine, hexamethylene tetramine, and metramine, and the dose of each was 15 grains daily in divided doses, given from the commencement of symptoms of the fever. Forty-seven cases were treated with urotropine, and of these only one presented a slight transient albuminuria; 137 cases received hexamethylene tetramine, of whom 15 developed more or less severe nephritis, and 7 had transient albuminuria; 26 cases had metramine, out of which number three developed nephritis and one albuminuria; while out of 90 cases treated without drugs 8 developed nephritis and two albuminuria. The author's conclusion is that urotropine is decidedly of value as a prophylactic, and advises that it should be given in all cases for 28 days from the beginning of the disease. It should not be allowed, however, to interfere with the other precautionary means adopted, such as diet, avoidance of exposure, etc. M.

Treatment of Epilepsy with Food Poor in Nitrogen.—The older physicians were accustomed to feed epileptic patients on a diet containing little proteid, and in order to test the value of this, Voisin and Norero (*Rev. Mens. Des. mal de l'Enf.*, 1905, S. 252) have tried with some of their patients a diet composed of milk and vegetables. In addition the ordinary salt of the diet was replaced by the corresponding bromide. Simple removal of sodium chloride from the food without replacement by bromide was found to have no effect. Ten epileptic patients were kept on the low nitrogen diet for a period of four weeks, and then gradually various articles of proteid nature were added. The diet was well borne, but apparently had no special effect on the fits, as neither the number or character of these were altered. M.

Barberio's Spermin Reaction.—Lewinson (*Berlin Klin. Woch.*, 1906, No. 41) writes on this test, which is likely to prove of value in medico-legal work. According to Barberio, yellowish, needle-like, or rhombic crystals form in human serum, when Esbachs re-agent is added to it or to a concentrated watery solution. The reaction, according to the present writer, is probable specific for human semen, since the spermatic fluid of several animals, and of fish, had failed to react. Emulsions of human tissues also fail to react, and, on the other hand, it has been shown that the addition of chloroform or of formalin to the semen do not at all interfere with the crystal formation. In cases of Azoospermia the reaction was sometimes negative and sometimes positive, from which it is concluded that the reaction does not depend on the presence of the actual testicular secretion. It is more likely that it is due to the presence of the prostatic fluid. M.

Pathology of Paralysis Agitans.—Naka (*Arch. für Psych. u. Nervenkrank*, Bd. 41) has investigated the pathological anatomy of two cases of paralysis agitans, as revealed in the brain, spinal cord, some peripheral nerves, and some of the muscles. Apart from accidental changes, he found in the muscles a great increase in the nuclei, and in the nerves the same, along with very marked thickening of the peri and endoneurium. In the spinal cord the well known senile changes were found, namely, pigmentation of cells, thickening of the neuroglia, softening of the ependyma cells, together with obliteration of the spinal canal, and corpora amylacea. In the brain the writer found slight cell changes in the Rolandic area, and in Purkinjes cells. M.

The Treatment of Lupus Vulgaris.—Evans (*British Journal of Dermatology*, February, 1907) discusses the present state of the treatment of this disease in the light of the results that have been obtained by the more recent methods. For the purpose of forming a comparative estimate of the various methods of treatment, he classifies them under the following heads:—1. Application of caustics and scarification. 2. Scraping with or without the after application of caustics. 3. Excision. 4. Actinic treatment. 5. Opsonic treatment. For purposes of treatment the body may be divided into two regions, in the first of which may be placed the face and neck, and in the second the rest of the body. In treating cases in the first class not only is the cure of the disease of importance, but the nature of the scar resulting from such cure is also of the first importance. An unsightly scar on the face, especially in women, is almost as great a disability to the patient as the original disease. Dealing with cases in the second class is comparatively simple, for the conditions to be satisfied are only rapidity and completeness of cure. Evans is satisfied as the result of his experience that either the method of scraping or excision best satisfies these conditions, for none of the "actinic methods" can give results which can approach these in rapidity and certainty. In dealing with lupus of the face excision is rarely possible, and the scar left after treatment by scraping or caustics is usually most unsightly. Evans is unable to endorse the high claims advanced by some observers in favour of high frequency in the treatment of lupus. With regard to the Finsen method and the Röntgen rays, either method can give most excellent results. There is little to choose between the scars left after treatment by either of these methods, although it has been claimed that the scar left by the Finsen light is softer and thinner than that left by the other method. Both methods appear to be equally thorough. Evans is inclined to think that recurrence may be more likely after the Finsen treatment, since the power of penetration is less than that of the X-rays. In regard to rapidity of action, the X-rays are much superior, and since a much larger area can be treated at one time, the duration of treatment is much less than with the Finsen method. With regard to the treatment of tuberculin, its use is especially indicated in cases where the area is large or the tendency to recurrence is great; but the number of cases for which it is suitable is limited, and even when it seems the best treatment the X-rays form a useful adjunct. K.

A Case of Multiple Leiomyomata of the Skin.—Beatty (*British Journal of Dermatology*, January, 1907) describes a case of this rare condition of the skin, of which only twenty-six cases have previously been described. The patient was a young man, æt. 28, who complained of an eruption on the left side of the forehead, on the front of the chest, and on the left upper extremity. The eruption had been present five years, but no very reliable account of its onset could be obtained. The patient thinks that the eruption first appeared on the chest and then on the face; the nodules all came out together and not in crops; in fact, the whole condition seemed to start at once, but gradually became more pronounced; there has been no increase during the past year. There are no subjective symptoms except some smarting when exposed to severe cold. The colour of the nodules is pale pinkish red, or that of the normal skin, and in size they vary from 2 to 4 mm. in diameter. In some places they are conglomerate, or run in the lines of the hair follicles to form ridges, but for the most part they are distinct from one another. They are firm in consistence, but not of cartilaginous hardness as described by Krzysztalowiez in his case. Histological examination of a nodule excised from the forearm showed the structure to be that of a leiomyoma. The mass of the myoma is in the deeper part of the corium, but in a few places narrow strands of muscle cells ascend obliquely from the main mass almost to the epidermis. In a few sections there was a thick muscular bundle close to a sebaceous gland and portion of a hair. This bundle was evidently part of the myoma, but no connection could be traced between it and an arrector pili. Beatty is inclined to think, though he was unable to prove, that the myoma has origin from the arrectores pilorum. K.

Paralysis of the Abducent Nerve.—Wilner (*Archives of Pediatrics*, January, 1907) describes the case of a child, æt. 9, who, while recovering from an attack of influenza, got an acute otitis media. The ear continued to discharge freely for several days, but the temperature varied between 99° and 104° F. The child complained of great pain in the side of the head, and a week after the onset of the otitis became drowsy, and developed an internal strabismus of the right eye. For some twenty-four hours the child remained somnolent and apathetic, temperature 99° F., and pulse irregular, and varying from 90 to 60. After remaining in this condition for about forty-eight hours, the child began to improve, and progressed to complete recovery, but the paralysis of the external rectus muscle did not finally disappear till about three months later. K.

Royal Army Medical Corps (London Companies).

MAJOR-GEN. LORD CHEYLESMORE recently presented the prizes at the Headquarters, Calthorpe Street, W.C. Col. V. Matthews, officer commanding, said the past year was the first since 1900 in which they had not actually lost in strength. Seventy-seven recruits were enrolled, as against 55 last year, and the strength of the companies totalled 312, as against 305. A vote of thanks was passed to Lord Cheylesmore on the motion of Col. Sloggett, P.M.O. of the corps in the London District, seconded by Col. J. Cantlie, M.B.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

Sional.—If X bought the practice on the understanding that the appointments would be transferred as you say, he went beyond what caution would require. Y obviously could only do his best to obtain transference, and if he has failed in the case mentioned it would be graceful on his part to remit the purchase money in respect of it. The agreement should have been so worded as to cover the point, namely, that if the appointments were not obtained the purchase money would be proportionately reduced. On the facts stated, we think X would not have any legal ground for action, and we should advise a compromise on the lines suggested, namely that Y should remit the £75 (*i.e.*, £50 at one and a-half years' purchase), the amount earned during the period of introduction being equally shared.

ANOTHER CURE-ALL GONE WRONG.

At an Extraordinary General Meeting of the members of the Oneida Medicine Company, Limited, held at the registered offices of the Company, in London, a few days since, the following Resolution was duly passed:—

"That it has been proved to the satisfaction of this Meeting that the Company cannot, by reason of its liabilities, continue its business, and that it is advisable to wind up the same, and that accordingly the Company be wound up voluntarily." The public would appear to need-a-medicine the Oneida Medicine Company failed to supply.

DR. PATON AND THE MEDICINE MEN.

The life of Dr. Paton, the famous missionary to the New Hebrides, whose death was recently announced, was crowded full of struggle and adventure, and narrow escape among the savage races of the Pacific. Again and again his life was in danger. Very striking is the story of how he defied the medicine men to kill him by magic. First they offered to kill him on the spot by incantations and rites. They set to work, and Dr. Paton looked on smiling and not a whit the worse. Then they said they would kill him within a week, as they had not enough medicine men on the spot to do it right away. Dr. Paton told them to set to work as hard as they liked, and get as many magic men as they liked, but that he would turn up alive next Sunday. The witch-doctors worked their hardest during the week at all sorts of death-dealing rites; but when Dr. Paton appeared on the Sunday, alive and well, they had to confess themselves beaten. They declared that Dr. Paton must be a magic man also, and that his God must have been stronger and beaten their gods.—*Aberdeen Evening Gazette.*

Romanus.—The person named is not on the medical register, nor has he ever been. Does he describe himself by any title implying that he is a medical man?

THE GRUB HABIT.

The Islington coroner, at an inquest recently, asked a witness if the deceased had been in the habit of taking drugs.

Witness: Very much, sir.
The Coroner: What kind of drugs?
Witness: Oh, I thought you said grub.

Meetings of the Societies, Lectures, &c.

Wednesday, February 27th.

Hunterian Society (London Institution, Finsbury Circus, E.C.).—8.30 p.m.: Pathological Meeting.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. M. White: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. G. H. Savage: The More Recent Treatment of the Insane.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Cliniques:—Dermatological (Dr. Meachen), Ophthalmological (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Thursday, February 28th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical) 5.15 p.m.: Lecture:—Dr. B. Abrahams: Some Common Types of Neurasthenia.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Clinique:—Medical In-patient (Dr. Chappel). 4.30 p.m.: Lecture:—Mr. Cantlie: Demonstration in Relation to Tropical Disease.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Ul-erythema: I., Centrifugum: II., Telangiectic; III., Ophryogenes.

Association of Certificated Dispensers (Apothecaries' Hall, Blackfriars, E.C.).—7.30 p.m.: Address:—Dr. F. S. Toogood.

Friday, March 1st.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Dr. E. Waggett: Clinique. (Ear).

North-East London Post-Graduate College (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Ophthalmological (Mr. Brooks). 3 p.m.: Clinique:—Medical In-patient (Dr. Leslie).

West Kent Medico-Chirurgical Society (Miller Hospital, Greenwich Road, S.E.)—Clinical Evening.

Vacancies.

New Saughton Hall Private Asylum, Polton.—Resident Assistant Medical Officer. Salary £120 per annum, all found. Applications to Medical Superintendent.

Leeds General Infirmary.—Resident Surgical Officer. Salary £150 per annum, with board, residence, and washing. Applications to the Secretary of the Faculty.

York County Hospital.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to Frederick Neden, Secretary and Manager, York.

London Open-Air Sanatorium, Pinewood, Wokingham, Berks.—Assistant Resident Medical Officer. Salary £100 per annum, all found. Applications to the Secretary, London Open-Air Sanatorium, 20 Hanover Square, London.

Bristol General Hospital.—Bacteriologist. Salary £240 per annum, Applications to the Secretary at the Hospital. W. Thwaites, Secretary.

Galway Hospital.—Resident Medical Officer and Compounder of Medicine. Salary £75 a year, with apartments and rations. Applications to S. J. Leonard, Clerk.

Appointments.

Coates, Charles Joseph 'Adams, L.R.C.P. and S.Edin., L.F.P.S. Glasg., District Medical Officer by the Shepton Mallet (Somerset) Board of Guardians

Drury, W. H., L.R.C.P. and S.Edin., L.F.P.S.Glasg., District Medical Officer to the West Ham Board of Guardians.

Jenkins, T. J., L.R.C.P.Lond., M.R.C.S., House Surgeon at the Cardiff Infirmary.

Lockyer, Cuthbert, M.D., B.S., F.R.C.S., M.R.C.P., Consulting Gynæcologist to St. Mary's Hospital for Women and Children.

Martineau, A. J., F.R.C.S.Edin., Honorary Surgeon to the Throat and Ear Hospital, Brighton.

Milne, Mearns A., M.B., Ch.B.Aberd., Medical Officer to the Montrose Parish Council.

Ogg, A. W. T., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer of Health for the Burgh of Rothes, Morayshire.

Rees, Morgan James, M.D.Lond., L.R.C.P., M.R.C.S., D.P.H.Lond., Medical Officer of Health of Aberdare.

Scatliff, H. H. E., M.R.C.S., L.R.C.P.Lond., Assistant Surgeon to the Brighton and Hove and Sussex Throat and Ear Hospital.

Births.

Morley.—On Feb. 22nd, at 45 High Street, Portsmouth, the wife of G. F. Morley, M.R.C.S., of a son.

McClure.—On Feb. 24th, at 9 Newton Place, Glasgow, the wife of J. Campbell McClure, M.B.—a son.

Walker.—On Feb. 20th, at "Sunbury," Dormans Land, Surrey, to Dr. and Mrs. H. J. Davey Walker—a daughter.

Marriage.

Sargent—Ashman.—On Feb. 21st, at the Congregational Church, Sneyd Park, Bristol, Percy W. G. Sargent, M.A., M.B., B.C., F.R.C.S., of Harley Street, London, eldest son of Mr. and Mrs. E. G. Sargent, of Pembroke Road, Clifton, to May, youngest daughter of Sir Herbert and Lady Ashman, of Cook's Folly Bristol.

Death.

Dow.—On Feb. 19th, at St. Luke's Hospital, Constance, widow of the late James A. Dow, Esq., late of the Accountant-General's Department of the Admiralty, and third daughter of the late George Lewis Cooper, Esq., F.R.C.S.Eng., in her 60th year.

INCORPORATED DENTAL HOSPITAL
OF IRELAND, DUBLIN.

The Board of Governors of this Hospital require the services of Medical Gentlemen to act as Anæsthetists, also the services of Qualified Dentists, to fill the Office of Prosthetic House Surgeon, Assistant House Surgeon, and Extra Assistant Dentists to the Hospital.

Applications to be forwarded on or before Saturday, March 2nd, 1907, to
WILLIAM ATKIN SHEA, J.P., Registrar,
from whom all information may be obtained.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, MARCH 6, 1907. No. 10

NOTES AND COMMENTS.

A New Old Bailey.

THE opening of the new buildings of the Central Criminal Court for London last week was made the occasion of much rejoicing and junketing. A magnificent pile of great architectural pretensions has been made to replace the historic Old Bailey, where the last scene but one of a thousand sordid tragedies has been played out under the limelight of legal effulgence and vulgar curiosity, and the presence of the King himself was obtained to give splendour to the inaugural ceremony of the new Court. With the usual fanfare of trumpets and the accolade of knights, the doors of the splendid building, which cost over a quarter of a million sterling, were opened for the trial of the miserable wretches whose crimes against society form the chief item on the menu of the halfpenny press. It is a curious commentary on the mental attitude of people towards crime that the erection of a huge and costly building for the trial of malefactors should be considered a praiseworthy civic achievement, and still more so that its opening should be made the occasion of a Royal progress and general hilarity. While thankfully acknowledging that the administration of justice in the British Isles is probably purer and fairer than in any other country, one cannot but consider it a bitter sarcasm on a thousand years of civilisation that gross crime in the community should require larger accommodation for its sifting, and that there should be feelings of joy over an event of the kind. Surely if the health and morality of a country—for they are almost synonymous—were scientifically organised and catered for, a reduction of the machinery for the trial of offences would be regarded as progress, and the demolition of criminal courts hailed with delight. But till the educative mission of hygiene has advanced very considerably we shall presumably continue to plume ourselves on the architectural dignity of new old Baileys.

Sic itur ad astra.

THERE is no man who has to smile his way through the world like the medical practitioner, and no man to whom the external appearance of success means so much. The doctor lives upon his credit with his fellows more than anyone else, and however low the state of his finances, he knows his only chance of keeping up is to assume an air of prosperity. How many aching hearts and empty pockets there are behind brass-plates and red lamps, no one knows. A pathetic instance of the narrow margin on which many a medical man works came to light last week, when a removal order was applied for at Newport in the case of an inmate of the workhouse there. This inmate, it turned out, was a medical man holding university degrees, who for some years had been medical officer to the workhouse at Eastry (Kent), and, later, district medical officer to the guardians of the same place, but who, through ill-health and increasing competition, had lost his appointments and practice, and been reduced to penury. By the irony of fate he now finds himself transferred as a pauper to the very workhouse which he had served as a medical officer.

Crocker v. Doyen.

JUDGMENT has at last been given in the case of Crocker *versus* Doyen. The Court, after a long trial, found that the contract was freely entered into by Mr. Crocker; that even if the fee (100,000 francs) was exaggerated, the plaintiff consented to pay that sum, and as the contract did not violate any legal principle, it could not be set aside; that no undue pressure on the mind of Mr. Crocker was used by Dr. Doyen; and that if the full contract was not carried out, it was through Mr. Crocker's own action in taking his wife away from France. No one, we imagine, will be disposed to quarrel either with the law or the common-sense of this decision. If a man believes wild statements made by irresponsible people, and pays money on the strength of them, he has only himself to thank if he is disappointed in his bargain. Dr. Doyen, in spite of his vagaries, remains a legally-recognised practitioner, and the principle of "no cure, no pay" is not one sanctioned by the profession. American millionaires will find in their own country surgeons as competent in the treatment of cancer as any we know of in France or elsewhere. If they wish to indulge in fancy treatments, well, they must pay the piper.

Sanitary Jaunts.

THE pleasant *fetes champetres*, which are held every summer by certain scientific and other learned bodies, are something of a tax on the hospitality of municipalities, and even the payment of the expenses of representatives sent by other towns is a "burden" on the rates which is apt to be adversely commented on. We are not therefore surprised to find that the canny Scots, after a good deal of subterranean grumbling, are banding themselves together in an attempt to secure that their siller shall be laid out to the best advantage. The two chief hygienic organisations, the Royal Sanitary Institute and the Royal Institute of Public Health, have, nominally, precisely the same objects, but owing to certain differences in *personnel* each prefers "to keep itself to itself," as the saying goes. By this duplication of machinery a good deal of extra expense is involved, and as each body holds an annual congress to which representatives of all sanitary authorities are invited, neither can afford to let the attractions of its gatherings fall below the level of the other. The town councils of the chief Scottish towns have begun to show signs of striking at having to pay each year for two separate jaunts for its officers and representatives, and a joint meeting was held last week with the object of prevailing on the two institutions to hold either combined congresses, or alternate ones. If any alteration be brought about as the result of this action, we fancy from what we know of the two institutes that it is likely to take the latter than the former shape.

This Way Madness Lies.

FAITH can not only remove mountains and heal the sick, but also, on the evidence of Dr. Ormsby, police surgeon of Dover, cause insanity. Last week a man who appeared before the Dover magistrates was found to be a lunatic, the mania from which he was suffering having developed since he became connected with a sect of Faith Healers who practise their ministrations in that town. Dr. Ormsby, in giving evidence, said that the man was insane, and he was the third person connected with the sect who had been similarly affected during the last fortnight. The Faith Healers, he thought, had "a knack of sending people mad at Dover." That is no doubt the case, but an even more important deduction would seem to be that it is from persons of weak intellect that the ranks of Faith Healers are recruited. Like the physician in Macbeth, this sect seems to find its sphere of successful activity severely restricted to corporal ailments.

A Toothsome Morsel.

AN extraordinary case was recently tried at Manchester Assizes, wherein a widow, described as a greengrocer, confectioner, and holder of an "off" license, sued William and Ada Grundy, described as "dentists" for the loss of her daughter through their alleged negligence in extracting her teeth. The child, who was not quite nine years old, was taken by her mother to the defendants to have some teeth out, and according to her theory, one of the teeth was swallowed during the operation, with the result that fatal pneumonia was set up. According to the mother's evidence, the operation was a sort of family affair, a bedroom chair being brought in, Mrs. Grundy holding the child's head, and the maid-servant her hands, while Mr. Grundy pulled out the teeth. Three were asserted to have been extracted, and the modest fee of 1s. 6d. only was demanded, a rebate of a penny per tooth being made in favour of the patient. The mother, Mrs. Wells, was anxious to retain the trophies of the operation, and a search was made on the floor, but only one tooth could be found. Mr. Grundy suggested the pup might have swallowed the remainder, which Mrs. Wells thought was "a funny thing," adding naïvely, "they'll be bad to digest." As the child was taken ill that day and died of pneumonia, the conclusion was come to that she must have inhaled the missing teeth. In the absence of post-mortem evidence, the point was a delicate one to decide, and the dog being unable to give evidence, the matter balanced about the credibility of the lady-greengrocer's theories and those of Mrs. Grundy's husband.

Unconscientious Objectors.

A CONTEMPORARY, in discussing the recent vaccination debate, relates an interesting story told to Mr. Labouchere by Mr. John Bright. The latter was staying with the Duke of Argyll, and one day, while talking to a keeper about breeding terriers, he was informed that there was great difficulty in rearing them owing to the ravages of distemper. Mr. Bright advised the man to vaccinate them, and was astonished to hear some years later that his suggestion had been carried out, and had produced a highly beneficial effect on the infantile mortality among the Duke's terriers. We do not know whether the procedure would be regarded as coming under the ban of the Home Office, but, if not, it would be interesting to have the experiments repeated. There is no particular reason in pathology why vaccine-lymph should protect puppies from distemper, but as its initial trials in the human subject were empirical, it might be found that keeper's experience was in accordance with some law undreamed of in our philosophy.

LEADING ARTICLES.

THE HEALTH OF DUBLIN.

THE report of Surgeon-Colonel Flinn to the Local Government Board for Ireland on the sanitary conditions of Dublin, to which we draw attention in another column, is the most important document bearing on the subject since the report of Lord Cadogan's Committee was published in 1900. The citizens of Dublin are so accustomed to a death-rate constantly among the highest in Europe, that they have come to regard it almost as a natural phenomenon, with which it is useless, if not indeed impious, to attempt to tamper. They must learn that, until the Public Health Authorities have done all in their power to improve the health of the city, its high mortality must be regarded as due not to natural causes, but to wilful neglect. The present report, in its terse official language and in its obvious attempt to avoid exaggeration, is in fact the most scathing indictment of the Health Authorities which could be made out. In 1900 Lord Cadogan's Committee made eighteen recommendations for the improvement of the health of the city. Some of them were of far-reaching importance, some were matters of detail, but nearly all of them were adopted formally by the Public Health Committee of the Corporation of Dublin. Of the eighteen, four have been carried out; five more have to some degree or other been acted on; but, let our readers observe, no attempt has been made to meet the other nine. It is to be noted that these recommendations have not been rejected, but merely that they have been shelved. Amongst them is the suggestion that an assistant medical officer of health should be appointed, who should give his whole time to the duties of the office. It can hardly be expected that one gentleman, however untiring, who does not give his whole time to the duties of the office, is sufficient to attend to the entire sanitary administration of such a city as Dublin. It is true he has the assistance of the "District Medical Officers of Health" — the dispensary medical officers of the city—but their sanitary duties are entirely secondary to their other work, and are requited on that understanding. We doubt if there is another city in the kingdom of the size of Dublin which is without a single whole-time medical officer of health. It is time for the citizens of Dublin to stir themselves. The callous contempt for their lives shown by the Corporation of Dublin, should long since have spurred them into activity. The success of the Health Party at the recent elections in Belfast shows what can be done if once interest is roused. We believe, moreover, that nothing less than radical reform is necessary. Nothing should be allowed to stand in the way of ridding Dublin of its present reputation of being the most unhealthy city in the kingdom. In this matter, too, the medical profession of Dublin have a responsibility to fulfil. It is their duty to see that the public is made fully aware of the present scandalous condition of affairs, and to point out the path of reform.

CORONERS' FEES AND HOSPITAL MEDICAL WITNESSES.

THE usages that spring up in the course of time around a profession are often of an anomalous and indefensible nature. The fact is perhaps hardly to be wondered at, for after all practice must necessarily be moulded more or less upon precedent in all law-abiding communities. Whether the usages and the injustice spoken of are to be at the expense of the public or of any particular profession depends to a great extent upon the organisation of the latter. Lawyers, for instance, have always shown themselves able to protect their own corporate interests to the uttermost degree, but when we turn to medical men we find that in many ways they allow their rights to be unduly trespassed upon. In this place we wish to advert to a single injustice, namely, the refusal of coroners to pay the fees of an expert witness to any medical man giving evidence in his capacity of honorary or paid medical officer of a hospital. The point was raised not long ago at Weybridge, where Dr. Howard Wilson demanded a fee for giving evidence in a case where a patient died in a cottage hospital. It should be noted that this institution had no honorary medical officer, and that any medical man was entitled to charge patients for attendance therein. In face of these facts the Surrey coroner, Mr. G. Roumieu, declared his inability to pay any fee. In the most candid way imaginable he admitted that this state of affairs is nothing short of a scandal. "In a case of this kind," he said, addressing Dr. Wilson, "you follow the man to the hospital, but if you had sent him to his own home and attended him there you would have been entitled to a guinea for giving evidence. It seems a great anomaly that I cannot pay you because you sent him there, thinking it was the best place for him. You come here, lose your time, and are debarred from getting your guinea. It is an injustice, but it is the law." In ordinary voluntary hospitals neither paid nor honorary medical officers get fees for evidence in the coroner's court. Hence the curious fact that if a patient dies on the way to hospital the house surgeon or house physician gets a guinea for attending the inquest, whereas he would be entitled to no fee if the person gave any sign of life after entering the gates of the institution. The history of how the anomaly arose was ably sketched out by Mr. Roumieu;—

"Before 1835 medical men were never paid at all for attending inquests; but about that time a Bill was introduced in the House of Commons by the coroner for Middlesex to make provision for the payment of doctors for giving evidence at inquests and for making post-mortem examinations. There was a terrible outcry. People said it would be a great tax on the rates if doctors were paid in all cases. People were taken in many cases of accident to the hospitals, and in the large hospitals of London especially; there were in consequence a great many deaths in comparison to the populations of the districts in which they were situated. Many inquests were held in these institutions, and the payment of doctors in hospitals, it was said, would lead to a heavy charge on the rates. In order not to jeopardise the passing of the Bill, the member who introduced it agreed to a section being added, excluding the cases of people who died in hospitals and public institutions 'supported by voluntary contributions or otherwise.' These words embraced a great deal. At that time cottage hospitals were not thought of any more than were motor-cars. Cottage hospitals had been introduced, and they were the most valuable and useful institutions possible. If cottage hospitals had been in existence in the days of William IV. they would in all probability not have been included in the clause relating to hospitals. Doctors in any of the large hospitals and lunatic asylums were not paid; but coroners paid doctors who were engaged in workhouse infirmaries, because there was an allusion in the particular section of institutions which were paid for and maintained out of the rates. It had been held that a workhouse or a workhouse infirmary was not a public institution. This was an anomaly, but there it was."

So far as the workhouse resident and other medical officers are concerned, we would respectfully call the attention of the Home Office and of the Local Government Board to the absolutely illegal way in which their fees at inquests are often withheld, often under unlawful pressure from the guardians, who not unfrequently make compliance with this illegality a condition of engagement. The matter, as we have often insisted, deserves the attention of our professional Defence Unions, and of the British Medical Association.

CURRENT TOPICS.

The Trailing Skirt.

AMONG the evergreens of current journalism none has a hardier growth than that of the trailing skirt and its dangers to health. Nor can it be denied that in this particular trade the ready writers of Fleet Street have science on their side. As a collector and distributor of germs it would be hard for the most perverted ingenuity to devise a more effective agency than a long trailing feminine skirt. For that matter the whole skirt, quite apart from its nether fringe, is a contrivance the existence of which it would be difficult to justify on common-sense grounds. In China womankind wear nether garments precisely and exactly corresponding to those of man, and no one is a bit the worse for it, while the Chinese woman gains in freedom and elegance of movement, to say nothing of the shifting of the weight of the clothing from the hips to the shoulders. But if fashion decrees that long skirts are to be worn by civilised Western women, then, science or no science, they will continue to sweep the pavements of our streets and the floors of our houses. In Prague the Sanitary Committee of the Municipal Council has forbidden ladies to wear long trains to their dresses. The death-rate of the city is excessive, owing chiefly, it is said, to a bad water supply. To attempt to reduce mortality from such a source by the curtailing of a minor distributing agency would strike the average English sanitarian as seizing the stick at the wrong end. For all that, it is to be hoped that the men of Prague will be able to enforce their sanitary views upon their wives and daughters. In this country a similar step would probably within a week lead to a revolution before which the recent revolt of the suffragettes would shrink to the level of mere child's play.

The Mosquito "Torture Trough."

LAST week the antivivisectionists of Manchester were moved to tears by a gentleman from Leeds who had visited the Pasteur Institute of Paris. With much power of literary expression he described the monkeys, dogs, rabbits and smaller animals that were being subjected to scientific observation and experiment. This sapient gentleman, however, came to the conclusion that all this work was done by men who could not really claim to have alleviated human suffering one iota. We wonder if the lecturer had ever seen a human being dying from hydrophobia. The sight is a terrible one, and once seen would probably reconcile him to the sacrifice of a thousand lower animals could the disease be thereby lessened or counteracted. It is well known amongst medical authorities that a large proportion of cases treated at the Pasteur Institute recover, especially if taken there soon after inoculation. Against that overwhelming expert verdict the Leeds "lecturer" pits his unskilled opinion. A trifle of that kind, however, does not stay the hand of the antivivisectionist when on the warpath. To the medical philosopher human life is sacred and all other forms of life subordinate. Indeed, that expresses the ultimate belief of the antivivisectionist when he sits at the dinner table or goes out in search of sport. It is only when medical men want to make researches with the view of preventing human maladies that the antivivisectionist grows excited. As a rule he would not hesitate to kill a mosquito or other venomous insect at sight. Yet an antivivisectionist witness before the Royal Commission last week gravely declared herself against experimentation upon mosquitoes. The human antivivisectionist is the vivisector, inasmuch as he wishes to circumvent the series of venomous and fatal inoculations which nature has placed it in the power of many lower creatures, as, for instance, the mad dog, the plague-infected rat, and the malaria-laden mosquito, to inflict upon mankind. Meanwhile the antivivisectionist artist may find a capital subject for his artistic pen in picturing the "mosquito torture trough."

The Embarrassment of the Pasteur Institute.

THE Pasteur Instute is labouring under a trial of essentially Gallic complexion. A gentleman with the classical name of Osiris lately enriched that abode of scientific research and treatment with a legacy of one million pounds sterling. As a matter of fact, after all claims on the estate were settled, the amount available to the Institute was reduced to the comparatively modest sum of £120,000. Even the latter reduced amount, however, has furnished certain friends of the Pasteur Institute with the materials for a Jeremiad. Excess of wealth, so runs their lament, is fatal to scientific effort, in proof whereof they instance the illustrious Pasteur himself, who began with nothing and accomplished everything. That is very well so far as it goes. Some of the world's greatest scientific achievements have been accomplished by poor men working upon scanty means. Modern scientific research, however, often demands an extensive outlay of money. Indeed, the necessity of endowment of scientific research by the nation has become an accepted axiom among most modern political economists.

Emergency Beds at Hospitals.

THE rejection of urgent cases by large general hospitals is always a serious matter, opening the door, it does, to the possibility of public scandal no less than of injury to individual sufferers. A writer in a lay contemporary has recently raised the question in a pointed way by referring to a case in which the poor woman who was bleeding internally "was refused by three or four London hospitals on the ground that all the beds were full." Without discussing the merits of this particular incident few who are acquainted with hospital life in the United Kingdom will deny the possibility of such an occurrence. The evil appears to arise from the want of close supervision of the nature of the cases and the social position of the patients occupying the beds of our charitable hospitals. Were chronic and other maladies unsuitable for hospital treatment carefully weeded out the pressure upon the wards would be lessened, not to mention the further relief that would be afforded by the exclusion of patients who should be paying their own private medical attendants in their own homes. In any event every properly organised general hospital should reserve a certain number of beds, say one in twenty, for emergencies, and for those alone. By strict adherence to this simple method many distressing scandals would be averted.

A Poor Law School Scandal.

MR. LOCKWOOD, the Local Government Board inspector, has made a report of the West Ham Workhouse School that recalls the scandals of Bumbledom in its worst days. Owing to inadequate laundry arrangements blankets and counterpanes were piled for months in a corner waiting to be washed. In one dayroom, 28 ft. by 16 ft., as many as 200 boys were sometimes congregated. In the infants' feeding room, 27 ft. by 18 ft., used sometimes also as a sleeping room, 109 infants were seen at dinner, with twelve small boys sitting on the floor. From amongst other sensational statements the following may be selected :—"There is no receiving ward for children coming in. The superintendent informed me that they are never without many cases of infectious diseases, such as measles, chicken-pox, scabies, ringworm (thirty-two cases now), and ophthalmia, besides such as are sent away, as scarlet fever, etc.; and that it is not possible in the space available in the infirmary to separate the infectious cases; so that he has known instances of children coming into the infirmary with one complaint, such as ringworm, being infected with measles by the measles patients already there."

Cerebro Spinal Fever.

FRESH outbreaks of epidemic cerebro-spinal meningitis continue to be reported from various parts of the United Kingdom. It will be interesting to watch the progress of the malady in Leicester, which has been recently invaded, inasmuch as that ancient town has pinned its faith to sanitation alone in the fight against small-pox. If its practical hygiene standard be this ideal Leicester ought to suffer lightly from cerebro-spinal fever, which is a disease of over-crowding and bad environment. London appears to be waking up to the seriousness of the situation. The County Council has approved the recommendation of the Public Health Committee to make the malady notifiable for six months. It has further decided to spend £200 for the taking of precautionary measures against the spread of the disease. The Port Sanitary Authority of London has also decided to include cerebro-spinal meningitis amongst the notifiable infectious diseases. There have been already several deaths from that cause in the metropolis and cases are under treatment at various general hospitals. The outlook, therefore, has considerably increased in gravity during the past week.

PERSONAL.

DR. MERYN GORDON, Dr. HOUSTON, and Professor P. F. FRANKLAND, F.R.S., have been called in to advise on the Belfast water supply.

MR. EDGAR H. BROWNE took the chair at a meeting at Liverpool, held with the object of forming a local committee in connection with the approaching second International Congress on School Hygiene.

MR. WATSON CHEYNE will open a discussion to-morrow at the Harveian Society on "The Diagnosis and Treatment of Fractures in the Neighbourhood of a Joint."

MR. CHARLES JAMES OLDHAM, F.R.C.S., of Hove the well-known ophthalmic surgeon, who died on January 24th, left about £50,000 for educational purposes, and several Strad violins to the British Museum. His estate is valued at £77,959.

DR. G. B. MASON, Medical Officer of Nevis, West Indies, has been promoted Medical Officer and Magistrate of the Windward District of the Island of Dominica

NURSE SARAH CROSS has been presented with an illuminated testimonial by the Board of the Middlesex Hospital, in recognition of her devotion to the sufferers from the Jamaica disaster.

THE annual court of governors of Middlesex Hospital last week was presided over by Mr. Henry Morris, in the absence of Prince Francis of Teck.

AT the London County Council Election, on March 2nd, we notice amongst the successful candidates the names of Dr. R. M. Beaton, Dr. J. Davies, Dr. A. Salter, and Dr. P. Vosper; amongst those defeated were Drs. Davidson and Fletcher Little.

AT the Royal Commission on Vivisection held on February 26th and 27th, Viscount Selby presiding, Mr. A. R. Cushny, Professor of Pharmacology and Materia Medica in University College, London, and Miss A. Kenealy, from the Parliamentary Association for the Abolition of Vivisection, gave evidence.

MR. J. B. CHRISTOPHERSON, M.A., M.D. (Cantab), the Senior Medical Inspector of the Sudan Government, has been appointed Director of the Sudan Medical Department, to date from the 1st of January.

THE Holywell Rural Council have re-appointed Dr. Jas. Williams, of Castle-hill, Holywell, as medical officer of health for the Holywell district. He has been termed the "Grand Old Man of North Wales medical officers," having held the office over half a century.

A CLINICAL LECTURE

ON

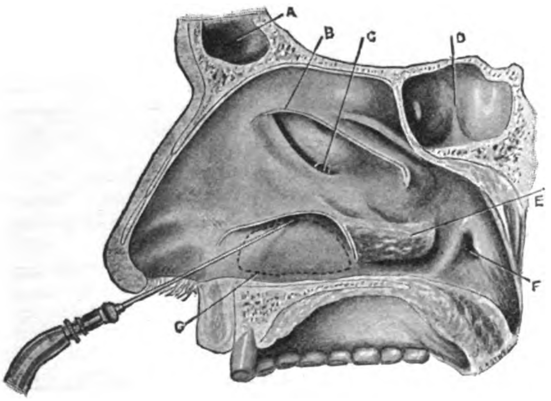
EMPYEMA OF THE MAXILLARY ANTRUM. (*a*)

By PATRICK DEMPSEY, F.R.C.S.I., M.R.C.S.Eng.,

Surgeon for Diseases of the Throat, Nose, and Ear, Mater Misericordiæ Hospital, Dublin.

Suppuration of the accussory cavities of the nose has within recent years justly claimed much attention. Badly drained, and easily overlocked, these purulent collections may easily cause not only much local trouble, but also symptoms of a very remote nature. I intend to-day to concern myself entirely with the maxillary antrum and I may preface my remarks by saying that it is quite impossible within the confines of this lecture to treat the subject exhaustively. The surgery of any region is intimately bound up with its anatomical relations and to the antrum this rule applies with emphasis. Without going into unnecessary details, let me therefore remind you that it is a hollow space roughly triangular in shape and situated in the sup. maxilla, the orbital place of which forms its roof, and the alveolar process the floor. The outer wall of the nose is its base, while the facial and zigomatic surfaces are responsible for the outer wall of the cavity. A glance at this recent specimen in which the antrum has been laid open will give you a clear idea of the relations.

Lateral Wall of Nose.



A.—Frontal Sinus. B.—Edge of Cut Middle Turbinal. C.—Opening of Maxillary Antrum. D.—Sphenoidal Sinus. E.—Inf. Turbinal, Anterior Half of which has been removed. F.—Eustachion Tube. G.—Dotted Line corresponding to Portion of Antro-Meatal Wall removed in Radical Operation. Needle in position for Experimental Puncture.

The middle turbinal has been removed (Fig. 1, B), in order that a good view of the hiatus semilunaris may be had. At the posterior portion of this latter you can see the normal opening of the antrum (Fig. 1, C), and I should like you to note how high this is situated with relation to the cavity which it must drain in the event of suppuration. Observe closely, also, the floor from inside. In this particular specimen the roots of the second bicuspid and first molar are separated from the cavity by a considerable thickness of bone, but in many cases they actually project so far into the antrum as to be quite visible when this latter is opened. It must strike the most casual observer, therefore, that the anatomical conditions most likely to be of clinical interest are those depending on the proximity of the nasal fossæ and teeth. And so it largely is in practice. The view formerly held that diseased teeth were practically the only cause of suppuration has of later years been disproved. Grünwald (*a*) out of 98 cases could only trace the disease directly to the teeth in 14, but in my experience the average is higher. I have notes of 33 cases, and in 12 of these a bad tooth was the unmistakable cause. Most common of all histories given by patients is " severe cold in the head, followed by a nasty nasal discharge." Whether the " cold " has been a genuine attack of influenza or an acute rhinitis is not always easy to find out at the time when the case comes under observation, but there can be no question, as maintained by Hajek (*b*), that the influenzal bacillus is a common cause. Such a good authority as Killian believes that a great number of cases are due to attacks of simple rhinitis and most observers agree with this view. There are many other points in the ætiology, but I shall only mention that erysipelas of the face, typhoid, and other infectious fevers are occasionally met with as predisposing agents.

The next point to be considered is, what are the most characteristic signs and symptoms of suppuration in the maxillary antrum? By far the greater number of my patients sum up their complaint with the words " constant cold in the head," and I must warn you to be always on the look-out for sinus disease when you listen to a similar statement. Question as to *whether the " cold " is unilateral*, and find out if the patient has at any time noticed an offensive odour, for this latter is frequently present. That offensive odour is perceived is not remarkable if you bear in mind the fact to which I have already drawn your attention, viz., the height of the normal maxillary ostium. So close to the roof of the latter is it that unless the head be tilted or lowered the contents must of necessity be to a certain extent stagnant, and thus an easy prey to putrefactive charges. This anatomical fact will also account for the *gushing or periodic character of the discharge* often complained of and due to the relative lowering of the opening as a result of changes in the head's position. Headache is a fairly common symptom, sometimes of a boring nature, sometimes neuralgic. In some of my worst cases it has been entirely absent, but at the same time it is astonishing the number of patients who have for years been martyrs to headaches directly due to suppuration of one or more sinuses, and who have been treated with all the analgesics in the Pharmacopœia, change of air, electricity, etc., and who have never suspected or had it suggested that the cause might possibly be nasal. Hajek draws attention to the fact, and I have noticed it also myself, that sufferers from chronic suppuration of the accessory cavities are particularly sensitive to even the mildest forms of dissipation. Smoking, even in moderation, or a very small quantity of alcohol may cause headache and depression out of all proportion to the exciting cause. Nasal obstruction due to hypertrophic changes or polypi, interference with smell, bad taste in the mouth, possibly gastric disturbance due to trickling down of pus *via* the pharynx are other symptoms which are often present.

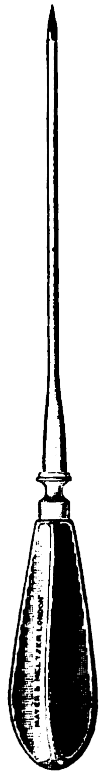
So much for the more important symptoms, all of which may be elicited without intranasal examination.

(*a*) A lecture delivered at the Mater Misericordiæ Hospital, January, 1907.

Let us now suppose that we examine the interior of the nose of a typical case of chronic antral suppuration. The first point in the examination that has frequently struck me is that the side—in unilateral cases—which is affected is the narrower one; that is to say, if any deflection of the septum or spur be present the side on which one or both of these exists is the one more usually diseased.

No pus may be seen in the nose, but as a rule on careful examination a yellow streak is to be observed in the region of the middle meatus and this may be increased in quantity by tilting the head towards the unaffected side so as to lower the natural means of outflow. Even when no pus is seen in the mid-meatus, this particular region always appears to me to wear a somewhat characteristic look. The ant. end of the mid-turbinal is nearly always hypertrophic in varying degrees, the meatus has a moist appearance, and is often "mottled" with specks of yellow. A preliminary spraying of a 5 per cent. solution of cocaine is a great aid to clearing up the field, but I always like to get a first impression of parts as they actually are.

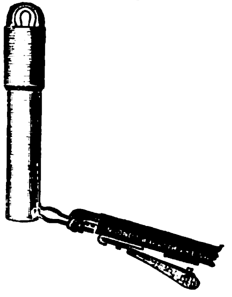
Take it, therefore, that we have some or all of the signs I have mentioned, plus the presence of pus in the mid-meatus which has reappeared after mopping up on lowering the head; how is the diagnosis to be completed? That the antrum certainly contains pus can be proved by washing it out with some clear fluid and noting the character of the latter on return. This little operation, known as experimental puncture of the antrum, is performed as follows:—A small pledget of wool soaked in a 20 per cent. sol. of cocaine is pushed in between the ant. end of the inf. turbinal and the lateral wall of the nose.



Complete local anæsthesia will be produced in about three minutes. Having removed the wool, take a stout hollow needle, such as the one I show you, known as Lichtwitz's, pass it backwards and upwards between the inf. turbinal and the lateral wall of the nose for a distance of about one inch, and then push sharply through in an outward direction (see Fig. 1, in which ant. ½ inf. turbinal has been removed). Failure to puncture nearly always arises from not getting the point of the needle sufficiently high up; it should be right under the attachment of the turbinal, in which region the bone is quite thin. The antrum may be also punctured through the middle meatus, but there is always a slight risk of entering the orbit, which in some cases indeed descends so low as to make this accident unavoidable. The needle having entered the cavity, some clear bland antiseptic fluid is syringed through it and its character observed as it issues from the nose. Pus, if present, cannot escape observation.

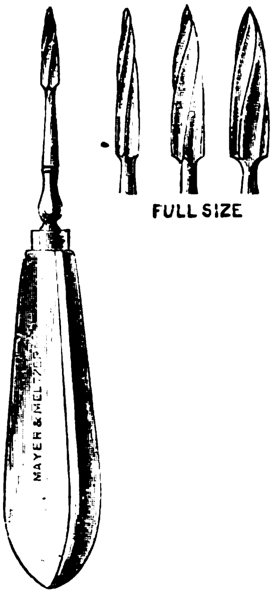
Next in diagnostic merit is that known as "transillumination." It consists essentially in introducing a bright light into the mouth in a dark room, closing the mouth and noting the effect on the face of the passage of the rays of light through the facial bones. Dental plates must, of course, be first removed.

This experiment is easily carried out by means of such an apparatus as the one I show you. The lamp is an 8-volt one and may be switched on after introduction into the mouth by pressure on the small lever which is present on the handle. The current may be taken from main or accumulator. In a normal case, and provided that the bones are not too thick, the inducing of the current is followed by (1) a bright glow over the cheek; (2) above this, but separated by a dark patch, *a bright crescent*, the "infraorbital crescent of Heryng"; (3) a red glow in the pupils; and (4) a subjective sensation of light experienced by the patient (Brown Kelly). In suppuration of the antrum, Nos. 2, 3, and 4 are absent. *The* important phenomenon, and the one to which I pay most attention, is the absence of the infra orbital crescent. With very rare exceptions, I have always found this sign absent in disease, and I look upon it as very reliable. At the same time, I have never yet operated on an antrum without having first performed an "exploratory puncture."

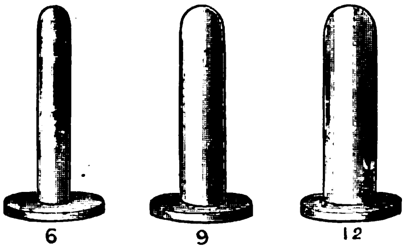


The simplest possible form of treatment consists in removing, if necessary, the second bicuspid or first molar tooth, drilling up into the antrum, through the alveolar process, introducing a plug which remains *in situ* and which may be removed by the patient to perform daily lavage by means of a cannula attached to some such arrangement as a Higginson syringe. I employ vulcanite or rubber plugs. The choice of tooth will be influenced by the presence of disease; other things being equal, I make my opening through that part of the alveolar corresponding to the root of the first molar.

This little operation is satisfactory for acute cases, but when the disease has been present for a lengthened period it rarely does more than relieve troublesome symptoms, and then only when lavage is carried out with great regularity.



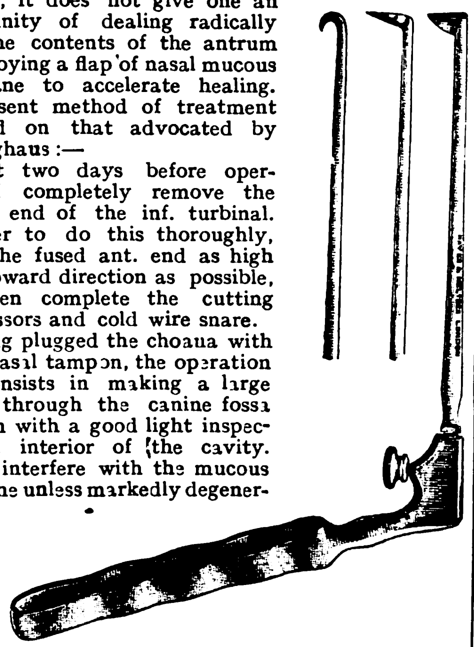
As a more radical method of treatment, Küster some years ago advised that the antrum should be approached through the canine fossa. A large opening could be made in this region, the antrum inspected, diseased mucous membrane or polypi removed, and the cavity then treated by daily packing with gauze. Subsequently, when the wound has become small, a vulcanite plug might be fitted through which lavage could be carried out until all discharge has ceased. This operation has given poor results in my hands and may be now disregarded. All the more modern methods of treatment aim at establishing a free communication between the antrum and the nose. This method of operation may be carried out from the nose and is strongly advocated by Lack. Removal of the ant. half of the inf. turbinal is absolutely necessary in order to obtain a view of the inf. meatus (Fig. 1), through which the communication is made, and various forms of cutting knives and punches have been devised to



facilitate the operator. This method has its advantages but apart from the difficulty of making a wide opening, it does not give one an opportunity of dealing radically with the contents of the antrum or employing a flap of nasal mucous membrane to accelerate healing. My present method of treatment is based on that advocated by Bonninghaus:—

About two days before operation I completely remove the anterior end of the inf. turbinal. In order to do this thoroughly, I saw the fused ant. end as high in an upward direction as possible, and then complete the cutting with scissors and cold wire snare.

Having plugged the choana with a post-nasal tampon, the operation itself consists in making a large opening through the canine fossa and then with a good light inspecting the interior of the cavity. I don't interfere with the mucous membrane unless markedly degenerate, but polypi, etc., should be removed. The next step is to make the communication with the nose by freely removing that portion of the antro-meatal wall (see dotted line G, Fig. 1) corresponding to the ant. half of the inf. meatus. In order, however, to accelerate healing, it is advisable to save the mucous membrane of the inf. meatus, so that it may be subsequently used as a partial lining for the antral cavity.



This is a matter of some difficulty and I get over it in the following way. With the index finger shoved well into the inf. meatus so as to act as counter pressure I employ a small trephine from the antrum side. I trephine very cautiously and stop as soon as the instrument is plainly felt by the finger in the nose and then proceed to remove the trephined piece of bone with a fairly sharp thin bent elevator. To do this is not difficult, and then, with the same elevator, the mucous membrane of the entire inf. meatus may be stripped off.

I next proceed with a Grünwald's forceps to nibble away the bone corresponding to the stripped mucous membrane, and having done so form a flap from the latter by means of two vertical and a horizontal incision. The flap is turned down into the antrum, and the original wound over the canine fossa brought together by a couple of catgut sutures.

In the removal of the antro-meatal wall it is of importance to leave as little ridge as possible between the floor of the nose and the antrum, and also to make the opening as far forward as possible to facilitate subsequent treatment through the nose.

It is well to tampon the cavity for a couple of days after the operation in order that the flap may keep in position, and subsequent treatment consists in daily irrigation of the cavity with a bland antiseptic *via* the nose. In my two last cases, having at the preliminary operation removed the portion of inf. turbinal, I stripped the mucous membrane from the inf. meatus and introduced a strip of gauze between it and the antro-meatal wall. This made the subsequent removal of the bone without injury to the mucous membrane very simple, but it is not an easy procedure unless the patient is tolerant. Time does not permit to discuss other forms of operation, but I must just mention, in conclusion, that Kretschmann (*c*) and Denker (*d*) prolong the original incision to the middle line, turn up the soft parts and procure their nasal flap before opening the canine fossa, the difference between the two operations being that Denker is more radical in the removal of bone, taking away, as I understand him, the entire ant. portion of the nasal lateral wall. I believe the method I employ to be equally as efficacious and not so troublesome. In conclusion, let me press home to you the fact that chronic suppuration of the antrum is frequently met with, often overlooked, and a disease which when chronic requires surgical treatment of a radical nature.

References:—

(*a*) Grünwald: Nasal Suppuration, 1900.

(*b*) Hajek: Erkrankgungen der Nebenhölen der Nase, 1899.

(*c*) Kretschmann: *Munch. Med. Woch.*, January 3rd, 1905.

(*d*) Denker: *Archiv. fur Laryngologie und Rhinologie*, 17 Band. Heft. 2.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by E. W. Scott Carmichael, M.B.; F.R.C.S.E., Senior Demonst. of Anatomy School of Medicine; Assistant Surgeon Royal Hospital for Sick Children, Edinburgh, on "Some Pneumococcal Affections requiring Surgical Treatment."*

ORIGINAL PAPERS.

PSYCHORHYTHM AND RECURRENT PSYCHOSES. (a)

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PART I.

THE following remarks will be confined to a group or groups of cases characterised by their periodicity or recurrence at fairly constant intervals.

By the term "psychorhythm" I mean the rhythmical recurrence of certain psychic states. There are some mental characteristics which are common to us all. In early life we acquire mental impressions more readily in the mornings, and the later hours of the day are more suitable for the processes of digestion or mental rumination—if I may use the term. As we progress towards senility there is apt to be a curious renewal of the process, *i.e.*, our brains, during the early hours, ruminate upon the earlier acquisitions, and under certain conditions of bodily health it is in the early hours that facts both pleasant and unpleasant are apt to recur. This fact is well known both inside and outside asylums, and in many cases of melancholia, the earlier hours of the day are fraught with the greatest sufferings and dangers. My experience has taught me that the earlier hours of the day are those most to be dreaded by the morbid mind, and this is most characteristic in adult life, especially so when insufficient rest and sleep begins to usher in a neurasthenic state, the result of a life of nervous and mental toil. The later hours of the day are characterised by an apparent increase of the vital functions, with, however, a diminution of the stability of the reflecting powers, a diminution of the controlling faculties, and, consequently, a greater tendency to impulsion. These characteristics of normal life are to be seen in exaggerated form in the sane as well as in the insane. Thus it is that resolutions are made and broken with equal facility, in accordance with the law of periodicity or psychorhythm.

I give merely this one instance of daily rhythm, for to enumerate the results learned from psycho-physical methods of research upon the daily variations of the mental faculties would require several hours.

(*a*) Read before the Harveian Society, February 14th, 1907.

These psychorhythms, however, are not confined merely to daily variations. Most of us are conscious of certain periods of fitness and unfitness, of days of depression and days of gladness. Stable indeed is the man who knows no variation in his mental calibre and moral worth. As Emerson says, "there shall be alternation for evermore," and perfect stability is suggestive of fixity. Charcot's dictum that "immobility is the finest movement of the soldier," is best exemplified in the stuporose and cataleptic, and the only true stability of mind known to me is to be seen in the monoideistic person who knows no emotion. It is the rule rather than the exception, therefore, for all of us to have psychorhythms, and the various types I shall mention are mainly exaggerations of these conditions.

Normal variations occur in relation to our sensory and perceptive powers, our memories, feelings, and actions. These variations are not only normal but symptomatic of mental and physical health.

The seasons and climate have some interesting relationships to mental disturbances which we may note in passing. Parchappe and Esquirol are agreed as to the greater frequency of attacks of insanity, or at least admissions into asylums in the summer months. Guislain observes that there is a relation between the warmth of the atmosphere and mental disturbance. A fall of temperature, on the other hand, often calms the insane. MM. Aubauel and Thore observe, as the result of their investigations, that the month of June appears (in France at least) to have the most influence in producing insanity, then July and August, next May and April, January having the least influence. Periodical or recurrent insanity is especially manifested in the spring. It is a fact, nevertheless, that we do not find more insanity in hot climates than in cold. According to the records of Sydenham, Benedict, and Brierre de Boismont suicides are more frequent in the months of spring and summer. The last-named observer found that of 3,518 cases of suicide committed in France, in which the exact period of the commission of the act was discovered, 2,092 were in the day, 658 in the night, 766 in the evening.

To the alleged influence of the moon I will refer briefly. The operation of the stars, if not the moon, on disease, was recognised by Hippocrates, and that of the moon was certainly admitted by Galen. In connection with the observations that light in itself tends to excite, and darkness to calm many of the insane, Rush concludes that the cases are few in which the insane feel the influence of the moon, and that mere increase of light is sufficient to explain excitement in such cases. Esquirol, Teuret, Mitivié, Woodward, and others have investigated this subject with failure to find any relation between them. They find coincidences and nothing more. "Many patients are certainly more excitable and restless on pleasant moonlight nights than in dark and gloomy weather, but this," says Hopkins, "would seem to be occasioned by the real or imaginary sight of objects in or without the building, such as men, trees, animals, etc., or the motion, perhaps, of the passing clouds. I think we may rightly assume that light stimulates the brain to activity, hence the greater excitement of some patients at the period of the full moon. Moreover, one noisy patient awakens others, hence a general disturbance in the wards of asylums. Coincidence also has to be reckoned with. Thus the menstrual period of the female with recurrence of sleeplessness and excitement, or metabolic phases, such as uric acid crisis in the male, may coincide with the phases of the moon.

I now propose to speak of certain exaggerations of the psychorhythmic process which tend to cross the borderland of sanity. These cases fall into two large groups, and may be described as perversions of mind due to

1. Deprivation of factors pertaining to complete consciousness.
2. Faults in metabolism and toxæmiæ.

The first group comprises a wide range of conditions in some respects comparable to the insanities resulting from deprivation of the special senses. The loss of any of the five special senses by which we keep in touch with our environments necessitates a re-adaptation of the remaining senses with possible over-stimulation of them. The result of hyperactivity of these senses without the corrective action of the missing sense is apt to result in false constructions or delusions. The cases to which I now refer, however, do not result from deprivation of any one special sense, but rather do they depend upon some cerebral condition whereby certain regional acquisitions and modes of mental reaction are periodically and temporarily cut off from the consciousness as a whole. Consciousness when complete, *i.e.*, with full and complete adaptation of the subject to the environment, depends upon perfect anatomico-physiological arrangements. The answer of cerebral anatomy and physiology to the question of the localisation of consciousness has been of little value hitherto, and we are still unable to account for the phenomenon of consciousness by the study of material structures. I do not for a moment pretend to be able to explain the mode by which the subject obtains its view of the objects correlated with cerebral activities in widely-apart localities. Without going so far as Kirchhoff, who believes that all internal processes constitute consciousness, and that there are no individual modes of consciousness, I believe there is evidence that consciousness may exist in conjunction with activities occurring in one or several of the regions of the cerebral cortex, while other regions are synchronously inactive as physical concomitants of mental phenomena. In fact, it seems fair to assume that full knowledge or complete consciousness is dependent upon complete seriality of perception and memory derived from activities within the whole cortex, and possibly incomplete knowledge or partial consciousness may be derived from a disruption of that seriality or sequence through inactivity of part of the cortex. This leads me to the consideration of the phenomena of double consciousness, and the various epileptiform states which would appear to warrant this assumption, and by its aid some of the greatest of the difficulties of these conditions may be unravelled.

Unconsciousness may be *partial* or *complete*. By "*partial*" is meant a suspension of psychical or physical elements which are necessary to a full or complete consciousness. By "*complete*" is meant the seriality of thought and discrimination (or knowledge) which is available by reason of perfect action throughout the cerebral cortex.

Partial loss of consciousness is exemplified in those individuals who, by reason of disorder or disease, suffer from partial amnesia. Ribot compares each particular form of memory with a contingent of clerks charged with a special and exclusive service. Any one of these departments might be abolished without serious detriment to the rest of the work, and that is what happens in these partial disorders of memory. It may be objected that in these partial amnesias there is not immediate loss of consciousness to present facts. The answer is manifest. Any present data which are incapable of being incorporated with the general stream of consciousness, seriality of thought, or knowledge, by reason of some cerebral defect, are outside the limit of "present knowledge," and the reflex, if there be one, is the result of activities within the undamaged remainder, and therefore only incomplete, and oftentimes merely automatic.

At the risk of some repetition, I would further exemplify this contention by comparing the highest evolved centres to a huge congerie of units or groups of units which are functionally continuous under certain conditions of contiguity with the periphery and with each other. These units may be compared to lamps, which give light when their respective electric phenomena are in operation. Provided that the switches and transmitting agents, both peripheral and central, are functionally operative, they light up in turn in response to the stimulus, be it peripheral or central. Carrying this hypothesis further, just as the switches, couplings, or currents may under one series of conditions become functionally inert at one time, leading to inability to produce light in one or several sets of lamps, so under another series of conditions may the same switches, couplings, or currents again become functionally active and determine the existence of light.

It seems justifiable to assume that the recurring amnesic defects which go so far to constitute what we call double-consciousness, are due to failure under one set of conditions to switch on lamps which had previously been alight under another set of conditions, and which may again be lighted under that other set. This hypothesis would appear to demonstrate how it is that there may be no end to the number of personalities in one individual.

Of all the forms of psychorhythms, alternating or recurring psychoses, none exceed in interest these conditions of double, or, more strictly speaking, partial consciousness.

This condition has been compared to dream, somnambulistic, epileptic, amnesic, and insane states, and I have elsewhere cited instances of the various gradations between them and health.

In childhood, night terrors or somnambulism may precede a condition in which during the day time there are moral, or volitional perversions, of which, in the fully awake state there remains no memory or power to recall. These children usually belong to the front of unstable neurotics who may become criminal or insane according to surroundings. In early life their instability is manifested by convulsions during teething. At puberty they suffer from night terrors, various forms of epileptiform automatism, habits of lying, thieving and moral depravities. At adolescence they are apt to become insane or criminal, and of all resultant forms of insanity most to be feared dementia precox is the worst. The children of drunken or neurotic parents are the most liable to suffer in this way, although I have quite recently seen four instances in which the patient has been the last born of a large family, and when the father has been over fifty-five years of age.

The next type is one in which the abnormal state is preceded by profound sleep. In these cases the sleep may be followed by partial awakening attended by confusion and pranks of the senses, and later in the day complete awakening. In other types the automatic states are preceded by profound sleep, and the normal is only reached again after prolonged sleep. Other types which may be mentioned briefly are: Conditions of temporary, periodic or recurrent amnesia due to shock or injury. I have seen several cases in which not only has unconsciousness immediately followed the injury, but at a subsequent period, months or even years later, curious anomalies of consciousness have occurred. These abnormal states may be likened to double consciousness, inasmuch as the patient may for weeks or even months respond to external impressions in a dazed confused manner, and be apparently in a degree conscious. On awakening, however, to full consciousness there is more or less complete failure to recall the details of the partially conscious period.

The epileptiform types of mental disturbance need not detain us, as they are already so well recognised.

The condition of double personality, however, is not so well recognised. There are several main groups. In *complete* alteration, the personality of the individual is entirely different in the two states; there is no continuity of thought, and the memory of one state is absent during the occurrence of the other. In the *partial* types the variations may depend upon sensory experiences which are different to those habitual to the normal self, and there may be new bodily sansations, or loss of old ones, and there may be illusions of identity of part or of the whole of the individual.

The *anæsthetic hysterical types* are those in which the symptoms are mainly hysterical with anæsthesia and temporary amnesia. In these cases there are certain "inhibitions" which prevent the recall or revival of the former sensations. Thus the occurrence of anæsthesia or a kinæsthesia may be attended by and followed by an amnesia which forms the basis of a change in personality. Another type in which the individual assumes the possession of a mediumship, and acts as if animated by others living or dead, is fairly common. Automatic writing, inspirational speaking, trance utterances, etc., fall into this category.

Before leaving this part of the subject I would refer to the recurrence of mental disturbance mainly attributable to expectant attention. The occurrence of one or more attacks at a certain season, or in association with certain states, such as the puerperal, is apt to lead the individual to anticipate a recurrence, and this in no small measure favours the onset of the mental trouble. With regard to puerperal insanity, it is well known that recurrence of the malady may sometimes be avoided by the avoidance of pregnancy for four or five years.

(To be continued.)

THE POOR-LAW MEDICAL SERVICE IN IRELAND. (a)

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To the Poor-law system in Ireland a renewed interest has been given by the recently-published Report of the Viceregal Commission. It is quite remarkable the unanimity with which this Report has been praised—a compliment which rarely falls to the lot of such documents; and I select that part of it for discussion which deals with the State Medical Service for Ireland, simply because it is the only part which is to any extent open to criticism.

The Poor Law Medical Service forms so large a part, and is so important a factor in the medical life of Ireland, that anything which affects it affects the entire medical profession in Ireland. It is not too much to say that only through this service can the profession in Ireland ever hope to take a full and active part in the national life of the country; only through it may we hope to secure for the profession a place in the social and political world commensurate with its public utility.

The dispensary doctor used to be the *Pooh-Bah* of his district, without, however, those comfortable emoluments which enabled the gentleman of Gilbertian fame to accept with resignation his multifarious duties.

I start with the incontrovertible proposition that the Poor Law System cannot remain as it is. No doubt, as some may say, it will be a long time before any of the reforms suggested in the report are put into effect; but, nevertheless, I hold firm to the opinion that once a system is found to be—as this one is—out of joint with the times, that then the period of its extinction is not far distant. I assume, as I believe I am justified in assuming, that should any change be made in the constitution of the present poor law system in Ireland, the dispensary medical service, as well as the workhouse and county infirmary services, must of necessity be included in the readjustment. It would not be possible to rearrange the management of the sick poor to any advantage without at the same time altering to a certain extent the construction of the different medical staffs that attend upon them. I would deprecate, however, most strongly, any attempt to amalgamate the coastguards, police, Irish lights, etc., services, with the Poor-law medical service. These services are perfectly distinct and separate, and have a character and objective quite different from the Poor-law Service.

The position of affairs in this year of grace 1907 is this: the State suggests the formation of a State medical service. The representatives of the people do not want a State medical service. The medical profession may be said to be fairly divided in opinion. They are, and have been for many years, extremely discontented with the conditions prevailing in the service with respect to pay, pension, promotion and position. I would suggest that the medical profession should try to bring about some compromise between the present arrangement and the proposed one—admitting on the one hand that the State must have, in lieu of finances supplied, a voice in the disposal of the money, in the fixing of the standard, in the arranging of the work; and that popular representatives should have, on other hand, the final election of the man who is to be the people's doctor and live amongst them, and have at least as much control over his actions as they have at present.

(a) Being an abstract of a Paper read before the State Medicine Section of the Academy of Medicine, on Friday, February 8th, 1907.

The county hospital scheme, with smaller district hospitals affiliated, advocated by the Commissioners, appears to have met with general approval, and in formulating some such alternative scheme as I have mentioned, I will take this as a basis. I assume the abolition of workhouses as such, and their conversion to other specific purposes. I take it that no time or money would be expended in opposing the establishment of these county hospitals, especially if buildings already in existence were used, and I also assume that the necessity for having district hospitals would be readily admitted. By no other means would the poor in outlying districts be so effectively reached and treated. I do not know what the Commissioners meant by "district hospitals." To my mind the residence of each dispensary doctor would need to be one. Having established the county hospital in the most central town of the county, it would then be advisable to map out afresh the dispensary districts, many of which are at present unnecessarily inconvenient, both in size and shape. This would not mean the undue multiplication of districts; quite the reverse. In the centre of each district the dispensary doctor's residence should be placed, and would, of course, belong to the office, and be free of rent, and attached thereto all that would be necessary to constitute an emergency hospital. There would be, say, four rooms, arranged in wards, a pharmacy, with all drugs and apparatus suitable for urgent cases, as well as the ordinary ailments, which two classes of case would be, it is contemplated, alone treated there. Attached, also, should be a residence for a district nurse, who should have a midwifery diploma. As the districts would be more conveniently arranged, fewer outlying dispensary depots would be necessary, but wherever required they should be established and attended by the medical officer. By these means, and also by the establishment of a complete and extensive system of telephonic communication, which will, no doubt, take place in the near future, the doctor would be quite in touch, and capable of dealing with any case that might arise, and the poor could feel that they were within reasonable reach of medical assistance. The county hospitals should have at least two resident medical officers, and also an out-patient department. This would obviate the necessity for having dispensaries in the immediate neighbourhood of the hospitals, for there is no reason why the hospital medical officers should not visit at the houses of the sick poor, within a certain distance of the hospital. The county hospital surgeons would be, in fact, the dispensary doctors for the area around the hospital. It would be desirable to have one of these medical officers an operating surgeon, one a physician, and in places where there are three residents, one a gynæcologist. There should be no difference in rank or remuneration between the county hospital medical officers and the dispensary or district hospital medical officers, except those which fortuitous circumstances might give rise to; but lest these should amount in practice to something considerable, it should be the rule that positions falling vacant should be filled from the ranks of the service before new appointments be made.

To insure that the dispensary, or, as they would be called, district hospital surgeons, would have the requisite experience—besides the cases treated in his own small hospital, the district hospital surgeon should have the right of assisting at operations, and visiting in consultation with the resident all patients from his district in the county hospital.

The above is a sketch of a very simple mechanism, but one which from my experience as a country dispensary doctor could be made a very effective and comprehensive one. The salaries of all the medical officers would be the same, say £200 per annum, rising to £400, together with registration and vaccination fees, etc., and residence free of rent and taxes. All this should be paid by the State. An annual holiday of one month should be granted to each medical officer as a right, free of expense. Every medical officer in the service should be permitted to retire on half-pay after 20 years' service, and should be compelled to resign at 65 years of age on two-thirds of his salary and emoluments. This would bring about a healthy circulation in the service, good alike for the poor and the profession, and has been found beneficial in nearly every other service. The grave objection to the Commissioners' report, and one which would be fatal to its adoption, is the constitution of the council, or board of control, which, according to them, would be necessary. I foresee that endless disputes would arise on this point, and that—apart from the objection to having any more boards added to the 42 already in existence in Ireland—it would be hopeless ever to construct a board that would please everyone. This would tend towards what I most dread—namely, the indefinite postponement of the settlement of this vital question. Let us see if we could not dispense with another board altogether. Let the State, or the Local Government Board, have inspectors, as at present, increased in number if necessary, to make sure that the system is properly carried out, to prevent abuses creeping in, and to hold inquiries when called for. Let the management of each county hospital and its affiliated district or dispensary hospitals be in the hands of a large and representative committee. The committee of management might be elected at their first meeting by the county council, and could be made up of, say, one councillor from each district, the county medical officer of health (of whom more anon), one representative of the government, and two clergymen—one from each of the two prevailing denominations of the place. Of course I only throw out this suggestion for discussion. In the hands of this committee would rest the election to all medical posts in the county, though, of course, subjected to the formal sanction of the Local Government Board. In order to guarantee a high level of efficiency, which is really all that the State should require, let only those who, being fully qualified in medicine, surgery, and midwifery, and registered, have, in addition, an extra certificate in the practice of obstetrics, a certificate in lunacy, and at least twelve months' experience (not necessarily continuous) as *locum tenens* in dispensary districts, or in lieu thereof, one year's experience in a large hospital, be eligible for appointment in this service, and none others. By this method not alone would good men be procured, but only those who have served, so to speak, an apprenticeship would be admitted into the service. This I consider of paramount importance. If desired, a post-graduate course might be made a condition of promotion or increase of salary, so as to maintain a high level of proficiency. There can be little doubt that the people would not object to a State service on these lines. The State meaning in this connection that the funds necessary are provided by general, not local taxation.

I would suggest, both on the score of equity and expediency, that the county and district hospital medical officers—*all* of whom on my plan would have dispensary duties to perform—should (in addition to the fixed salary and emoluments paid by the State for the definite work of treating the sick poor in the hospitals and dispensaries) be paid by the local authorities a small fee on each red ticket or case visited at the patient's home. I do so for the following reasons:

It is but fair that a man should be paid in proportion for extra work done. At present if a disease becomes epidemic the medical officer is put to great expense for extra car-hire. He is bound to attend dispensary patients first, and if these are numerous, most of his time is used up, to the great detriment of his private practice. Again, the better a man does his work, and the more confidence consequently the poor people have in him, the more calls he gets—all without further remuneration, or even recognition. It would be a check on the improper issue of tickets, and a guarantee that only those entitled to it would receive medical relief, as is the case at present with regard to outdoor relief.

It would also induce the county councillors to take a direct interest in the proper distribution of medical aid to the sick poor, and would be an index to the efficiency of the work performed. It would assuredly prevent the degrading effect of the present system on the minds of the poor people, and they would value more highly medical assistance they knew would be directly paid for. It would enable the medical officer to obtain payment from those well able to pay who now receive medical advice at his expense.

This plan, while just, is no more liable to abuse than the present method of administering outdoor relief, and could be safeguarded in a similar manner. I mentioned just now a county medical officer of health. As we are all aware, the Public Health Department in this country is a farce, and certainly stands in need of extensive reformation. In the first place, dispensary and hospital medical officers should neither be asked nor allowed to do public health work. When it is fully realised what the work of a medical officer of health *should* be, it will be seen that it would be quite incompatible with his duties as a dispensary or general practitioner, which necessarily bring him into private and confidential relations with his patients. No man living by the practice of medicine, and having a *clientele* with whom he must be on good terms, could possibly do public health work efficiently or thoroughly. Men who enter the ideal public health service, which we may hope to see established some day, will be expected to devote their whole time to this class of work, and will be paid salaries sufficient to render them independent of any other source of income. Special qualifications, such as a D.P.H., are necessary, and will be, no doubt, required of them; but then their reports will be received with the respect due to them, and executive power will, of course, be granted to them. Each county should have at least one medical officer of health, and he should be responsible to the State, and do nothing else but direct and see that the various works and regulations for the maintenance and improvement of the public health are satisfactorily carried out. This medical officer of health should have as many sub-sanitary officers under him as would be necessary, and he would be a suitable person to have on the public boards and committees, his opinion on medical matters being a valuable one, while his position would be an independent one. Detailed reference to the public health service is, however, at present outside my scope, and I merely allude to it here to show that I am very much opposed to having the duties of attending to the sick and doing sanitary work combined and performed by the same person.

THE War Office intimates that a number of Queen's South Africa medals and clasps for ex-members of the Royal Army Medical Corps, Royal Army Medical Corps (Militia), Cape Medical Staff Corps, Medical Staff, Rhodesian Field Force and Natives (attached to Medical Units) still await claimants. Applications for these decorations should be addressed to the Secretary, War Office, accompanied by discharge certificates and full particulars of service with other corps.

CLINICAL RECORDS.

A CASE OF FATAL EXTRAVASATION OF URINE FROM THE URETER CAUSED BY THE ULCERATION DUE TO A MINUTE CALCULUS. (a)

By RAYMOND JOHNSON, F.R.C.S.,
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THE case was that of a man, æt. 35, who had recently undergone an operation for an irreducible omental hernia in the right inguinal canal. The operation was in no respect unusual, and a considerable mass of omentum was removed after being ligatured in sections with fine silk. The wound pursued a normal course, and the patient's convalescence was uninterrupted until the thirtieth day, when, after a light meal, a violent attack of vomiting occurred, and severe pain was experienced across the lower part of the abdomen. The vomiting only recurred once on the following day, but considerable pain persisted and gradually became limited to the left iliac region. When seen on the sixth day after the onset of the abdominal pain the patient looked pale and ill; the pulse was 88 and of good quality; temperature slightly raised; tongue moist, but coated. The abdomen presented slight general fulness, especially above the outer half of Poupart's ligament on the left side; in this region there was marked tenderness, which extended somewhat backwards towards the loin. No other facts of importance could be elicited by abdominal or rectal examination, and the site of the operation for the hernia on the right side presented nothing abnormal.

From the evidence it was concluded that the patient was suffering from a localised peritonitis in the left iliac region, but no satisfactory explanation was forthcoming. In spite of the localisation of the symptoms to the left side the possibility of appendicitis was entertained. It was not thought that suppuration had occurred. The patient was put on a strict spoon diet and belladonna fomentations were applied to the abdomen. Two days later the local signs had become somewhat more pronounced, and there was slight dulness above the outer part of Poupart's ligament. The presence of pus was suspected, and operation was performed. An oblique incision was made over the area of dulness, and after dividing the muscles of the abdominal wall the œdematous transversalis fascia was exposed. On dividing this a cavity containing thin pus with a powerful ammoniacal urinary odour was reached. It was uncertain whether this cavity was behind or in the peritoneum, and exploration with the finger merely showed that it extended a short distance upwards and downwards. A large drainage tube was inserted. It thus seemed evident that an infection of the peritoneum or retro-peritoneal tissue had occurred from the bladder or left ureter, but the cause was not known. The urine contained a very faint cloud of albumin, but was otherwise normal. Retention of urine during the first day or two after the operation for hernia a month previously had necessitated the use of a catheter, but there had been no signs of cystitis. It was further learned, as possibly having a bearing on the case, that some months previously, when away on a holiday, the patient had experienced an attack of not very severe pain in the back, which, however, only lasted one day.

On the day after the abscess was opened violent hæmorrhage occurred from the wound, during an action of the bowels, and the patient was *in extremis*. On removing the dressings it was found that the bleeding had stopped, and the patient rallied after an intravenous saline infusion. No further hæmorrhage occurred, but the patient's feeble condition prevented any attempt at further exploration. Small quantities of pus and urine continued to escape from the drainage tube, the temperature remained irregular, and death occurred on the fourth day.

(a) Read at a meeting of the Harveian Society, Feb. 14, 1907.

At the autopsy it was found that the abscess cavity extended in the retro-peritoneal tissue along the whole length of the left ureter from the kidney to the bladder. Lying in the abscess cavity was a small oval crystalline calculus, which proved to be composed of oxalate of calcium, and weighed eight grains. The left ureter at a point two inches below the renal pelvis presented an ulcerated opening at the seat of a slight dilatation. The urinary organs were otherwise normal, and no other stone was found. There was no peritonitis.

The difficulty of diagnosis in this case has been sufficiently indicated, and before the operation the true nature of the local inflammatory condition was not even suspected. It was, indeed, regarded as a local peritonitis, probably due to an infection from the appendix or large intestine.

The hæmorrhage was doubtless due to the sloughy state of the tissues around the abscess, but its exact source was not discovered.

If the condition of the patient had permitted further interference the right treatment would probably have consisted in freely enlarging the incision upwards and backwards, and, after discovering the state of the ureter, removing the kidney.

The case is a striking illustration of the fact that even a very small renal calculus, productive of few, if any, definite symptoms, cannot be regarded as a source of no danger.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

OPERATION FOR IRREDUCIBLE HERNIA WHICH PROVED TO BE OF CONGENITAL ORIGIN, AND RADICAL CURE.—Mr. H. BETHAM ROBINSON operated on a man, æt. 39, who had been admitted for irreducible inguinal hernia. The man gave the following history :—For six months he had noticed a hernia on the right side which had been easily reducible till one week before; since then it had become very swollen, and he had not been able to get it back. There was some tenderness on pressure over the line of the inguinal canal, but there was no marked pain ; there was no obstruction of the bowels. On examination, in the front of the right half of the scrotum was a cystic swelling extending upwards above the level of the external ring, but placed a little outside it. This upper end was definitely pointed. This swelling was translucent, and had impulse on coughing. Along the line of the inguinal canal was a hard cord-like thickening, which after coming through the external ring was placed behind the former fluid swelling, and traced down in the scrotum, extending half-way down the former swelling, and ending in a definite knob-like projection. In this, again, there was impulse on coughing. The testicle was not able to be defined. Before operation the nature of this scrotal swelling was not clear. The history suggested the possibility of the fluid part being a hydrocele of a hernial sac, but the want of recognition of the testicle made this diagnosis uncertain. An incision was made over the front fluid swelling and ordinary clear hydrocele fluid was let out. It was then found that this sac was, so to speak, a diverticulum from the posterior swelling, and had a blind upper end placed outside, and a little below the external ring as made out before. The posterior cord-like swelling was now better defined at its exit from the external ring. The front wall of the canal was freely exposed by dividing the internal and external Obliques, and a hernial sac was exposed with the elements of the spermatic cord spread out all round it. On opening up the sac it was found to be filled with matted omentum, which, passing down in the posterior sac in the scrotum, surrounded a small testicle. The anterior cystic swelling was then shown to have communicated with the posterior one by means of an opening placed in front of the lower part of the latter. The matted omentum was separated, tied off in the inguinal canal and the stump returned into the abdomen. The wall of the anterior sac, which was shown to be a diverticulum from the real hernial sac, was cut away and the real hernial sac behind was also divided above the testis. The large opening thus made above the testicle was closed by a purse string suture, and by this means a tunica vaginalis was made. The real hernial sac was then separated from the constituents of the cord as far up as the internal ring; at this site its neck was transfixed with a silk ligature which was tied round the neck and the redundant sac cut away. The inguinal canal was then closed with silk, Bassini's method being adopted. On completion of the operation it was noticed that the right half of the scrotum proper appeared to be ill developed, and that the testis occupied a site rather outside the scrotum, *i.e.*, the cruro-scrotal position. Mr. Robinson said that the operation thus proved what was the nature of the hernia and how very unreliable the history had been. The hernia was of the form called " congenital hernia," that is, the whole length of the processus vaginalis testis had remained unclosed, so that the abdominal structures which had descended were in direct apposition with the testicle. As so frequently occurs in these cases the development of the testis itself was defective and its descent incomplete. A feature of the case was the diverticulum in front from the sac containing the testis filled with fluid diagnosed previously as a hydrocele. The non-recognition of the testicle before the operation was owing to its reduced size and to its being covered up by the matted omentum. Such diverticula he thought were rare, and no special view could be advanced to explain their production. The important points of the case, he considered, were :—(1) That although the man had a true congenital hernia, he, at the age of 39, only gave a history of six months presence of the hernial swelling ; (2) the nature of this congenital sac with the anterior diverticulum, and (3) the probable descent of the testis out of its proper course.

The patient made an uneventful recovery, and left the hospital about three weeks after the operation.

ROYAL SOUTHERN HOSPITAL, LIVERPOOL.

EXCISION OF HALF THE TONGUE, PRELIMINARY LIGATURE OF THE LINGUAL ARTERY— SECONDARY HÆMORRHAGE—RECOVERY.—Mr. NEWBOLT operated upon a man, æt. 49, who was suffering from an epithelioma involving the right half of the tongue. The growth had existed for three months, and was caused by an injury from a broken tooth. The glands below the jaw on the same side were involved. The latter were dissected out and at the same time the right lingual artery was ligatured. The right half of the tongue was next removed through the mouth, and as the growth extended back towards the root a wide excision was done and parts of the tonsil and fauces were taken away. A vessel in the pillar of the fauces was secured and also the cut lingual, but the operation was practically bloodless. All went well until the fifth day afterwards, when at 5 a.m. the patient began to bleed freely from the mouth. Mr. Newbolt saw him at 6 a.m., and as it was impossible to see where the bleeding came from, the patient was removed to the theatre, the wound in the neck rapidly opened, and the external carotid tied. The bleeding at once ceased and the patient made a good recovery. The bleeding, Mr. Newbolt remarked, apparently came from the fauces, probably from a wounded ascending pharyngeal or one of its branches. In this case, he said, the lingual has been tied as the neck had to be opened up in order to remove the glands, the patient having expressed the wish that the whole operation should be done at one sitting. It rendered the removal of the tongue practically a bloodless operation. No doubt the hæmorrhage came from another vessel, either the ascending pharyngeal, its branches, or possibly the ascending palatine branches of the facial; its late onset was rather remarkable, inasmuch as the wound was sweet and no sloughs were present. Microscopically the growth was a typical squamous celled epithelioma; the glands, however, showed no cancerous deposit. The operation proved to be a highly successful one, the patient remaining well up to the present time, nearly five years having elapsed. Mr. Newbolt considered that the preliminary laryngotomy with removal of the tongue, followed by the removal of the glands later on, as advocated by Mr. Butlin, was undoubtedly the best practice. When, however, the patient wished the operation done at one sitting the ligature of the lingual avoided the necessity for the laryngotomy, as in the majority of cases the wound in the mouth was a dry one and the surgeon could see what he was doing, a matter of necessity in this class of case. Of course, there were exceptions to this rule.

TRANSACTIONS OF SOCIETIES.

HARVEIAN SOCIETY OF LONDON.

Ordinary Meeting, Thursday, Feb. 14th, 1907.

The President, Dr. Sidney Phillips, in the Chair.

Mr. Raymond Johnson, F.R.C.S., read the notes of a case of

FATAL EXTRAVASATION OF URINE FROM THE URETER CAUSED BY THE ULCERATION DUE TO A MINUTE CALCULUS.

(which will be found fully reported on p. 256).

Mr. Campbell Williams remarked on the unique character of the case, particularly the spot in the ureter at which the calculus had become impacted, stenosis at the site being practically non-existent. He pointed out that in the urethra an impacted oxalate of lime stone produced more distress than either a phosphatic or uric acid calculus. The remark was equally applicable to renal colic, the passage of the oxalate calculus causing more distress, even when very small, than other varieties.

Mr. Crisp English spoke of the effect of the shape of the calculus: the small pointed stones are more dangerous than larger rounded ones.

Dr. T. B. Hyslop read a paper on

"PSYCHORHYTHM AND RECURRENT PYSCHOSES"

(which will be found fully reported on page 252 of the present issue).

Mr. Campbell Williams said he was interested to hear Dr. Hyslop's remarks upon the effect of hot weather in the production of mania. He had noted on every voyage which he had taken to Australia that the somewhat abrupt variation of temperature in mail steamers, *i.e*, from cold to heat, was invariably signalised by some unfortunate neurotic, who had been sent a voyage for the benefit of his nervous system, becoming acutely maniacal as soon as the tropical heat affected him. As regards the statement that the curing of either eczema or psoriasis had any bearing on a maniacal outbreak he pointed out that it was probably a coincidence and instanced that these two diseases and lichen planus were probably the most common skin diseases met with, and consequently one would therefore expect mania and cure to be quite a common event. That the causation of these diseases was possibly due to the absorption of intestinal toxine was a theory now receiving attention. Lichen planus when cured by salicine or mercury, given internally, pointed to an intestinal origin—not a syphilitic one, as had been deduced, because it yielded to mercurial treatment, for mercury, like iodides, benefits other diseases as well as syphilis.

Dr. Poynton remarked that insanities alternating with other forms of bodily disease were conditions of supreme interest, and alluded to a case of recurrent and obstinate psoriasis, in which where the rash had disappeared the patient became temporarily insane, and recovered again when the rash reappeared. He also alluded to insanity in mumps, and to the curious cases of infantile eczema in which death followed the disappearance of the rash, the symptoms of the fatal illness being cerebral, with or without hyperpyrexia, and the post-mortem lesions negative. He believed and hoped that certain observations that he had made with Dr. Paine and Dr. Gordon Holmes might in the future result in the elucidation of these difficult points. In six cases of fatal chorea, including one of chorea gravidarum, they had found a bacterium in the meningis or brain, which was identical with that found in other rheumatic lesions, and had found in the brain definite, though not gross changes in the nerve cells. If this bacterium eventually proved to be the exciting cause of rheumatic fever, including chorea, as he believed it would, then here was a cerebral infection which caused chorea, and, moreover, sometimes a mental chorea or form of insanity, for undoubtedly some, and especially adult cases of chorea, might be temporarily insane. The nervousness and night terrors of rheumatic children were, when viewed in this way, also of interest.

The President, Dr. John Broadbent, and Dr. Spilsbury spoke, and Dr. Hyslop replied.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of State Medicine.

Meeting held Friday, February 8th, 1907.

The President, F. C. Martley, M.D., F.R.C.P.I., in the Chair.

REPORT OF THE VICEREGAL COMMISSION ON THE POOR LAW.

Dr. Thomas Donnelly read a paper on the above subject, an abstract of which appears under "Originl Papers" on page 254.

REMARKS ON THE POLICY WITH REGARD TO TUBERCULOSIS OUTLINED IN THE REPORT OFTHE VICEREGAL POOR LAW COMMISSION.

Professor McWeeney read a paper on the above subject. He began by referring to the increase of tuberculosis in Ireland, mentioned by the commissioners in par. 102 of their report. Although quite conscious of the gravity of the problem, he was not at all certain that the figures justified any statement stronger than that whilst the mortality from tuberculosis in England was coming down "by leaps and bounds" it was not showing any tendency to decline in Ireland. The explanation was, no doubt, that whereas in Ireland very little was being done, and that sporadically, in England, amongst other factors, the efforts of independent, whole-time county medical officers of health produced results which could not be hoped for under the excessively bad system which in Ireland placed the health officer's interest in direct opposition to his duty. The recommendation of the Commission that the disused workhouses should be converted into consumption sanatoria deserved their hearty approval, all the more so if Dr. Newsholme's contention be right—that the decrease of the disease in England is mainly due to its increased institutional segregation. The speaker thought it a wise suggestion of the Commission that not only curable but advanced and infective cases should be removed to the contemplated sanatoria. The removal of such from their homes was one of the most essential parts of the campaign, but in Ireland it would be objected to if there were not some prospect of cure held out. By proper classification and rigid observance of regulations he thought that the association in one institution of curable and advanced cases might be rendered unobjectionable. The suggestion of the Commission that consumptive inmates of lunatic asylums should be segregated in a few specially adapted workhouse sanatoria he regarded as particularly valuable, in view of the great difficulty in rendering such cases non-infective. He thought that county councils should have a free hand in devoting public funds to sanatoria, and not be limited to one penny in the pound rate as at present. In conclusion, he looked forward with confidence to the growing-up round the sanatorium of auxiliary institutions such as the dispensary and the volunteer philanthropic committees with the object of providing ex-patients with suitable outdoor or hygienic work, so as to prevent relapse, and sustenance for the wives and families of consumptive working men, so as to secure for them while in the sanatorium that peace of mind which is an indispensable factor in the cure. He pointed out how state invalidity insurance fulfilled this need in Germany, and expressed the hope that workmen's friendly societies would undertake a similar function here. The speaker concluded by saying that the members of the Commission, two of whom he was glad to see present, had by their statesmanlike report earned the hearty thanks of all interested in the struggle against tuberculosis.

Dr. LEONARD KIDD (Enniskillen), said he considered Dr. Donnelly's suggestion that the resident medical officers should do dispensary duty to be impracticable, because if the hospitals were to be levelled up to a high standard it would be a physical impossibility to have high-class surgical work and dispensary work done at the same time. He thought that each large county should have an independant medical officer of health, to whom the dispensary doctors, if they were sub-officers of health, would report. The present method of reporting to the district councils reduced sanitation in the country to a farce. He thought the name "State service" unfortunate, and suggested a "public health and sanitary service." What they ought to have was a board of public health presided over by a minister of Cabinet rank. Although a remnant of the Council of the Irish Medical Association had passed a resolution against the service, they knew that the association was practically unanimous in its favour. The profession was overwhelmingly in favour of some such form of service, and that solely in the interests of the sick poor. The only qualification for admission to hospital should be that of sickness. He was altogether opposed to lines and recommendations from subscribers, especially shopkeepers. There should thereforebe an enquiry officer attached to each hospital. The hospitals should be supported by the county rate, but it would be a pity if the interest of charitable people was killed. Governing bodies might be appointed from members of the county councils and people who lived near the hospitals. Salaries should be fixed to bear some ratio to the work done, and should be proportionately larger in the poorer districts where private practice was small. The clerical work in the country should be reduced to a minimum, and there should be some central body to purchase and test all drugs and apparatus and supply them to the country. He did not consider a single workhouse in Ireland suitable as a sanatorium, from a curative point of view.

Dr. KENNY (Granard) expressed general approval of the report. He did not think the people would have any objection to the profession taking up the control of the State service. They might be inclined to dabble in their affairs, but if the profession showed that their chief concern was to do effective work the public would support them. The profession had pronounced itself very strongly in favour of the recommendations of the committee, not only at public meetings but also in the country, where poor law officers were derelict and without means of communicating with the centres in Dublin. The change to an efficient county service was bound to be beneficial.

Dr. WRIGHT (Dalkey) did not think anyone could doubt that the national medical service would be of great benefit to the sick poor. The carrying out of the recommendations would mean that the younger men would be sent to the outlying districts where they were most needed. Nor could there be any doubt as to its benefits to the profession, since it opened up the possibility of promotion. Boards of guardians would, of course, oppose the recommendations from a natural dislike to have patronage and influence taken from them. The Commission, however, only proposed to take away the election of the medical officers, and he thought any opposition would be got over if it was clearly understood that the State would pay, and that the boards would have full control over their medical officers while holding office. The rates available for sanatoria should be unlimited.

Dr. P. J. GARLAND thought the crusade against consumption should be initiated by a reformation of the public health service in the country. It was controlled, not so much by its officers as by the tenement house and slum owners, whose interests were so jealously looked after by the local bodies that it was impossible for an active and efficient officer to discharge his duties. That department must be taken over entirely by the State.

Mr. M ARDLE said that shortly before the meeting of the Irish Medical Association he objected very strongly to the State medical service under the conditions laid down. Afterwards, when he had learned more about it, he became an enthusiastic supporter of the recommendations of the Commission. The provisions for the benefit of the people generally were so sound that it would be criminal to oppose the scheme for any petty reasons. He did not think there was any need for an alternative scheme. They should confine themselves to broad principles and not to minor details of policy. He thought the question of consumption held a position second to none in importance in those recommendations. If they could not eliminate it they could check it.

Dr. DELAHOYD said the operation of the poor law system had had a demoralising effect on the country, and had destroyed thrift. It would be useless for them to support a State service that would do away with the principle of local control. All entrants should start on equal rights, but there might be certain allowances suited to certain individual conditions.

Mr. W. MICKS and Dr. COEY BIGGER also spoke, and explained some of the recommendations of the Commission that had aroused adverse criticism.

Dr. DONNELLY, in replying, said his paper had justified itself in eliciting such a valuable discussion. If they were to get anything done in a reasonable time there must be some compromise. The trend of popular opinion was against centralisation, and the bulk of the people objected to the service.

Dr. MCWEENEY, in replying, said he agreed that a penny in the pound rate would be insufficient to cope with tuberculosis, but they should see what they could do with that for a beginning. In view of the tremendous mortality from tuberculosis they ought no longer to postpone their efforts, and should not wait for the remodelling of the public health service.

Mr. M'ARDLE proposed the following resolution:—"That the section of State medicine of the Royal Academy of Medicine in Ireland desire to express its approval of the suggestion contained in the Report of the Viceregal Poor Law Commission to convert the entire Poor-law medical service in Ireland into a national service, to be paid by the State, to be entered by a competitive examination, the members of such service to be jointly controlled by the central body and the local bodies, and that the medical profession should have one representative on the central body."

Dr. CRAIG seconded. The resolution was passed.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, FEBRUARY 14TH, 1907.

The President, Mr. FRANK T. PAUL, F.R.C.S., in the Chair.

SUBMUCOUS RESECTION OF THE NASAL SEPTUM.

Dr. W. PERMEWAN read a paper on "Submucous Resection of the Nasal Septum." He described in detail, and illustrated by lantern slides reproduced from Dr. St. Clair Thomson's drawings, the method introduced by Killian, of Freiburg, and then briefly indicated the procedure adopted by Freer, of Chicago. Dr. Permewan insisted on the advantage of operating under cocain, without a general anæsthetic, and said there was practically no pain, no shock and no hæmorrhage. He thought that a satisfactory result could always be predicted, if the operator had sufficient experience and sufficient patience, but the operation should not be undertaken by anyone unskilled in nasal surgery. He then demonstrated the operation on a dissected specimen, and showed the instruments used.

Dr. McDOUGALL thought the submucous operation had a great future before it. He considered it an interesting speculation whether the efforts which had been made in recent years to establish free nose breathing in children would reduce the frequency of intranasal operations in later life.

Mr. T. GUTHRIE could corroborate what Dr. Permewan had said as to the great value of the operation. He asked what Dr. Permewan considered to be the earliest age at which the operation should be performed. Freer regarded it as suitable for all ages, but stated that in children a recurrence of the deformity was probable unless the operation was a very thorough one. Was there any risk that, in children, the operation would involve a subsequent dropping of the bridge of the nose?

Dr. Bark and Mr. T. C. Littler Jones also spoke.

PULSATING EXOPHTHALMOS.

Mr. A. NIMMO WALKER showed a case of pulsating exophthalmos successfully treated by ligature of the common carotid artery.

The patient, a married woman, æt. 29, had been admitted into St. Paul's Eye and Ear Hospital in May, 1906, with the history that six weeks previously she had been struck on the left temple by a large piece of wood, and on the following day had noticed a swishing noise in the head which became gradually worse, with increasing swelling of the left eye. The left eye was found to be proptosed, with dilated episcleral veins, hazy cornea and œdematous conjunctivitis, while the right eye also was congested and prominent; pulsation could be felt in both eyes, and, with the murmur, was controlled by pressure on the left common carotid. The artery was tied, and a month afterwards the eyes were about normal. At the present time, eight months later, the only abnormality was enlargement of the episcleral veins of the left eye, the sight of which had recovered from doubtful perception of light to normal vision with the help of a correcting lens. The vision of the right eye had always been normal.

Mr. WALKER thought that in this case the artery had leaked into the cavernous sinus, but that this, far from being a contra-indication to operation, as had been previously taught, was indicative of its immediate necessity; whether the lesion was aneurysm or aneurysmal varix, early ligature was recognised now as the right treatment, a result largely due to the teaching of his father, Mr. G. E. Walker, who had advocated this operation ever since his first case in 1878.

THE HOUSING OF THE WORKING CLASSES IN LIVERPOOL.

Dr. E. W. HOPE, medical officer of health, gave an account of the position of the city in regard to insanitary property, and the measures taken by the Corporation to deal with it.

He explained the reasons in connection with the rapid growth of the city, which led, during the early part of the century, to its development upon lines resulting in the erection of many thousands of dwellings of an insanitary character. A heavy legacy of insanitation had thus been left for future generations to deal with. In 1883, a special commitee was appointed to deal with the masses of insanitary property existing in the city, and from that year onwards, at varying rates of progress, the work had been proceeded with under the provisions of the Liverpool Sanitary Amendment Act. Dr. Hope explained the difficulties which had to be contended against, and stated that upwards of a million sterling had been spent by the Corporation in removing insanitary dwellings and re-erecting suitable habitations upon their sites.

The compensation for public-house property constituted a heavy item in the outlay. These premises, however, are not spared, as the Council are well alive to the immense injury done by drunkenness in this City.

Apart from the action of the Corporation in removing slums, commercial enterprise had been active; railway companies, warehouse companies, and so forth had swept away large numbers of insanitary dwellings.

In 1883 some 16,000 insanitary dwellings existed. These had now been reduced to between 6,000 and 7,000, and the Corporation had recently decided, pending the sanction of the Local Government Board, to deal with six more areas under the Housing of the Working Classes Act, and to erect suitable dwellings upon them. These schemes were estimated to cost £270,000.

The paper was illustrated by a number of slides showing the old and the new buildings, and the various points in connection with these latter.

Dr. S. H. HOUSE exhibited a number of lantern slides, illustrating the life of the slum children, made from photographs taken in the course of his work as medical officer to the Society for the Prevention of Cruelty to Children.

Dr. G. G. STOPFORD TAYLOR said that the demolition of public-house property would not stem the tide of drunkenness. Education, regular employment and public opinion could alone effect a reformation in the habits of the drunkard, and when these failed his children should be taken from him and brought up at the expense of the State in order to protect them from their vicious surroundings.

Dr. W. CARTER thought that the solution of the slum problem would largely depend upon the solution of the drink problem. Every successive medical officer of health for Liverpool had complained that their efforts at improved sanitation in the houses of the poor were rendered largely nugatory by the prevalence of intoxication. Years ago when the late Professors Parker and Sanderson were invited by the Corporation to inquire into the causes of the insanitary condition of Liverpool they gave a conspicuous place in their report to drunkenness among the working classes. The facts stated by Dr. Hope that £5,000 a year was taken at three public-houses in one of the lowest districts of the city, and that in the whole city from one and a-half to two millions sterling were spent yearly in intoxicating liquors were alarming. It was a good thing for Liverpool that its great public officers were not merely hard routine officials, but had the enthusiasm of humanity to aid them in their great work.

Dr. A. G. Gullan, Dr. Whitford, Dr. J. Hill Abram and Dr. H. Armstrong also spoke.

NOT a single death has occurred for more than a year in the little Devonshire village of Clayhidon, which has a population of 463.

CENTRAL MIDWIVES BOARD.

Meeting held February 28th, 1907.

The President, Dr. Champneys, in the Chair.

Three letters were read by the Secretary to the effect that the Roy. Coll. Phys. had re-elected Dr. Champneys to represent them on the Board for the ensuing year; that the Royal Soc. Apoth. had re-elected Mr. Parker Young to represent them, and a third from the Clerk of the Privy Council transmitting an order to extend the present rules to March 31, 1907.

The question arose of sanctioning Whitechapel Infirmary and Paddington Workhouse as a training school for midwives. Sanction had already been refused on account of structural defects. Mr. Fordham moved that with regard to Whitechapel such refusal be rescinded. This was duly seconded and carried, but the same movement by Mr. Parker Young on behalf of Paddington found no seconder.

Mr. Fordham also moved that "A sub-committee be appointed to consider points of the Midwives' Act which required amendment with a view to laying same before the Privy Council, and a request for their embodiment in a Government Bill during the coming Session." This was duly seconded and carried.

Letters from Dr. Wheatley, Salop, and Dr. Niven, Manchester, requesting information as to the necessity of workhouse nurses holding the Board's certificates received answer that the Privy Council and the Local Government Board were considering the matter.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 3rd, 1907.

Hæmorrhage of the Digestive Tract.

Hæmorrhage of the digestive tract is frequent and often grave. A certain number of therapeutic remedies have been tried, but large warm enemas and chloride of calcium would seem to give the best results.

The hæmostatic and antisphlogistic properties of hot water have been known for a long time, yet it was only in the last half of the last century that it was used under the form of injection in the treatment of certain maladies. Trousseau recommended it for metrorrhagia; Eissenmann in nephritis and peritonitis; Emmel in gynæcology in general; Réclus recommends hot enemas in the treatment of uterine affections; R. Tripier in that of gastrorrhagia and dysentery.

As to salts of lime, Green twenty years ago demonstrated that they favoured the coagulation of the blood. A few years later after the experiments of Arthus and Pages, Wright brought to light the action of chloride of calcium, at first in vitro, afterwards in vivo. From his researches he concluded that given in relatively weak doses, chloride of calcium was a good hæmostatic. This conclusion was confirmed by Carnot and more recently by Mathieu, who, little satisfied with the usual remedies employed to arrest the hæmorrhage of typhoid fever patients, tried the association of hot enemas and chloride of calcium. The clinical experiments having been satisfactory, he concluded by treating systematically by this method every case of gastro-intestinal hæmorrhage.

The first thing to be done in case of abundant hæmorrhage from the stomach or intestines, is to enjoin absolute rest in bed and on the back. All nourishment by the mouth is suppressed until the hæmorrhage is somewhat arrested; if it is a manifest case of ulcer of the stomach, nothing but a tablespoonful of water from time to time should be allowed for a few days. But nutritive enemas might be administered if necessary. If the clinical symptoms point to hæmorrhage of the intestine the same *regime* should be followed. If the nutritive enemas are ill supported, or that the general condition is very grave physiological serum might be injected under the skin. To immobilise the abdomen, one can choose between the ice-bag and hot poultices, but to moderate the peristaltic movements of the intestine, nothing is equal to opium given in quarter grain doses at intervals.

If, in spite of all, the hæmorrhage does not cease, M. Dieulafoy recommends surgical interference (?).

M. Mathieu prefers to the usual hæmostatic remedies, hot enemas associated with chloride of calcium.

The cold baths and the milk are suppressed for two or three days and this latter replaced by a certain quantity of water. Morning and evening an enema of boiled water at 118°. To each enema is added one drachm of chloride of zinc, while half a drachm is given in a mixture by the mouth. The quantity of water used for the enema should be at least a quart, and administered very slowly (about a quarter of an hour) by means of an ordinary douche, while a quarter of a grain of opium is given every two hours for four doses.

For hæmatemesis the treatment is much the same, but here it is advisable to have recourse to injections of serum and nutritive enemas to keep up the condition of the patient. The hot enemas are specially useful in removing the clots of blood from the intestine, which otherwise would putrefy and become a source of intoxication and consequent fever.

Sciatica.

A new sign of sciatica has been observed by M. Moutard-Martin—in the case of sciatica of the right leg, for instance. The patient is placed in the dorsal position, low and without a pillow. The left leg is seized and bent gently but progressively on the pelvis, and at a certain moment a sharp pain is felt by the patient in the gluteal region on the right side. To this curious phenomenon he gives the term "counter-lateral," and has observed it in several cases, and would seem to be pathognomic and consequently useful in doubtful cases. Naturally, in order to have the full benefit of the experiments the case should be one of unilateral sciatica.

The Smoking Habit.

Everyone knows how hard it is for a smoker to break off the habit; it is just as difficult for many as to give up the morphia habit. A Russian military surgeon has discovered a very easy, if not very agreeable, means of realising the desire. It consists simply in rinsing out the mouth with a weak solution of nitrate of silver (nitrate of silver 5 grs., water 3 ozs.) After this little operation tobacco smoke produces a most repugnant sensation which effectually destroys all desire for a long time.

Treatment of Appendicitis.

Prof. Robin exposes in succinct language his mode of treating an ordinary case of appendicitis, and which differs in several points from the classical treatment recommended and followed by the majority of practitioners. The patient is in bed, with the ice-bag over the painful region, and all food, even milk, suppressed. only small quantities of water allowed. He begins treatment by a purgative, castor oil or calomel of which two grains are given every hour for four hours. The ice is not applied until the purgative has taken effect, as otherwise it would retard its action. When the patient has been well purged, he examines the condition of the stomach. If it presents signs of hypersthenia he orders an absorbent powder:—

Calcined magnesia, gr. 30.
Bicarb. of soda, grs. 15.
White sugar, grs. 15.
Codeine, gr. 1-10.
Prepared chalk, gr. 12.
S.N. of bismuth, gr. 12.

Each time that the patient any kind of gastric malaise, he is given one of these powders.

Twelve hours after the purgative, he irrigates the intestine with a quart of boiled water cooled down to 100° to which is added two or three tablespoonfuls of olive oil. Before applying the ice, he anoints the flank with—

Strong mercurial ointment, oz. 1.
Belladona extract, dr. 2.

If the patient suffers, he relieves it with

Codeine, gr. ½.
Gentian Extract, grs. 2.

For one pill. Two or three daily.

The patient remains in bed and on the water diet with the ice-bag on the abdomen as long as he feels lancinating pain or tenderness to pressure over the appendix.

When all sensibility has disappeared the patient may begin to take nourishment—milk at first for a fortnight, then farinaceous substances, and finally vegetables, but for months or for years the smallest quantity possible of animal food should be taken.

The consecutive treatment of appendicitis consists in regularising the intestinal function and so avoiding a relapse.

To insure the evacuation of the intestine, Prof. Robin strongly recommends the following:—

Bircarb. of soda, dr. 2.
Sulphate of soda, dr. 1.
Phosphate of soda, dr. 1.
Water, qt. 1.

Of this solution, three ounces are taken (warm) on awakening, four ounces at 11, at 5, and at 9 o'clock in the evening, while large enemas are administered every three days at first and finally once a week, and each time, day or night, the patient experiences more or less gastric disturbance he takes one of the above absorbent powders.

In summer a cure at Châteu Guyon or Plombieres will be found beneficial.

Such is the treatment advised and followed by Prof. Robin, who is no mean authority. It differs from the received treatment in the administration of an effective purgative, large enemas and the suppression of opium.

It is only right to say that in his description of treatment of appendicitis he eliminates infectious appendicitis consecutive to grippe, scarlatina, typhoid fever, traumatic appendicitis, and that due to the presence of foreign bodies in the appendix. All these belong more or less to the domain of surgery.

GERMANY.

Berlin, March 3rd, 1907.

Subcutaneous Injuries of the Pancreas and their Treatment.(a)

This subject was brought forward by Hr. Karewski at the Medicinische Gesellschaft. He recommended the earliest possible surgical interference in all cases of contusions of the abdomen. In such injuries crushing of the liver, spleen and pancreas not unfrequently took place. These contusions sometimes only caused slight symptoms during the first few hours, and if we waited to perform laparatomy until the symptoms were well marked, it would then be frequently too late, as such grave changes would have set in as could lead only to fatal termination.

Injuries to the pancreas, owing to the protected situation of the organ were rare. Garré had only met with thirty such cases recorded, and in only eight was the pancreas the only organ injured. Only three recovered.

The young patient shown had been run over after being knocked down by the shaft of the vehicle, which struck him over the abdomen. He was able to walk home, but abdominal pain soon coming on, he was admitted into the speaker's clinic. Laparotomy was performed at once. The abdomen contained a large quantity of blood, especially in the region of the gastrocolic ligament. By careful exploration the head of the pancreas was found to be crushed. Complete recovery took place. Here, as in all the cases known, the injury to the pancreas was first discovered at the operation. There was no special reason to suspect any injury to the pancreas, as such injuries gave rise to no pathognomonic symptoms, except hæmorrhage into the bursa omentalis with palpable tumour formation. In regard to the point of time at which severe symptoms first appeared, there was no agreement. One should not, therefore, procrastinate when symptoms were undecided, but should do laparotomy at once. Cases which had outpouring of blood and pancreatic juice, but in which the peritoneum was not torn, were the exception. Here a retro-peritoneal hæmatoma was formed, and one could wait. When rupture of the peritoneum did take place, a tumour formed sometimes from retention of the blood in the bursa omentalis; one might also wait in such a case. In deeper tears of the peritoneum, where the blood and juice flowed into the peritoneal cavity, there was danger of general peritonitis. The case led to some interesting physiological results. The patient passed 400 grm. of pure pancreatic juice daily through the fistula and lost a good deal of weight. The secretion being so free, it was difficult to close the fistula. On a fatty anti-diabetic diet as suggested by Wohlgemuth the pancreatic secretion diminished. The diminution was very considerable, and in a comparatively short time, under the application of very strong bactericide remedies to the wound (vioform and airol), the fistula was brought to close up.

Hr. Grouzdew reports in the *Col. f. Gynækol,* 46, 1906, a case of

Retention of a Foreign Body in the Abdomen.

The patient had been operated on for ovarian cyst seven years before. The case ran a normal course. After a year, however, the patient began to have abdominal pains; these increased until she had to seek relief. The pain was mostly by the side of the cervix, where about 2 cm. from it the tip of an iron instrument was felt to be very firmly fixed. The other end of the instrument could be felt in Douglas' pouch. Posterior colpotomy was performed and the foreign body extracted. It proved to be a pair of Ferrier forceps 22 cm. in length. Only the top of the instrument was free. The other part was covered by a firmly adherent membrane, consisting of sclerosed connective tissue.

The operator always after laparotomy washed out an abdominal cavity with artificial serum. In doing this every part of the abdominal cavity was looked after. But such unfortunate accidents were very difficult to avoid. It was curious that the foreign body had never caused any rise of temperature during the whole seven years the patient carried it.

Principles for the Assistance of the School Teacher in the Campaign against Communicable Diseases.

"Grundzüge für die Mitwiskung des Lehrers bei der Beteampfung Ubertragbarer Krankheiten." This is the title of a little work written for the purpose of giving instruction to teachers, and especially those of the elementary schools, in the essentials of the infectious diseases, the manner in which they spread through schools, and the measures that should be taken to arrest the spread of infection. The idea is a good and useful one. One part of the brochure gives a short, clear and intelligible description of the symptoms of the various infectious diseases. The book is published by Julius Springu, Berlin, and costs 1.50 marks.

The Antiseptic Action of Mentsrual Blood.

Professor O. Von Peterson, of St. Petersburg, has an article on this subject, to which a reference is made in the *Deutsch Med. Zeitung,* February 7th, 1907.

Several patients were admitted into the hospital under Professor Peterson's care with numerous soft sores on the introitus vaginæ. A few days afterwards menstruation came on. During the period of the menstrual discharge no dressings were applied to the sores, but they were left entirely to themselves. On the cessation of the period, when the sores were again inspected, instead of the ulcers being worse, as was expected, they were found to be perfectly clean, with well granulating surfaces.

(a) This case was reported on by Hr. Wohlgemuth at the Verein f. Innen Medizin (see Medical Press and Circular).

Systematic observations were now instituted as to the effect of menstrual blood on soft chancres, and the same fact was constantly observed. All the sores that were washed with menstrual blood cleaned up, whilst others near them, but not washed, underwent no change. It is claimed, therefore, by the writer, that menstrual blood has, without question, a distinct antiseptic action.

The action is a specific one; the solvent action of the blood serum takes the bacteria and destroys them as well as the detritus of the surfaces of the wounds.

AUSTRIA.

Vienna, Mar. 3rd. 1907.

Rontgen Rays in Basedowi.

Rudinger has been experimenting with the Rontgen Rays in Morbus Basedowi and agrees with Stegmann that the rays applied to the thyroid gland has a marked effect on its reduction. It should not be constant but alternating as the negative rays are characteristic in the metamorphosis and produce the best results.

Glycosuria.

Brug affirms that the pancreas is not the only gland that produces the saccharine metamorphosis. His experiments accord with Kulz, Falkenberg, and Hirsch, all of whom found by removing the thyroid glycosuria of a severe type was induced often leading to speedy death, which could be arrested or improved by the use of the thyroid tablets. Boldt relates the history of a case occurring in his practice where he had been using pot. iodide for the reduction of a gland which succeeded, but to his surprise the gland no sooner disappeared than glycosuria of a very bad form set in. From this he infers a close connection between the glandular system and glycosuria.

Tetany.

Escherisch gave the clinical history of a case of tetany which has died in one of the spasms since he showed it some time ago to the Gesellschaft der Aertze. It died, he said, from expiratory apnœa, notwithstanding the application of all therapeutic efforts known to the profession. Preparations from the organs of the throat were carefully examined, and the epithelial bodies in the thyroid gland were shown to be quite altered and bleeding profusely. This is the third case within a very short period in which he has been able to prove that hæmorrhage of the epithelial bodies exists in cases of severe tetany.

Hochsinger asked if no hæmorrhage was to be found in other organs of the body, to which he replied that hæmorrhage in the epithelial bodies was usually accompanied with bleeding in the thymus, epicardia and pleura, besides a quantity of pigment being found in other parts.

A Large Boy, but Imbecile.

Knœpfelmacher showed a six-year-old child with the whole body well proportioned and having an excessive growth. His length was 146 cms. or 4 ft. 8 ins., his upper extremities 57 cms., lower 67 cms., the hand 15 cms. and the foot 16 cms. The whole skeleton is strong and well developed; the muscles are equally strong and robust, but the most noticeable point was the extraordinary development of the genital organs which appeared far beyond puberty. He thought there was some connection between this overgrowth and the mental imbecility that existed. Zappert recorded the history of another case from Hudovernig having a similar appearance which he treated with ovarian tablets with a wonderful result. The mind improved, the whole functions of the body became more active and the overgrowth rapidly checked.

Funnel-Shaped Thorax.

Preletner showed a child with a hollow deformity in the anterior wall of the thorax where the sternum was so depressed that a funnel-shaped cavity was formed in the region of the manubrium. It was 3 cms. deep and commenced with a sharp curve at the costal cartilages. The deepest part of the funnel was at the xiphoid process. According to Zucker Randl this deformity is produced in the fœtus by the chin being compressed in utero firmly against the sternum. Hageman on the other hand attributes this to the pressure of the heel on the part in a narrow uterus, while Ebstein thinks the deformity is hereditary, due to a suppression of growth. Heuter considers the rhachitis sufficiently accounts for the organic changes. No hypertrophy was present in the right ventricle.

HUNGARY.

Budapest, March 3rd, 1907.

At the recent meeting of the Budapest Royal Society of Physicians and Surgeons, Dr. Hasenfeld read a paper on the

Etiology of Aneurisms of the Aorta.

He said that aortic aneurisms caused by trauma in perfectly healthy individuals are very rare, but certainly do occur. He believes that small tears are replaced by cicatricial tissue which cannot withstand the continuous pressure. The injury is generally very severe, and directed against the thorax. Infectious diseases as a cause are of more importance in the smaller vessels than in the aorta, but it is possible for an infectious thrombus to lead to ulceration with weakening of the walls or for an acute aortitis to be followed by predisposing chronic changes. Alcohol, nicotine, lead and senile atheroma all play a subsidiary role as compared with syphilis. The pathological study of almost all aneurisms will show lesions characteristic for lues, and ruptures of the elastic membrane, as have been described by others, are hardly ever seen.

Dr. Vas spoke on the

Titration of the Gastric Juice.

Volhard was first, who observed that if some albumin is added to gastric juice, phenolphthalein will eventually give much higher values than at first, and the change of colour will take place considerably later than with litmus. Dr. Vas explains this with the fact that peptone binds alkali just as readily as it does acid, and that phenolphthalein indicates only the presence of free alkali. It is therefore much more accurate to determine the total acidity with alizarine or with red and blue litmus paper. The author further said that Töpfer's method is based on wrong principles, but gives fairly accurate results; the alizarine does not indicate the free hydrochloric acid, but the total acidity, and by subtracting the phenolphthalein figures from those obtained which is about the same as the combined acid.

Dr. Preisich discussed the question of

Acid Creamless Milk in Gastro-enteritis.

Since 1898 the most strenuous efforts by intestinal lavage, water diet, baths, astringents, etc., have been made by Dr. Preisich to overcome the gastro-enteritis of infants. But in spite of the most devoted care the mortality up to last May was in the neighbourhood of 50 per cent. At that time the treatment was changed to milk deprived of cream by centrifuging and acidified by pure cultures of the lactic ferment. From 30 to 60 cc. of this were given at each feeding. The cases treated were those of grave prognosis characterised by very profuse diarrhœa, rapid emaciation, bad general condition and high fever. In a remarkably short time the temperature subsided, vomiting ceased, the diarrhœa diminished, the stools becoming normal in forty-eight hours in some cases, and the weight was most noteworthy; other children treated at the same time by the older methods showed a rapid wasting. Out of fourteen almost hopeless cases, thirteen recovered. The milk was prepared at the local Pasteur Institute.

Dr. Behrend reports a case in which an infant was affected with a primary pyelitis. ("Orvosok Lapja Physician's Paper.") This affection may be readily overlooked, as the urine of babies is rarely examined.

Dr. Behrend's case had such a clinical picture that closely resembled typhoid. The symptoms consisted of a gradually increasing fever, which continually returned, even after the administration of antipyretics. This could not be accounted for by anything found on repeated physical examinations until the urine was carefully examined. This was found cloudy and full of bacilli and pus corpuscles. The treatment consisted of various antipyretic measures and bromide of sodium to guard against eclamptic seizures. Urinary antisepsis was secured by urotropin and turpentine. A cure resulted in from three to four weeks. The author, Dr. Behrend, advises that in every case of continued fever in a baby, where all other sources can be eliminated, including typhoid, the urine be carefully examined microscopically. Secondary pyelitis is common enough, but a primary form is rather rare, and should always be borne in mind in doubtful cases.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Edinburgh Royal Asylum.—Annual Report.—In his report for 1906 Dr. Clouston states that 1259 patients have been under treatment during the year. There were 385 admissions (169 men and 119 women), and 140 deaths (55 men and 85 women). Only 35 of the patients admitted were in really good bodily health. The number of cases of general paralysis was 55, or 9 less than last year. Dr. Ford Robertson and Dr. McRae, working in the Scottish Asylums Laboratory, had made distinct progress towards a true knowledge of the nature of this most fatal disease, and they hoped of its treatment with a view to cure. The patients they had had under treatment had, where the disease was in an early stage, shown a wonderful improvement; but the first thing to be done was to be able to diagnose it definitely in its earliest stages, so that treatment might be applied before the brain was seriously damaged. Had they a sure means of recognising the malady at its earliest stage, there seemed good scientific reason now for the conclusion that under specific treatment it might be arrested. Alcohol was, as usual, the commonest of all the outward causes of insanity. It was given as a cause in 29.5 per cent. of the male admissions, and 16.2 of the women. Taking that definite form of insanity called "alcoholic insanity," the percentage was 18 among the men, and 10.8 among the women admitted. The fact that of the total admissions to the institution during the 42 years 1864–1905, the majority of the patients were women was somewhat remarkable. He also commented on the low recovery rate—88 patients, and the rather high mortality. This resulted from the numbers of senile, paralysed and broken-down patients admitted. Heading the causes of death stood tubercle, chiefly among the rate-paid patients. Cray House still enjoys the credit of having had no deaths from tuberculosis since it was opened twelve years ago. The year 1907 marks the centenary of the asylum, its Charter having been granted in 1807. The poet Ferguson, the precursor and inspirer of Burns, went mad and died amid squalid surroundings in the old city Bedlam in 1774. This sad spectacle aroused the sympathy of Dr. Andrew Duncan, senr., Edinburgh's great medical philanthropist. He wrote a "proposal for establishing a lunatic aslyum in the neighbourhood of the City of Edinburgh" in 1792, and as a result, a body of trustees collected subscriptions and obtained a charter in 1807. The building was opened for patients in 1813. In no department of human effort to benefit humanity did a spirit of hopeless pessimism do more harm than in the treatment of the insane, and in no department was optimism more helpful. Commenting on the problem of the prevention of insanity, Dr. Clouston said technical insanity was the acme and caricature of the foolishness and weakness of mind which more or less pertained to all men, but it was not true that "all men are mad." That was a loose, if tempting, aphorism which gave a wrong impression of what man is, and of what madness is.

Cerebro-Spinal Meningitis.—In Edinburgh the disease shows no signs of abating. There have now been between 20 and 30 cases, nearly all of which have terminated fatally. A ward has been set apart in the city hospital for the reception of the disease, and the Town Council have issued a circular making the Infectious Diseases (Notification) Act applicable to cerebro-spinal meningitis for a period of six months. The majority of the patients, so far, have been children, and a number of them have been treated in the Sick Children's Hospital. The directors, however, have decided that in future cases are to be sent to the Fever hospital, as soon as the bacteriological diagnosis is made. It may not be amiss to point out that in many of the cases, even when acute, the symptoms of meningitis have been comparatively slight—a little stiffness of the neck, or pain on moving the head—and to a great extent masked by the constitutional disturbance. The bacteriological diagnosis of the disease, however, is extremely readily made. Lumbar puncture is a most simple and harmless procedure and should be employed in any doubtful case. If the fluid is turbid this is practically sufficient for a diagonsis, and where a smear is made and stained in the usual way with Leichmann's stain or otherwise, the meningococci can be recognsied without any difficulty. The disease really differs very widely in its clinical manifestations from tuberculous meningitis; so much is this the case that as we understand that during the present epidemic in Glasgow only two cases of tuberculous meningitis, have been sent into the Fever Hospital as cases of the epidemic cerebrospinal form. Practical experience therefore, shows that mistakes are not so frequent as might have been anticipated.

The Multiplication of Health Congresses.—If the banding together of health experts be a sign of the development of what Dr. Clouston has happily termed "a health conscience," the author of the phrase should be gratified that his object will soon be attained, for no one can have failed to note that "Health Congresses of all kinds, like mushrooms, spring up almost without warning, and afford, *inter alia*, many opportunities for civic delegates going on an agreeable jaunt, in which pleasure and business are skilfully compounded, at the expense of the long-suffering ratepayer. We are glad, therefore, to note that another conference of delegates from various Scottish corporations, *absit omen*, was held in Edinburgh last week, with a different object. It considered whether steps could not be taken to reduce the number of sanitary and other conferences which take place annually in different parts of the country. It was unanimously resolved "That in the opinion of this Conference it is very uudesirable that the Royal Sanitary Institute and the Royal Institute of Public Health should hold separate congresses every year," and "that a representation be sent to the Royal Sanitary Institute and the Royal Institute of Public Health urging these bodies to make an arrangement for holding a combined Congress, or holding their respective congresses in separate years.

Dr. J. M. Beattie, senior assistant to the Professor of Pathology in the University of Edinburgh, and Lecturer on Bacteriology, has just been appointed to the new Professorship of Pathology in the University of Sheffield. Dr. Beattie has already won his spurs as an investigator and a teacher and his appointment has been very popular. Much as his many friends will miss him from Edinburgh, they none the less join in congratulating him on his well-deserved promotion, and wishing him and his new university all success and prosperity.

BELFAST.

Cerebro-spinal Meningitis.—The outbreak of cerebro-spinal meningitis in Belfast shows no signs of having spent its force as yet. During the past week there were over thirty new cases reported, and twenty deaths. Several of the cases reported were of fulminating type, proving fatal before the patient could be removed to hospital. Every effort is being made by the authorities to check the progress of the disease, and the City Coroner holds inquests on those cases which have died without medical attendance, emphasising in his remarks to the jury in every case the absolute necessity of proper care for the sick. The total number of cases up to date is about 130, with 75 deaths. In Dublin we believe that two fresh cases have occurred during the past week, making a total of 12 cases with nine deaths.

Public Health.—"Coming events cast their shadows before," says the poet, and the truth of his statement can be abundantly verified in Belfast just now, where preparations are going on in many different quarters for the approaching Commission of Inquiry into the health of the city. The Corporation had a long and acrimonious debate on the subject and have arranged to employ two members of the bar to defend them, as they say they will be on their trial, which is perfectly true. The Citizens' Association and the Christian Civic Union are both considering the question of evidence before the Commission, and Dr. Calwell, ex-President of the Ulster Medical Society, has just issued in pamphlet form, with preface and notes, extracts from communications which he has made to medical journals and societies during several years past, all bearing on the public health question. The pamphlet will prove a most useful source of information to all interested in the subject.

Belfast Maternity Hospital.—The 113th annual meeting of this old charity was held last week, the Countess of Shaftesbury presiding. The medical report, read by Dr. Osborne, showed that 373 patients had been treated in hospital during the year—317 children were born, 160 males and 157 females. There were 21 still-born, and only one maternal death, that being a case of placenta prævia, admitted when almost moribund. In the extern department 310 women were attended in their own homes. The treasurer's report showed that while the ordinary income was £300 less than their expenditure, they had managed, with the help of a bazaar, to reduce the balance against them to £20.

Society for Providing Nurses for the Sick Poor.—The annual meeting of this Society was held last week, the Lord Mayor (the Earl of Shaftesbury K.C.V.O.) presiding. The report showed that during the year the nurses had attended 1,123 cases and had paid 33,932 visits. Dr. R. W. Leslie voiced the feeling of the medical men of the city in testifying to the very high opinion he had formed of the work done by the nurses, and several clergymen expressed the same opinion.

LETTERS TO THE EDITOR.

THE QUACK MEDICINE TRADE.

To the Editor of the Medical Press and Circular.

Sir,—The editor of one of the medical papers in his issue of this week asks "how long the Legislature will consider it consistent with the public health and well-being to allow the owners of 'patent medicines' to foist their wares upon the community?" The answer to this question is that the present state of things will continue until the medical profession takes steps to promote a change. Statesmen and politicians who compose the Legislature, as well as the whole of the educated public, are ignorant of the nature and extent of existing evils, and owing to the capture of the newspaper press by quacks, cannot gain enlightenment through any existing medium. The facts can be brought home to the public only through the medium of a Royal Commission. No one who examines the question fully can fail to recognise that the case for medical law reform will need demonstrating before it will stand a chance of being taken up by Parliament. The profession alone at present are able to appreciate the facts; they know that new legislation is called for far more for the protection of the public than the advantage of medical practitioners, it is their duty on humanitarian grounds alone to fight for reform. They have always fought for sanitary progress, and the more strenuously always when the prevention of disease was from the sordid point of view opposed to their own interests.—I am, Sir, yours truly,

Henry Sewill.

March 1st, 1907.

JUVENILE SMOKING.

To the Editor of The Medical Press and Circular.

Sir,—May I call the attention of your readers to the fact that the Day Schools Sub-Committee of the London County Council has had under consideration the question of juvenile smoking, and has just reported to their authority. They have dismissed the idea of legislation, the proposal to issue a circular to parents and guardians, and the suggestion of influencing children through teachers in elementary schools. The Committee have satisfied themselves that smoking by children prevails very widely, and have accepted the truth of the allegation that the habit forms a powerful factor in stunting growth and in producing disease. The Committee recommend that the County Council support the existing movement for legislation for the suppression of juvenile smoking, and propose to prepare a suitable leaflet for distribution among parents and school teachers. In the present state of the legislative machine, it seems a little doubtful whether the suggested new law lies within the sphere of practical politics; but a vigorous propaganda among parents and guardians, and among boys themselves, might produce results worth working for. Many sensible boys who err entirely through ignorance would refrain from smoking if once enlightened as to the hurtfulness of the habit. I think, Sir, this question evidently worthy of discussion by the readers of a medical journal.—I remain, yours faithfully,

Nestor.

MEDICAL ETIQUETTE.

To the Editor of The Medical Press and Circular.

Sir,—Can you or any of your readers bring enlightenment to my perplexed mind with regard to the following point of medical etiquette. I have always understood that it is contrary to such etiquette to send the reports of ordinary scientific meetings of medical societies or to send medical books for review to the lay press, or to advertise medical books in the lay press, and yet within the past few weeks glaring examples of these three proceedings have occurred, without provoking medical comment.

In a Dublin daily paper, the *Freeman's Journal*, some three weeks ago there appeared a fairly full report of the meeting of a medical society belonging to one of the Dublin medical schools. The report not only gave the substance of what each speaker had said, but announced the agenda for the next meeting. Indeed it was so full as to suggest that it had been contributed to the paper in question by one of the officials of the society. I may further mention that the meeting in question was an ordinary one, and not any special meeting which possibly might have been of interest or value to the general public.

In another Dublin paper, the *Irish Times*, a few days afterwards, I noticed a review of a large Atlas of Anatomy, edited by a well-known anatomist, and published by a highly respectable firm of publishers.

Finally, in a London weekly journal, the *Spectator*, I find the advertisement of a work on ophthalmology by one who, I believe, is an ophthalmologist of high standing in his profession.

These three cases have led me to wonder whether the opinion I had previously held of the inadmissibility of such practices is a correct one. Correct or incorrect, it is shared by a number of medical writers, who lose popular fame and notoriety by refusing to permit their books to be advertised and reviewed in lay journals, and by a number of medical societies who lose similar fame and notoriety by not sending a record of their doings to lay journals. If my opinion is incorrect, why should they lose this notoriety? If, on the other hand, my opinion is correct, then, Sir, I suggest that some authority, either the medical press, the Royal Colleges, or the General Medical Council, should convey a stern reproof to these gentlemen who presumably act, or whose publishers act for them, in a manner contrary to medical ethics, and to such societies as act in a similar manner.—I am, yours, &c.,

X.

THE ORGANISATION OF POOR LAW MEDICAL RELIEF (OUTDOOR).

To the Editor of the Medical Press and Circular.

Sir,—In a few days there will be an election of guardians. May I impress upon your readers the importance of securing the nomination and election of candidates who are in favour of out-door relief of Deserving Aged Poor where practicable, and of making such out-relief adequate.

The Local Government Board itself issued a circular to this effect in August, 1900 (which may be bought for 2½d.), and until old-age pensions can be obtained, this is far better than offering to the veterans of industry a painful choice between the workhouse and starvation or at least great destitution. Also, it is most important to elect guardians who will give outdoor medical relief (in the first instance) to all poor persons unable to pay a doctor, without placing obstacles in the way such as making the relief a loan, or requiring the patient (or in the case of a child, a parent) to appear before the Guardians. Of course, when the doctor has seen the patient he can decide whether it is a case to be treated at home, or in the Poor Law or some other infirmary or hospital. The great point (for the public health) is to take care that cases of illness come before the doctor at a very early stage. By this means we may check infectious diseases such as measles, whooping cough, fevers of various descriptions and phthisis. Cutting down medical relief is dangerous to the public health.

Yours faithfully,
J. Theodore Dodd,
A Guardian and Councillor of the
City of Oxford.

March 2nd, 1907.

OBITUARY.

ERNEST EDWARD KING, M.R.C.S., L.S.A.,

On Monday morning the death occurred at Broad Street, Ludlow, of Mr. Ernest Edward King, after a short illness. Deceased was registered on December 18th, 1879, and was Licentiate of the Society of Apothecaries, London, 1879, and member of the Royal College of Surgeons (England), 1881. He came to Ludlow over twenty-four years ago as assistant to the late Mr. Henry Hodges, surgeon, Broad Street, and after a few years he commenced to practise on his own account, and soon built up a large connection. He was of a kindly and genial disposition, and during his residence at Ludlow he made many friends. He was thoughtful and kind to the poor, and during the late severe weather he opened a private soup kitchen at his own house, where he had from 50 to 60 of the poor children and fed them. He was a Churchman and a strong Conservative. He was a fluent speaker and during the last General Election he rendered yeoman service in the cause of Mr. Rowland Hunt, M.P. He was chairman of the Broad Street Ward Conservative Committee. About a fortnight ago he was out on his rounds when he had a sudden seizure of the heart. He was brought home, and the best medical advice was obtained, and on Sunday last it was hoped he was improving, but on Monday morning he had another attack which proved fatal. Much sympathy is expressed for his widow and son and daughter. On Thursday morning at 6.45 the remains of deceased were removed by train to Saffron Walden, Essex, for interment. The members of the family, Mrs. King (widow), Mr. Eric and Miss Ena King (son and daughter), Mr. Arthur King and Mr. Herbert King (brothers), and Miss Davenport, left Ludlow on Wednesday evening. The funeral took place on Thursday afternoon, at Saffron Walden. A large number of beautiful wreaths were sent.

THOMAS HATFIELD WALKER, L.R.C.P., L.R.C.S.Ed., F.C.S.

We regret to announce the death of Dr. Thomas Hatfield Walker, Newcastle. Dr. Walker was born at York in 1850, and was educated at the University of Edinburgh. About twenty-five years ago he came to Newcastle, but while taking no prominent part in public affairs he was warmly interested in subjects relating to hygiene and the physical well-being of the people. For many years he acted as public analyst to the city of Carlisle, and was also toxicological chemist for Newcastle. He was an expert in water analysis, and introduced a new method of estimating nitrates in water. He wrote numerous papers in scientific journals on sewage irrigation, disinfectants, and other subjects connected with public health.

SPECIAL ARTICLE

THE HEALTH OF DUBLIN.

The Report of Surgeon-Colonel Edgar Flinn, Medical Inspector of the Local Government Board, on the sanitary condition of Dublin (*a*) which, in spite of its being dated 1906, was only issued to the public a few days ago, is a document of importance. Surgeon-Colonel Flinn has inquired into the subject from many points of view—sanitary, social, and economic—and his conclusions should be of much practical value to an energetic Public Health Department.

The area included in the City of Dublin is 7,894 acres 2 roods 10 perches and the estimated population at present is 293,385 persons. The average density of the population is, therefore, 37.1 persons per acre.

The geological formation is nearly altogether drift, except in the vicinity of the Liffey, where there is a deposit of river gravel.

Surgeon-Colonel Flinn gives a table of the population in 1901, classified according to occupation. More than one-half of the entire population come under the heading of "Indefinite and Non-productive," whereas only about one-fourth is "Industrial."

Two Commissions of Inquiry have in the past considered the health of Dublin. In 1879 a Royal Commission was appointed whose chief concern was with the system of sewerage. In its Report special attention was drawn to the insanitary condition of the tenement houses, and to the presence of slaughter-houses in improper places throughout the city.

In 1900, on the suggestion of Earl Cadogan, then Lord Lieutenant of Ireland, a Committee was appointed by the Local Government Board to report upon the causes of the high death-rate and the measures which might be taken to improve the health of the city. The report of this Committee contained eighteen important recommendations, dealing with such serious matters as the condition of tenement houses and of housing the poor generally, the scavenging of streets and lanes, slaughter-houses, public baths, provision of hospital accommodation for infectious diseases and the reorganisation of the Department of Public Health. Surgeon-Colonel Flinn states that "the Public Health Committee concurred in very many of the recommendations made by the Committee and efforts have been made to carry out some of these recommendations."

(*a*) "Report on the Sanitary Circumstances and Administration of the City of Dublin, with Special Reference to the Causes of the High Death-rate." By Surg.-Col. D. Edgar Flinn, F.R.C.S., D.P.H., Medical Inspector of the Local Government Board for Ireland. Dublin H.M. Stationery Office. 1906.

Of the eighteen recommendations four have been followed, five have been partially carried out, while no steps have been taken with regard to the other nine.

During the period 1895–1905, the average annual death-rate in Dublin has been 27 per 1,000. In Belfast it has been 22.3, in London 17.7, in Liverpool 22, in Manchester 21.6, in Edinburgh 16.7, and in Glasgow 20.7.

The death-rate in Dublin from all causes exceeds by a great deal, therefore, that of the other large towns. During the past five years no less than 6,245 deaths were registered in Dublin from phthisis, and 3,019 deaths were registered from other forms of tuberculous disease. During the same period the average annual death-rate from all causes has been declining throughout the United Kingdom. Dublin has participated in this decline as regards its death-rate from all causes as well as from zymotic diseases. The death-rate from phthisis still remains at a very high standard, and exceeds that of all other cities and towns in the kingdom. During the past ten years it has shown no tendency to decline; if anything the death-rate from this cause has shown an upward tendency, and it yet remains one of the principal causes that is accountable for keeping the Dublin death-rate so high above a normal standard.

The question of a sanatorium is at present engaging the attention of the Public Health Committee. Of its necessity there can be but one opinion, having regard to the large number of deaths that are yearly occurring in Dublin from tuberculous diseases.

Diseases of the organs of respiration (exclusive of phthisis) are accountable for a large number of deaths in the City of Dublin. A large percentage of cases occur amongst the poorer classes—insufficient clothing, exposure, and privation being fruitful causes of these diseases.

In the year 1900, 1,608 deaths were registered from diseases of the respiratory organs; 1,544 deaths occurred in 1901; 1,654 in 1902; 1,436 in 1903; and in 1904, 1,469 deaths were registered from these affections.

The deaths of children under one year of age per 1,000 births in the period 1894–1904, have been 161.4 per annum in the North Dublin Union, and 173.7 in the South Dublin Union. There are many contributory causes of infantile mortality in Dublin, most of which were preventable, but there is one which apparently exceeded all others in potency, viz., the prevailing and widespread ignorance amongst mothers as to the proper feeding of infants, and also to grave alimentary conditions brought about by wrong feeding.

There has been a remarkable decrease in the number of cases of typhoid fever in the past few years. Thus from 1,038 cases in 1900 there has been a steady decline to 437 in 1905 and the deaths have declined in the same period from 99 to 40.

Surgeon-Colonel Flinn speaks highly of the purity of the Dublin water supply. He believes, however, that the disuse of the old pump-wells throughout the city, in use previous to the introduction of the water supply, has rendered the subsoil of Dublin waterlogged. Such a condition may have a serious effect on the health of the city.

The entire sewerage of the city, which hitherto discharged directly into the Liffey, will henceforward be conducted in a main sewer to the Pigeon House. It will there be purified, the clarified effluent being discharged into the open sea, and the sludge carried by barges and deposited in the sea some miles out.

But little improvement has been made in the system of public and domestic scavenging. Dust-bins are not collected daily, watering of the streets is insufficiently performed, and the sweeping of dry streets by the machine brush is both a nuisance and a danger.

Dairy regulations are fairly well carried out, but there is room for considerable improvement. Much milk, however, arrives from the country, from cow-houses which are not under supervision of any sort.

Surgeon-Colonel Flinn makes an elaborate investigation of the social and economic conditions of the poor in Dublin, and of the attempts which have been made to improve them. He states that "the wage earned by the average labourer in Dublin is inadequate to maintain a family in a state of physical efficiency."

He quotes the opinions of the Medical Superintendent Officer of Health, and the District Medical Officers of Health on the subjects of his inquiry, and he details the duties performed by the staff of sanitary sub-officers.

He concludes that it is quite clear that the chief causes which contribute to the high death-rate in Dublin are:—poverty, with its attendant evils; tuberculous disease, intemperance, insanitary conditions under which the poorer classes live, overcrowding, and want of knowledge in the feeding and care of infants.

He recommends various measures for dealing with these evils, including improved water supply to tenement houses, improved housing of the working classes, daily removal of the contents of dust-bins, strenuous measures against tuberculosis, the removal of slaughter-houses from their present sites, and the better control of the meat and milk supplies.

The Report is illustrated by maps showing the geological formation of the neighbourhood of Dublin, and the areas of greatest poverty of the city.

REVIEWS OF BOOKS.

CLOUSTON ON THE HYGIENE OF THE MIND. (a)

Dr. Clouston's "Hygiene of the Mind" is one of the earliest numbers of the New Library of Medicine which Messrs. Methuen and Co. are publishing. This library is avowedly popular in aim, its object being to present medical problems of general interest in such form that thoughtful people without scientific training can grasp them and receive authoritative guidance as to the correct attitude to adopt. To judge this book fairly, then, it must be constantly borne in mind that it is not written for the alienist or even for the medical practitioner, but for the intelligent layman. Now the hygiene of the mind is, as a distinctive science, something of a novelty, and to present a new science in acceptable form to the non-scientific person requires an amount of courage and earnestness which can only spring from strong belief. Dr. Clouston writes with a confident touch which bespeaks not only conviction but a desire to impart that conviction to others, and there is no doubt that there are a great many people, especially such as have the guidance of youth, to whom this book should be instructive, stimulating, and—if we may venture so far—corrective. A great deal that Dr. Clouston says may seem trite enough to the family doctor, but it will be fresh enough to those into whose hands the book should fall, and they will learn roughly what is the prevailing opinion of the bulk of the profession on the topics dealt with. Indeed, Dr. Clouston, if not daringly original, is comfortably free from fads; his advice is always temperate, sane and sound. We greatly admire the ability with which he has evaded expressing any definite views as to the mind itself; no decisive view is called for in a treatise of this kind, and would if expressed tend to create prejudice, for does not everybody know his own mind? Dr. Clouston has skated over very thin ice, and though he inclines now to the materialistic, now to the idealistic, he never plumps for either, and we think he is very wise. So, too, with regard to religion. He combines insistence on using the religious emotion in education with a scientific exposition of the parts of religion which may judiciously be kept in the background; yet he never commit himself. Again we think he is very wise. Throughout the pages there is a good deal of interesting gossip—anecdotes, personal experiences, and apt illustrations—while here and there we light on a good epigram, such as (p. 214): "The safest marriage always consists of a mutual admiration society of two." Is it not rather a pity—in fact, rather more than a pity—in a book designed to help mental culture, to express the pessimistic doctrine (p. 205) that, "The saving grace of common sense is not one, unfortunately, that can be acquired by any amount of care or resolution"? Perhaps it is not, but then what is the use of mental hygiene? We cannot help being surprised that a literary Scot such as Dr. Clouston should express the view that it is doubtful if the author of "The Cotter's Saturday Night" knew that excesses tended to shorten life, and it is questionable whether scientific men can side with the splendidly poetic, but highly fanciful view of Keats' death that Shelley gives us in "Adonais." And while we are on the subject, does not Plutarch more than suggest that Alexander the Great died of typhoid? That, at least, has always been our own view. But this book, take it all round, is a sensible, timely, and instructive one, and the world would be a brighter and happier place if everybody lived up to its teaching.

(a) "The Hygiene of the Mind." By T. S. Clouston, M.D., F.R.S.E., Lecturer on Mental Diseases in the University of Edinburgh, etc. Ten illustrations. London: Methuen and Co. 7s. 6d. net.

HUMAN ANATOMY. (*a*)

It is difficult to speak temperately about Dr Sobotta's "Atlas and Text Book of Human Anatomy." To turn over its pages and to pore over its plates makes us wish to become students again, so that we might have the luxury of learning anatomy under conditions undreamed of when we started removing the fascia from the pectoralis major, and picking out the relations of the axillary artery. To say that we have never seen such accurate, helpful, life-like illustrations in anatomy sounds like using the language of exaggeration; but it is no more than the truth. This book is rightly designed an Atlas and Text-book, because the text is obviously complementary to the plates, which stand out as the commanding feature of a noteworthy volume. But we do not mean that the text is not good in itself; it is not only good, but very clear and accurate, for, though it does not deal with anatomy in its comparative and developmental sides, such as is needed for the higher examinations in this country, it is sufficiently comprehensive to supply the student with all he needs for the ordinary tests. And indeed, to give a complete survey of the anatomical field would have enlarged the book beyond reasonable and practicable limits. No student of the higher anatomy, no surgeon or practitioner, however, will ever regret buying it, for he can not only find all that is wanted in the way of regional anatomy, but he will be able at a glance to see exactly the parts he wants to see in their natural position and relations. The proverbial busy practitioner who has the work in his possession will have frequent occasion to rise up and call the publishers blessed, for having provided a ready-made (and odourless) dissecting-room at his elbow. The only drawback—and that is a slight one—is that the terminology occasionally differs from that current in anatomical schools in this country, but the editor claims that as these terms are the terms of the future it is worth while acquiring them. As to the plates themselves, they are all produced from actual photographs, so that the stereoscopic effect is given, and they have been artistically and discriminatingly coloured, so that each structure is allowed its full value. As a plate of the actual size to be used in the book was employed in the preparation of the photographs, the relative parts of structures are each precisely proportioned. We can only say that we can conceive of no more perfect illustrations being produced by any of the arts at present in use. Perhaps in fifty years fresh resources may enable the student to learn anatomy without the trouble of thinking, but in the meantime we can recommend this atlas as a bargain he will never regret.

MEDICAL NEWS IN BRIEF.

Lichfield Medical Man and his Fee.

At Lichfield, on February 27th, Dr. Rowland made an application to the city justices, under Section 285 of the Lunacy Act, 1890, for an order to be made on the Lichfield Guardians for a fee of one guinea for examining into the mental state of a woman on November 13th. Dr. Rowland is medical officer of the workhouse, and Mr. D. Harrison, who is a member of the Guardians, was the magistrate who saw the case with him. He claimed a fee of one guinea, but Mr. Harrison only allowed half a guinea as there was another case at the same time. The doctor wrote to the Guardians, asking for an order to be made, but they said they could not interfere, considering it to be purely a matter between Mr. Harrison as the magistrate and the doctor as a private practitioner. Dr. Rowland said Mr. Harrison knew the views of himself and other medical gentlemen in Lichfield and recognised that the fee for examining a patient, whether sent to the asylum or not, was a guinea. Mr. Harrison accepted his services as a private practitioner, and should pay the fee. Mr. Harrison said the Act stated that a justice should use his own discretion and allow what he thought was a reasonable fee. Mr. Keyte, relieving officer, really called in the doctor. He did not consider the patient was insane, but that it was merely a case of temper.—The Court took no action, Mr. Harrison promising to pay under protest if his views were clearly stated in black and white.

Remarkable Action.

An action presenting somewhat singular features was tried at the Manchester Assizes during last week. The plaintiff claimed damages, under Lord Campbell's Act, for the death of her daughter, which had been caused, as she alleged, by the negligence of the defendant, a dentist. The mother took the child, aged 9, to the defendant on August 30th. Three teeth were taken out at the time, but only one was found. The child at once complained of pain, began to cough, and speedily developed septic pneumonia, from which she died on September 23rd. For some unexplained reason no post-mortem was made, and although it must be presumed an inquest was held, no mention was made of one at the trial. The medical evidence supported the theory that one of the teeth had slipped into the windpipe and passed into the lung. It was stated that the condition of the child's throat made it certain a tooth had passed down; but the reported evidence is too general and vague to be of value. In the end the jury stopped the case on the ground that no negligence had been proved, and judgment for the defendant was recorded.

Illegal Operations.—Treasury Prosecution.

At Marlborough Street, Caleb Charles Whitefoord, 63, a disregistered medical practitioner, living in Upper Marylebone Street, W., surrendered to his bail on February 8th to answer the remanded charge of having performed illegal operations on women whose names, with one exception, were suppressed. Mr. Muir, instructed by Mr. William Lewis, prosecuted on behalf of the Treasury; and Mr. Forrest Fulton appeared for the defence. Several women spoke to having paid visits to Whitefoord, and described what happened. One of them, thickly veiled and apparently very ill, swooned in the witness-box and had to be carried out of court. Mr. Muir, having been informed that she suffered from epilepsy, said he would dispense with her evidence altogether. Mr. Denman, after evidence had been given at great length, again remanded the prisoner on the same bail as before—one surety in the sum of £500.

Is Paregoric a Poison?

A curious case was heard at Bridlington County Court last week, before Judge Dodd, when the wife of Mr. J. W. Wilcock, registered chemist, was sued by the British Pharmaceutical Society for having sold

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(*a*) "Atlas and Text-Book of Human Anatomy." By Dr. Johannes Sobotta, Professor of Anatomy in the University of Würzburg. Edited, with additions, by J. Playfair Mc urrich, A.M., Ph.D., Professor of Anatomy in the University of Michigan. Vol. I. Bones, Ligaments, Joints, and Muscles. 320 illustrations, mostly in colours. Philadelphia and London: W. B. Saunders and Co. 1906. 25s. net per volume.

poison to P.C. Bell, inspector under the Food and Drugs Acts, the penalty against an unqualified person being £5.

Mr. Laverack, for the plaintiffs, said the preparation sold was paregoric, which contained opium, and was scheduled under the Act. Mr. Baynes, public analyst, confirmed the statement.

Mr. Wilcock argued that paregoric was not a preparation of opium inasmuch as it did not contain a poisonous quantity of the drug.

His Honour held that the plaintiffs had proved that paregoric was a poison, inasmuch as it contained enough opium, beyond a doubt, to poison some children, and that it was included in the schedule of the British Pharmacopœia. The case was a very important one, and he would place every facility in Mr. Wilcock's way if he desired to appeal.

The Viewing of Dead Bodies.

Mr. Luke White, Liberal M.P. for the Buckrose Division of Yorkshire, has given notice that he will introduce in the House of Commons a Bill to dispense with compulsory viewing of bodies on the holding of coroners' inquests.

Dr. Hebert freshly charged.

The Guérin-Hébert case will now probably enter upon a new phase Dr. Hébert, who was to have been liberated yesterday evening, was kept in custody in consequence of a new charge, namely, that of having furnished Germany with certain papers and photographs of places on the French coast.

Irish Poor Law Reform.

The Royal Academy of Medicine in Ireland has passed a resolution expressing its approval of the suggestion in the report of the Lord Lieutenant's Poor Law Commission, that the entire Poor Law medical service in Ireland should be converted into a national service to be paid by the State, the service to be entered by a competitive examination and the members to be jointly controlled by the central body and the local bodies, the medical profession having representation on the central body.

Medical Sickness and Accident Society.

At the usual monthly meeting, held on 22nd ult., there were present: Dr. de Havilland-Hall, in the chair, Dr. M. Greenwood, Mr. W. Thomas, Dr. W. K. Sibley, Dr. J. Brindley James, Dr. J. W. Hunt, Dr. F. S. Palmer, Mr. F. S. Edwards, Mr. J. F. Colyer, Dr. St. Clair Shadwell, Mr. F. Wallace and Dr. J. B. Ball. The recent epidemic of influenza has largely increased the Sick Pay disbursements during the early part of the year, and in January amounted to the largest sum ever paid away in any month of the Society's working. The claims, though numerous, have been of short duration, and their total will make no appreciable diminution of the Society's reserves, which now amount to over £200,000. The number of members drawing half-pay, many of whom will probably never be able to resume work, is still growing.

London Inter-Collegiate Scholarships Board.—Entrance Scholarships and Exhibitions, 1907.—University College, King's College, and the East London College.

A combined examination for Entrance Scholarships and Exhibitions tenable at University College, King's College, and the East London College will be held in London by the London Inter-Collegiate Scholarships Board on Tuesday, 14th May, 1907, and following days. The competition is limited to those who have not previously been students at any one of the colleges, *except where the contrary is stated.* No competitor can be elected to more than one scholarship or exhibition. No candidates will be admitted to the examination for these scholarships and exhibitions unless they have passed the Matriculation Examination of the London University or any examination accepted by the University in lieu thereof, or are the holders of a School Leaving Certificate, or are able to furnish some evidence of having had a sound general education which is satisfactory to the Board. Application should be made to the Secretary of the London Inter-Collegiate Scholarships Board, University College, Gower-street, London, W.C., for forms of entry, which must be filled in and returned together with a certificate of age and one of good conduct from the principal of the candidate's last school or other satisfactory reference not later than 1st May, 1907.

The total value of the scholarships amount to over £1,500.

Prize for Industrial Hygiene.

The Council of the Society of Arts are prepared to award, under the terms of the Benjamin Shaw Trust, a gold medal or a prize of £20. The medal, under the conditions laid down by the testator, is to be given "for any discovery, invention or newly devised method of obviating or materially diminishing any risk to life, limb, or health incidental to any industrial occupation, and not previously capable of being so obviated or diminished by any known and practically available means." Intending competitors should send in descriptions of their inventions not later than December 31st next, to the Secretary of the Society of Arts, London.

PASS LISTS.

Royal College of Physicians and Royal College of Surgeons, Ireland.

The following candidates have gained the Diploma in Public Health:—Major E. G. Browne, L.R.C.P., F.S.I., R.A.M.C., John G. Devane, M.B.R.U.I., Capt. A. Leventon, F.R.C.S.I., I.M.S., with honours, T. Nicol, M.B.Edin., with honours, M. J. Russell, F.R.C.S.I., Major G. W. Tate, M.B.Dub. Univ., R.A.M.C., A. A. Woods, L.R.C.P.&S.I.

Royal College of Surgeons in Ireland.

The following candidates having passed the necessary examination have been admitted Fellows of the College:—John Armstrong, B.Ch., &c., Roy. Univ., Ire.; S. C. Clarke, L.R.C.S.I., &c.; Raghunath Vithal Khedkar, L.R.C.S., &c., Edin.; G.W. Little, L.R.C.S.I., &c.; A. A. W. Merrick, L.R.C.S.I., &c.,; and F. J. Palmer, L.R.C.S.I., &c., Captain R.A.M.C.

Irish Medical Schools and Graduates' Association.

The thirtieth annual general meeting of the Association will be held at the Hotel Cecil, London, on Saturday, March 16th, 1907, at 6.30 p.m., when it is particularly requested members will make an effort to attend. On the same evening the members of the Association will dine together at the Hotel Cecil, at 7.15, the president, Sir John William Moore, in the chair. Lieut.-Col. Rt. Hon. Sir Albert Hime, K.C.M.G., Ex-Premier of Natal, will be the guest of the Association.

Indian Medical Service.

Lieutenants to be Captains: R. Kelsall, M.B.; J. H. Burgess, M.B., F.R.C.S.; C. H. Brodribb, M.B.; J. McC. A. Macmillan, M.B.; C. A. Gill; W. E. J. Tuohy; T. F. Owens; R. F. Steel, M.B.; G. F. I. Harkness; A. C. Ingram, M.B.; G. W. Maconachie, M.B.; E. W. C. Bradfield, M.B.; A. W. M. Harvey, M.B.; C. I. Brierley; J. B. D. Hunter, M.B., and E. T. Harris. This is in substitution for the notification regarding the promotion of these officers in the "London Gazette" of November 13th, 1906.

M. Daniel Osiris, according to the *Figaro*, has left by his will a sum of £240,000 to the Pasteur Institute. The Pasteur Institute is already one of the best endowed scientific institutions in the world, and this windfall will provide it with an annual income of from £30,000 to £40,000.

The Exeter meeting of the British Medical Association will open on July 29th by a reception of memers by the Mayor of the town, Mr. W. H. Reed.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Trauma of the Abdomen.—In the *New York Medical Journal*, January 19th, 1907, A. E. Sellenings reports some cases of injury to the abdomen. He believes a study of the ætiology of these class of cases to be of great importance—the condition of the abdominal parieties, whether muscular or not; the hollow viscera, whether full or empty; the injury applied, whether it be slow moving or rapid; the amount of fat present. The recognition of the true lesions present after the trauma is very difficult. The resulting symptoms may be at once so meagre or so varied that no symptoms, or group of symptoms are of avail in establishing a diagnosis in most cases; shock, while often present, may be entirely absent. The author believes he is justified in drawing the following conclusions:—1. The diagnosis of traumatic lesions of the abdomen is most difficult. 2. The signs and symptoms are variable in their exhibition, and admit of no classification. 3. When there is an element of doubt in diagnosis, laparotomy is indicated. 4. History and nature of the injury may be the only indications for operation. 5. Early laparotomy will improve the percentage of recoveries. 6. Laparotomy, as a means of diagnosis, is without danger. 7. Tamponade is the best treatment for hæmorrhage in ruptures of the liver. G.

Fixation of the Bones in Excision of the Knee.—H. Groves describes a method (*Lancet*, February 23rd, 1907) which he has found very satisfactory in fixing the bones after excision of the knee. The method consists in cutting the bones with a mortised joint instead of leaving two smooth surfaces. The fixation is done by two metal rods, which are passed through the femur and tibia about three inches above and below the line of the excision. The rods project for a couple of inches on either side of the limb. Their free ends are then clamped together by two binding screws, which can be tightened until the joint is quite firm. These binding rods are removed under gas about two weeks after the operation. The author claims the following advantages for this operation:—1. That it fixes the bones together more firmly and more rigidly than any other method, because the fixation acts on dense bone of the shaft and not on the soft cancellous tissue. 2. That the bones are transfixed and held at points well away from the diseased area. 3. That the final fixation and tightening can be effected after the wound is sewn up and the limb placed on a splint. 4. That it saves the patient a great deal of pain in the dressings after the operation. 5. That it leaves no foreign bodies in the bones which may have to be removed by a subsequent operation. G.

Total Resection of the Thorax for Empyema.—C. Bayer believes that the chief dangers (*Zentralblatt für Chir.*, January 5th, 1907) in carrying out radical operations for long standing empyemata, which require extensive resection of the chest wall, are danger from hæmorrhage and from shock. The aim of his operation is to make his incision in such a way that there will be almost no hæmorrhage; that it divides only skin and connective tissue, going between the muscles in most cases, and cutting only unimportant muscles, while it still gives rapid and free access to all the ribs. The incision starts from a point about two inches behind the anterior axillary line, crosses this line close to the insertions of the serratus major, from the third to the tenth ribs. This incision causes almost no bleeding, and no muscles are cut, with the exception of a few fibres of the external oblique. The ribs, as many as are required, are then removed subperiosteally and the pleura opened with a thermo cautery. The operation can be easily and quickly performed, the drainage provided being in all cases excellent. G.

The Urinary Analysis of Operative Cases.—S. E. Tracy believes that surgeons (*New York Medical Journal*, January 19th, 1907) do not pay enough attention to the condition of their patients' kidneys, both before and after operation. He has carried out a research on this subject on a number of his own cases, and found that in 105 patients who had minor operations performed, twenty-seven per cent. had casts in the urine following the operation; of 123 patients in whom laparotomies were performed, in thirty-seven per cent. casts were found in the urine after the operation, while of 228 other cases operated upon nearly all of whom had ether anæsthesia, in thirty-three per cent. some change in the kidney occurred, as was evidenced by the presence of albumin, and epithelial, bloody, granular, or hyaline casts. Kelly has already drawn attention to the fact that chronic nephritis is frequently associated with malignant disease. The writer concludes his paper with the following remarks: That of the patients who come to hospital for operations, from fifteen to twenty per cent. suffer from some change in the kidneys, as is indicated from a careful study of the urine in every case. That the urine should be measured and examined for several consecutive days before a patient is given a general anæsthetic. That a chemical examination of the urine alone is not sufficient, and that in every uranalysis a careful microscopic examination should be made. That the urine should be measured and examined from every patient after a general anæsthetic has been administered, for should such a change take place in the urine the patient should be confined to bed, be kept very warm, and given saline, either by the rectum under the skin or by the mouth if the patient is not sick. With care such a condition will not last more than about six days, when the urine will once more become normal. Should the nephritis be neglected it may lead to permanent mischief in the kidneys. G.

Duodenal Ulcer and Its Treatment.—Mayo Robson (*British Medical Journal*, February 2nd, 1907) points out that operative experience shows that in a large proportion of cases duodenal and gastric ulcers coexist, and that the real proportion of duodenal to gastric ulcers is 1 to 2, or thereabouts. Gastric ulcer is commoner in women; duodenal ulcer is more frequently found in males. In the author's experience 86 per cent. in males to 14 per cent. in females. Most duodenal ulcers are within four or five inches of the pylorus. Dr. Ochsner has shown the presence of a sphincter just below the entrance of the bile and pancreatic ducts, and the duodenum above this has quite as much to do with digestion as has the stomach itself. There is apparently justification for classifying together ulceration of the stomach and duodenum. The symptoms often differ, however. Gastric ulcer is amenable to medical treatment in the earlier stages. It is questionable when duodenal ulcer has been recognised by definite symptoms, if it can ever be permanently cured by medical treatment alone. The clinical history of duodenal ulcer is more indefinite than in gastric ulcer, and symptoms may persist for a very long time in the former. Duodenal ulcer is commonest in the middle-aged. Pain is an important symptom. It comes on two to four hours after a meal, that is, when the stomach pours its acid contents into the duodenum. At this stage pain is sometimes relieved by food, because the acid is absorbed by the food in the stomach and the pyloric orifice closes for a time. The usual time for pain is at noon, about 5 p.m., and toward midnight. Pain tends to radiate towards the right loin and not towards the subscapular region as in gastric ulcer. Duodenal ulcer is usually characterised by periods of comparative good health between acute seizures. These periods may extend to weeks or months. In the acute stage there is rigidity of the right rectus, and tenderness usually just a little above and to the right of the umbilicus. Flatulency is more marked in duodenal than in gastric ulcer. There is dilitation of the stomach and hyperchlorhydria. It is exceptional to find any tumour. Acid eructations and heartburn are more frequent symptoms than vomiting. Appetite in many cases is good. Constipation is a very common symptom. Nutrition may not be seriously interfered with, but mental depression is common. A slight icteric tinge is almost constantly present in many cases. Also indican is usually found in the urine. Hæmorrhage and perforations are the most serious complications. Other serious complications are anæmia; cicatricial contractions leading to stenosis and secondary dilitation of the stomach; jaundice, pancreatic trouble, subphrenic and other abscess, disabling adhesions. Hæmorrhage is sometimes the first symptom to attract attention to duodenal ulcer. It is seldom revealed by hæmatemesis, as it usually passes downwards. Perforation is one of the most serious and frequent complications. Fortunately the gastric and duodenal contents at the time of perforation are only slightly septic, so that early operation should offer a good chance of success. Any other treatment than operation is useless. Repair of the rupture, simple drainage of the area of operation, and, if needful, drainage of the pelvis by the long tube inserted through an incision over the pubes, the drainage being assisted by the semi-recumbent posture, is all that should be done. Evisceration is unnecessary and dangerous. The author expresses a very decided opinion that posterior gastro-enterostomy is *the* treatment for duodenal ulcer. Subsequent to the operation the patient is always placed in bed well propped up, in fact, almost in a sitting position. Saline fluid per rectum in large quantities subsequent to the operation is of great service. As soon as the nauseating effects of the anæsthetic have passed off, one ounce of albumen water or other bland fluid is given every hour, and the following day two ounces every hour. The administration of food at frequent intervals is advisable for some time after operation, in order to absorb and neutralise the irritating acid of the gastric juice.

S.

The Surgical Treatment of Chronic Dysentery.—Captain Tucker, I.M.S. (*Indian Med. Gazette*, Feb., 1907) recommends appendicostomy in the chronic sloughing colitis of dysentery. He reports the following case. The patient, a man, æt. 30, had dysentery for four months. He had had another attack two years previously. He suffered from profound anæmia and marked wasting. In spite of medical treatment, patient got worse, passing four to seven large motions daily. The motions were bile-stained and offensive, and contained large pieces of sloughed-off mucous membrane. Operative treatment was undertaken. The appendix was exposed, and the cœcum sutured to the peritoneum of the anterior abdominal wall, three-quarters of an inch of appendix being left outside the wound. Four days later the tip of the exposed appendix was snipped off, and a No. 4 rubber catheter was introduced into the large intestine through the stump. Seventy-three ounces of a 1 in 400 solution of protargol were introduced. The following day the patient said he felt much better. Four fluid motions, each containing large sloughed-off pieces of mucous membrane, were passed. Sixty-three ounces of the same solution were injected. The injections were continued daily. After the fourth day the injections passed through the bowel without bringing away any more sloughs. On the ninth day the stool consisted simply of the irrigating fluid containing a large amount of undigested curds. The patient's general condition had greatly improved. During a slight attack of bowel irritability an astringent injection was used, and after some further delay in the stage of convalescence the stools became formed, of normal number, and gradually regained the pigmented condition which is characteristic of the normally functuring liver. The author considers this procedure much to be preferred to colostomy.

S.

The Surgical Aspects of Bronchiectasis, Particularly in Children and Young Adults.—Cumston (*Dublin Journal of Medical Science*, February, 1907) reports the following two cases. Case 1.—Boy, eleven and a half years old, since he contracted whooping cough at eight years of age, had a persistent cough, accompanied by profuse expectoration of a thick greenish sputum. The child was fairly well developed, and healthy in appearance. Some dyspnœa on exercise. The right side of the thorax dragged on respiration, and over the entire lower lobe there was diminished resonance and breath sounds. Numerous coarse moist râles were present. No tubercle bacilli found. On account of the tenacity of the cough in spite of the carefully directed medical treatment, operative interference was decided on. Subperiosteal resection of two inches of the seventh and eight ribs in the posterior axillary line was done. The wound healed by first intention. In three weeks the cough and expectoration had considerably diminished. In five months the general condition of the patient was excellent, and the amount of sputum voided in twenty-four hours would just about fill the bottom of a cup. No distinct dulness could be detected over the right side of the chest, and a weak vesicular murmur could be heard. Case 2.—Female, æt. 7, contracted measles eighteen months ago. This was followed by bronchitis, which has been almost constantly present ever since. Expectoration thick and yellow, but contained no tubercle. On the left posteriorly many coarse râles could be detected. About three inches of the eighth rib was resected subperiosteally. Two months later the severe cough and expectoration had disappeared. The thoracic cavities were symmetrical. The left lung was quite movable, and dulness and râles had disappeared. The author considers that resection of ribs in these kind of cases is a much more satisfactory and safe a procedure than pneumotomy.

S.

Treatment of Conical Cornea. — F. Stauffer (*Ophthalmic Record*, May, 1906) met a case of conical cornea which caused the patient, a young woman, no inconvenience beyond giving the eye an unsightly appearance. The apex of the cone eventually developed an ulcer which threatened the loss of the eye on account of its area and depth. Stauffer decided to remove an elliptical piece of cornea and to use sutures to keep the lips of the wound together. Taking a small curved needle and fine black silk suture, he passed it through the cornea into the anterior chamber, 3 mm. below and 2 mm. to the inner side of the centre of the cornea, bringing it out above at a corresponding point. A similar suture was passed on the outer side. An elliptical piece of the cornea, 3 mm. by 6 mm., was then removed between the sutures in the usual manner and the sutures tied. In twelve days firm union had taken place, and the patient was able to read and sew without the help of glasses.

M.

Retro-Bulbar Neuritis in Influenza.—Prioux (*Soc. Fran. d'Ophthal.*, May, 1906) believes that the systemic symptoms in influenza are due to the absorption of toxins, and that these occasionally affect the optic nerve as other known toxic agents do. He reports a case of influenza in which the right eye developed an acute retro-bulbar neuritis, the left eye showing a distinct œdema of the pupilla. There was a diminution of central perception of red and green, without any visible ophthalmoscopic changes in the right eye. On inunctions and leeches a cure resulted. No history or evidence of syphilis.

M.

NOTICES TO CORRESPONDENTS, &c.

ADVERTISEMENTS.

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SOUTHANTS.—The Budde process of preserving milk consists in the addition of peroxide of hydrogen to clean milk. The mixture is warmed for three hours at a temperature of from 51° C. to 52° C. The peroxide is decomposed and the nascent oxygen acts as a germicide. The milk is immediately bottled, and should keep sweet from eight to ten days. The amount of peroxide added is small, namely 15cc. of a 3 per cent. solution, so that the reduction of the proportion of fat is negligible. The system has been favourably reported on.

AN UNFORTUNATE QUOTATION.

A **NEW YORK** preacher besought his congregation to put the same trust in their pastors as they did in their doctors and lawyers. "If you get a prescription from your doctor, you take the medicine trustfully," and he added :—

"Yours not to reason why,
Yours but to do and die !"

REGISTERED.—It is a delicate point on which we are not infrequently asked for advise. We cannot advise you to use more than moral pressure, but this should be pushed as far as possible. Any respectable firm which values its reputation will do its best to withdraw from circulation anything offensive to you or any man similarly situated. But we do not advise legal proceedings ; they are costly and the issue would be very doubtful.

MISTURA.—There are many anæsthetic mixtures—*e.g.*, Beliroth's mixture (three parts $CHCl_3$, 1 each of alcohol and ether), Vienna mixture (1 part $CHCl_3$ to 3 of ether), the C.E. (2 parts chloroform to 3 of ether), and so on. The A.C.E. mixture was originally proposed by the late Dr. George Harley, and Mr. Martindale showed that the usual proportions, 1 of alcohol, 2 of chloroform, and 3 of ether, produced a mixture in which the evaporation of the constituents was uniform.

D. R. S.—Montana "Spotted Fever" is no relation to the other of that ilk, which is attracting so much attention at present. It is an acute febrile disease found in a certain part of Montana, and is believed to be caused by a similar parasite as Texas fever (*i.e.* a pyrosome). The organism is supposed to be conveyed from squirrels by certain wood-ticks.

L. N.—The dieting of thin people with a view to raising their weight is not so simple as is often supposed, for though fat relieves the intestines from excessive carbohydrate-digestion too much fat leads to bowel disturbance, and if no carbohydrates are taken, to acetonuria. Fat should be judiciously combined with carbohydrates therefore.

H. N. T.—The Royal Commission on Tuberculosis is still sitting and pursuing its investigations. It is impossible to say when its work will be considered to be completed, but we fancy few medical men will be dissatisfied if it goes on for years yet, as it is only by some such agency as this that public money can be got for scientific research. The cost of the Commission so far has been nearly £50,000.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 6th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Dr. A. Routh, Dr. Blacker, and Dr. C. H. Roberts. Short Communication :—Mr. A. Doran : After-history of a Case of Fibroid of Broad Ligament associated with an Ovarian Cyst reported in Vol. XLIII. of the Society's Transactions. Inaugural Address :—The President (Dr. H. R. Spencer).

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m.: Prof. W. B. Dawkins :—The Discovery of the South-Eastern Coalfield.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. : Mr. P. Paton : Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. D. Grant : Laryngeal Phthisis.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m. : Cliniques :—Dermatological (Dr. Meachen), Ophthalmological (Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, MARCH 7th.

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8.30 p.m.: Paper:—Dr. H. Howell and Dr. L. Jones : The Effects of Cervical Ribs.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Tichborne Street, Edgware Road, W.).—8.30 p.m. : Discussion on the Diagnosis and Treatment of Fractures in the Neighbourhood of a Joint (opened by Mr. W. Cheyne who will illustrate his remarks with skiagraphs). Prof. H. Marsh, Mr. E. Owen, Mr. P. Gould, Mr. A. Lane, Mr. R. Jones (Liverpool), and Mr. L. Thomas (Cardiff) have promised to take part in the Discussion.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m.: Clinical Cases.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson : Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. A. Whitfield : Lichen Planus.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m. : Gynæcological Operations (Dr. Giles). Cliniques : Medical (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Clinique :—Medical In-patient (Dr. Chappel).

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: On the Usefulness or Otherwise of the Electrical Methods of Treatment in Skin Diseases.

FRIDAY, MARCH 8th.

WIMBLEDON AND DISTRICT MEDICAL SOCIETY (Worple Hall, Worple Road, Wimbledon).—9 p.m. : Paper :—Dr. W. S. Colman : Pitfalls in Diagnosis.

CLINICAL SOCIETY OF LONDON (20 Hanover Street, W.).—8.30 p.m.: Papers:—Dr. G. A. Sutherland : The Medical Treatment of Congenital Pyloric Stenosis. Dr. A. F. Voelcker : Some Cases of Pyloric Stenosis in Infants. Mr. F. F. Burghard : The Surgical Treatment of Congenital Pyloric Stenosis.

BRITISH LARYNGOLOGICAL RHINOLOGICAL AND OTOLOGICAL ASSOCIATION (11 Chandos Street, Cavendish Square, W.).—4.30 p.m.: General Meeting. Exhibition of Cases and Specimens.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. H. L. Eason : Clinique. (Eye).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: —Medical Out-patient (Dr. Auld). Ophthalmological (Mr. Brooks). 3 p.m.: Clinique :—Medical In-patients (Dr. Leslie).

Vacancies.

Cornwall County Asylum, Bodmin.—Third Assistant Medical Officer. Salary £140 a year, with furnished rooms, rations, laundry, and attendance. Applications to Medical Superintendent.

Birkenhead Union.—Resident Assistant Medical Officer. Salary £120 per annum, with board, washing, and apartments. Applications to John Carter, Clerk to the Guardians, Poor-Law Offices, Birkenhead.

Aberdeen University.—The McRobert Fellowship for Cancer Research. —Fellow. Salary £200 per annum. Applications to Secretary of the Medical Faculty, the University, Aberdeen.

Birmingham Parish Workhouse Infirmary. — Assistant Resident Surgical Officer. Salary £104 per annum, with furnished apartments, rations, gas, laundry, and attendance. Applications to Charles Fletcher, Clerk to the Guardians, Parish Offices, Edmund Street.

Royal Victoria Eye and Ear Hospital, Dublin.—House Surgeon. Salary £40 per annum, with board and residence. Applications to Edward Parker, Registrar. (See advt.)

Wandsworth Union Infirmary, St. John's Hill, near Clapham Junction.—Male Junior Assistant Medical Officer. Salary £100 a year, board, lodging, and washing. Applications to the Medical Superintendent.

Bristol General Hospital.—Pathologist. Salary £240 per annum. Applications to the Secretary.

Appointments.

GLEGG, R. ASHLEIGH, M.D., Ch.B.Edin., D.P.H., Assistant Medical Officer of Health of the County of Ayr.

GOULD, HAROLD UTTERTON, M.A., M.B., B.C.Cantab, L.R.C.P.Lond., M.R.C.S., District Medical Officer by the Shaftesbury (Dorset) Board of Guardians.

GREEN, T. A., M.D., F.R.C.S.Edin., Surgeon in Charge of the Nose, Throat and Ear Department at the Bristol Royal Hospital for Sick Children and Women.

GROVES, E. J. C., M.B., Ch.B.Edin., House Surgeon at the Brighton, Hove, and Preston Dispensary.

HANLY, THOMAS FRANCIS, L.R.C.P., L.R.C.S., L.M.Edin., Medical Officer of Health for the Shaftesbury (Dorset) Rural District.

HARTIGAN, T. J. P., F.R.C.S.Eng., Dermatogist to the Alexander Hospital, Queen Square, W.C.

JOHNSTONE, G. A., M.B., Ch.B.Aberd., House Surgeon at the Bangor Infirmary.

MACPHAIL, DUGALD H., M.B., Ch.B.Glasg., Extra Physician to the Glasgow Central Dispensary.

MAY, W. NORMAN, M.B., B.S.Lond., Resident Medical Officer at the East London Hospital for Children and Dispensary for Women.

SEWELL, D. LINDLEY, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Honorary Assistant Surgeon to the Manchester Ear Hospital.

Birth.

CHANCE.—On Feb. 26th, at 90 Merrion Square, Dublin, the wife of Sir Arthur Chance, of a son.

Marriages.

BROWNE—ARTIS.—On Feb. 28, at St. James's, Piccadilly, Harry Fleming Browne, M.B., to Male Mabel Artis.

KEEBLE—GOLDSBROUGH.—On Feb, 23rd, at Camberwell Green Congregational Church, John Bright Keeble, of the British Central Africa Protectorate, to Edith, second daughter of Giles F. Goldsbrough, M.D., of Wimpole Street and Herne Hill, London.

MCSHEEHY—BUCKLEY.—On Feb. 27th, at the Servite Church, London, Joseph Thomas, eldest son of Surgeon-Major McSheehy, M.D., J.P. (late of the 5th Dragoon Guards), of Donoman, Wimbledon, to Katherine Josephine (Kitty), daughter of the late Fleet-Surgeon Buckley, R.N., and of Mrs. Buckley, 48 Cathcart Road, London.

Deaths.

TODD.—On Feb. 27th, at 126 Alexandra Road, Wimbledon, Nannie B. Todd, widow of the late Mark Stanley Todd, M.R.C.S., etc.

MACFADYEN.—On March 1st, at 14 Daleham Gardens, Hampstead, N.W., Allan Macfadyen, M.D., aged 46.

HARLEY STREET.—To MEDICAL MEN.—One of the best Houses in the Centre of the Medical Profession, with stabling, for Sale, having a lease of 33 years unexpired, at a very low ground rent.—For detailed particulars apply to W. Burnell Tubbs, Surveyor, 68 and 69 Shoe Lane, E.C., and 37 Barbican, E.C. Phone. 3,755 Central.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, MARCH 13, 1907. No. 11

NOTES AND COMMENTS.

Unregistered Dentists and Anæsthetics.

THE subtle distinction between unregistered and unqualified practitioners, both in medicine and dentistry, is quite lost on the public generally; the most they can be expected to understand is whether a man is or is not a "doctor" or a "dentist." The safeguard of registration as designed by the law is a clumsy business at best, and in the case of dentistry is of little value, for a practitioner has only to put a case of artificial teeth outside his door, or on the platform of the nearest railway station; with the inscription, "Teeth Painlessly Extracted," for him to be regarded as a dental surgeon. Indeed, to the poor the case of teeth is as pathognomonic of a dentist as the red lamp is of the doctor. Now, although the unqualified practice of dentistry is not, on the whole, attended with the same serious risks as that of medicine, it is a great danger to the public in respect of the administration of anæsthetics. It is generally agreed by medical men and dental surgeons that for the proper performance of a dental operation under an anæsthetic a qualified anæsthetist should be present, so that the dentist may give his undivided attention to his own work. In the case of unregistered dental practitioners, however, medical men are guilty of "covering" if they assist, and these people, consequently; are obliged to give their own anæsthetics—an art of course in which they have had no proper instruction.

Their Limitations and Responsibilities.

AT Nottingham last week a case in point occurred which shows what dangers the public must constantly be running through this practice. A woman went to an unregistered dental practitioner in that town and by him was given an anæsthetic while some extractions were done. Two of the teeth, however, were broken, and after suffering much pain for a week the woman went back to him and was given ethyl chloride, in order that the stumps might be taken out. According to a companion who was present, she "took it very calm," but the calmness soon passed into that form from which there is no waking. At the inquest, the dental operator said that he had given ethyl chloride 2,500 to 3,000 times in the last six years, an average of about eight times a day. A medical practitioner who was called in said he found the woman dead and that the dress was very tight round the waist. There was no obstruction of the respiratory passages and no disease of the heart. No wonder that the jury suggested in a rider to their verdict that "before ethyl chloride was administered in future patients should be examined by a doctor"; it would have been still more to the point if they had said that no unregistered person should be allowed to give an anæsthetic. Ethyl chloride is not a drug to be lightly handled, and the omission to take such a simple precaution as loosening the clothes round the waist shows how little sense of responsibility is attached to its administration.

Health Visitors.

ANOTHER class of persons whose limitations should be clearly defined are women health visitors. Now that the community is waking up to the terrible slur on its humanity which is cast by the high infant mortality of large towns, these visitors are becoming more common, and very properly so. Well-instructed health visitors who have tact and judgment can undoubtedly exercise a most beneficent influence in the homes of ignorant or careless parents, by impressing on them their duties to infants and by giving general advice as to cleanliness, clothing, and feeding in normal cases where no medical man is in attendance or likely to be called in. But it is obvious that the line between the duties of health visitors and those of medical practitioner is in many cases a narrow one, and if these ladies wish, as doubtless they all desire in principle, to be of real value in their districts, they must work in close co-operation with the people's own medical attendants. Otherwise unlimited sources of friction will arise, and their ministrations may be more productive of harm than good. We all know the temptation when dres't in a little brief authority to expand that authority, or, at any rate, to push it to its full limit.

And Their Functions.

AN instructive instance of the necessity for care in this direction is supplied by an inquest held early this month at Kensington on a child who is said to have been puny from birth. A midwife had attended the mother in her confinement, and a health-visitor from the Borough Council had seen the child ten days after birth. According to the mother's evidence, the child's breathing caused her some disturbance, and the health visitor prescribed some camphorated oil to be rubbed on the chest. The mother apparently persisted in this treatment for a long time, but the child growing worse and worse, she sent for a doctor. It was then exceedingly ill, and died a few hours afterwards from what the post-mortem revealed to be pneumonia. The jury brought in a verdict to that effect, adding the very proper rider: " In view of possible dangers arising from unqualified medical advice, we are of opinion that the borough officials should instruct their nurses to adhere strictly to nursing duties and to abstain from giving medical advice." There has been a good deal of local feeling expressed on the subject, but the warning is a timely one, and made in the best of good taste by impartial jurymen with the facts before them. Health visitors came into existence at the instance of the medical profession, and there is every reason why the most cordial relations should exist between both parties; but that can only be if each recognises its proper functions.

Fluid Fees.

There is no question in general practice so delicate and surrounded with pitfalls as that of the proper fee to charge patients. Although there are general rules for guidance, these are very fluid, and have to be interpreted in the widest fashion, so much do circumstances influence different cases. It is inevitable, therefore, that while most patients think they are charged fairly, and many, indeed, lightly by their medical attendants, there should be a residuum which considers particular bills too high. It is difficult for people to understand why the same amount of attention that costs them half-a-guinea should be given to others who only pay five shillings, but there is no alternative in practice but to charge not according to time or trouble, but according to people's means. At the recent Shropshire Assizes, Dr. J. A. Shackel was obliged to bring an action to recover £145 9s. from a baronet, Sir William Rose-Boughton, for attendance on his father, the defendant only admitting liability for £88 1s. 6d. The question at issue was whether a guinea a visit was too high a charge for attendance on a gentleman of the baronet's position, especially as Dr. Shackel had charged lower fees to other members of the family. Happily, judgment was eventually given in the medical man's favour, and it may be remarked that it is quite fair that a county gentleman of title and estates, whose life has publicity attached to it, should pay at a higher rate than a more obscure individual, and a guinea a visit, especially when there is a considerable journey to make, is a decidedly moderate charge under the circumstances.

Rank and "Gowd."

Eminent position in society has always been regarded as a good reason for assessing the value of medical services at a higher figure. The responsibility entailed on a medical man attending a person whose illness attracts wide interest is far greater than in the case of a lowly and uninfluential person, and as medical charges have a good deal of the " moral and intellectual damage " element about them, they are justly raised in the case of well-known and well-to-do people. Many of the subjects of the charges, however, wish to obtain all the privileges of their station without its corresponding obligations. We were once consulted in the case of one of the wealthiest peers in the country who objected to pay twenty guineas for a corresponding number of visits by a leading practitioner in a fashionable town. In such cases it is necessary to represent that " the rank is but the guinea-stamp," though the man does not always like producing the " gowd for a' that."

LEADING ARTICLE.

A NATIONAL ANTHROPOMETRIC SURVEY.

The scientific study of mankind in his collective relationships is obviously a matter of first importance as regards the future of the race. It has been to a great extent effaced, however, by the overwhelming amount of attention that has been demanded by the individual. Modern schools of statesmanship have, nevertheless, begun to recognise that the strength of a nation must ultimately depend on the general standard of virility attained by her citizens. Indeed, that is the great underlying principle of the gospel of public health, which has sought in many ways to protect the community as far as may be from the physical evils due to a bad environment. As a first step in any comprehensive study of the effects of modern life upon the individual it is clearly necessary to secure a fairly full knowledge of existing facts. As an illustration of the profound racial changes that can be brought about by environment, the interesting statements of Mr. J. Gray, an authority on the subject, may be quoted. He states that a recent survey carried out in Scotland showed that in Glasgow hair and eye colours had changed so radically that the population of the town could no longer be considered to belong to the same race as the normal denizens of Scotland. This change he attributed to the industrial environment of the city in question, which had eliminated certain types of the population and had more or less modified its general composition. Anthropometry proved conclusively that under modern industrial conditions people with fair hair and with blue and light-coloured eyes—the Saxon type—died out and disappeared. It is interesting to note that similar investigations in the crowded London slums of Southwark and the Borough led to the same conclusions. The result of these observations is the interesting general proposition that the fair race of the industrial slum area dies out at a far greater rate than the darker race. The explanation probably lies in the fact that fair people are less resistant to diseases that are common to industrial life. If that were not the case, we should expect to find that the fair-haired races were less resistant under all conditions of environment. It was shown, however, by anthropometric investigations in Edinburgh, which consists for the most part of residential districts, that the balance of the fair-haired and the dark-haired population is about equally preserved. If this doctrine be accepted, it is clearly advisable for all fair-haired and blue-eyed persons to go and live in the country, if they wish to attain the span of life allotted to mankind by the psalmist. The matter may, of course, be looked at from another point of view, namely, that the standard of environment in town and industrial life should be raised so that fair-haired folk would thrive and survive there no less than they would in rural quarters and non-industrial occupations. In any case, progress in scientific human culture demands the possession of full knowledge on which to base our proceedings. With that end in view, on the 5th instant, a deputation waited on the Prime Minister to urge the Government to establish a national anthropometric survey both of adults and of children, on the lines recommended by the Inter-departmental Committee on Physical Deterioration, in July, 1904. The Deputation included such well-known scientific authorities as Professor D. J. Cunningham Sir Lauder Brunton, the Rev. J. Gow, Sir W. S. Church, Dr. Arthur Keith, Dr. Arthur Thompson Dr. Tuke, and Mr. J. Gray. They pointed out that the machinery for such a periodical survey was ready, but a grant from the Government of between £4,000 and £5,000 was wanted to put it into efficient action. The reply of Sir Henry Campbell-Bannerman was encouraging, and pledged the Government so far as could be reasonably done by a cautious and responsible Prime Minister. The practical experience of the politician naturally suggested to him certain difficulties that might arise in the endeavour to enforce systems of examination upon rich and poor alike, as well as upon their children. In other words, the first element of success is to secure the approva of the public. He promised that the views of the deputation should receive careful consideration, and that the Government would be glad to givel them the modest sum asked for if they found the project generally approved. Here the matter rests for the present. It may be added that the object aimed at by anthropologists was defined by one of the deputation as the securing of a continuous record of exact measurements of the physical and mental characters of the population, and to take particular notice of the environment in which the subjects of the measurements lived.

CURRENT TOPICS.

Lead Poisoning by Drinking Water.

A RECENT report of Dr. Helwes on a large number of cases of lead poisoning at Diepholz suggests some interesting considerations. Thirty-one persons were affected ; they were all of the middle class, and the amount of lead in the drinking water varied from 0.2 to 3.98 mg. per litre. The familiar fact of the immunity of all save one single member of a household towards the poison was again illustrated in several instances, but no fresh light was thrown upon this somewhat curious anomaly. A less familiar and in some ways a far more serious matter is the fact that in by far the larger number of instances the appearance of lead poisoning was noticed only after the pipes had been in use for many years, and when examination of the metal work showed little or no trace of attack. Given the factor of individual susceptibility, there can be no permanent security while lead is used in the conveyance or storage of moorland water used for drinking purposes. It is certainly somewhat alarming to learn that lead pipes may be used for many years without deleterious effects and then suddenly give rise to plumbism. This information prepares us for the further conclusion of Dr. Helwes that more persons suffer from lead poisoning than is generally believed. The hint is well worthy of being borne in mind by all engaged in medical practice.

Episcopal Surgery.

AT a recent meeting of the Hostel of St. Luke, held in the Church House, Westminster, the Bishop of Selkirk gave some interesting details of his early experiences in remote regions where skilled medical assistance is not to be had. His experience in the Arctic regions, hundreds of miles away from doctors and nurses, made him appreciate such an institution for the clergy as the hostel. People had come to him to have fingers taken off and teeth pulled out. One lady came 1,500 miles to have a tooth taken out, a fact that emphasised in a remarkable way the horrors of toothache. He practised on his wife, and she practised on him, a method of acquiring clinical experience that is somewhat too limited for the ordinary medical student. Once when he lived among the Esquimaux in a snow house he became suddenly ill with pleurisy; so he mixed mustard and snow with splendid effect and made himself well again. His predecessor as bishop amputated a man's leg with a common saw and a butcher's knife. Much of the practice of surgery is clearly within the grasp of a man of resolution and manual dexterity, but the same observation applies much less to the more difficult methods of the physician.

The Prevention of Disorder in the Royal University of Ireland.

A WHITE Paper has been issued containing the text of a Royal Warrant to amend the Statutes of the Royal University of Ireland, and to confer upon the Senate the necessary disciplinary powers which recent events at the conferring of degrees showed to be badly required. The Warrant contains six provisions, the first of which enables the Senate to decline to award a pass to any candidate who shall be adjudged to have violated any of the regulations in connection with any examination. The Senate may also refuse to allow such a candidate to present himself for re-examination for such a period as they may think fit, and is given the power to impose a fine not exceeding five pounds. The Senate is further given powers to remove from the University Register any undergraduate who shall be adjudged by the Senate or by the Standing Committee to have been guilty of serious misconduct at any of the functions of the University, or to decline to allow such undergraduate to enter for any further examination in the University for such length of time as the Senate think fit, or to inflict such fine, not exceeding ten pounds, as they shall think fit. They are also granted similar powers with respect to graduates. It is to be hoped that these powers will be sufficient to enable the Senate to preserve order at its functions in future, and to prevent such University ceremonies from being converted into a semi-political bear-garden, to the discredit of University education in Ireland. *En passant*, we may note, however, that the issue of this Warrant seems to be superfluous if, as we are told, the Government intend to abolish the Royal University after Easter.

The Military Chest.

The grotesque side of army dress and carriage has furnished powder and shot to the caricaturists time out of mind. There seems to be hardly any absurdity too great for the military tailor bent on making the most of his "gilded popinjay" as a well-known statesman once somewhat unkindly called the British officer. Speaking seriously, it is somewhat hard to realise how brave and modest men, as most soldiers are in private life, can consent without a murmur to doff the sober dress of the modern gentleman and don the hues of the peacock, together with accoutrements that would look ridiculous in a circus entertainment. In point of fact progress in the army is a plant of slow growth, and it is wont to hug many a worm-eaten tradition as regards dress and drill and other details of its daily life. But the spirit of reform appears to have settled upon the War Office. We wonder if medical science will be called upon to advise as to the scientific treatment of the soldier. If so, one of the first things to go by the board will most likely be the erect bearing and puffed out military chest. The athletic layman does not stand as if he had a ramrod down his back, nor does he puff out his chest in the fashion of a pouter pigeon. It is more than likely that the habitual assumption of such a carriage during many hours of arduous work and exercise lead to serious damage both to lungs and to heart. Dr. Gordon Hogg, Coroner for West Middlesex, recently called attention to this most "pernicious practice" of puffing out the chest adopted in the British army. It seems quite clear that the excessive incidence of aneurism upon soldiers is directly due to the drillmaster's mistaken sense of propriety of carriage. Perhaps Mr. Haldane, who appears to be a kind of Hercules in such things, will seek medical counsel and advice upon this knotty problem.

Antivivisection and Falsehood.

There is nothing more painful to scientific men who are fond both of animals and of justice than the methods used by the rival antivivisection bodies to hoodwink the public on the question of experiments on animals. "Good wine needs no bush," and if the antivivisection cause were a good one it would gain respect and adherents by presenting unvarnished facts—indeed, one might go further and say that we can conceive of the public interest being served by honest opponents of experiments on animals, criticising fairly things which they deemed to be wrong, for just criticism temperately delivered is one of the most useful factors in the regulation of society—our whole system of Government depends on it. The antivivisectionists, however, positively revel in wild and wicked exaggeration, and do not scruple even to tell the grossest falsehoods. The honest man has no place in any of the antivivisection organisations of our time. One of the latest ebullitions from these tainted sources is a letter, entitled "What Vivisection Costs the Public," from Mr. Sidney Trist, Secretary of the London Antivivisection Society, which appeared in the *Star* of March 4th, and the *Western Daily Mercury* of March 2nd, and perhaps in other journals, for the letter appears to be of the kind that is sent simultaneously to leading papers, in which the statement is made that "every year the British Medical Association receives from the Treasury several thousands of pounds for 'scientific grants,' mainly vivisection. The taxpayer pays." The secretary of the British Medical Association wrote the *Star* the following day, giving this statement the lie direct. "This statement," he wrote, "is absolutely false and untrue." So far we have seen no apology, even the lamest, from Mr. Sidney Trist.

Deaths under Anæsthetics.

A correspondent has drawn our attention to a somewhat striking contrast between the number of deaths from anæsthetics in England and that in Ireland, as revealed by the statistics of the respective Registrars-General. It appears that in the year 1904 there were in England and Wales 161 deaths registered as due to anæsthetics, and in the following year 157. In Ireland there were only three deaths in each year. Moreover, of the 161 deaths in 1904 in England and Wales, 92, and of the 157 in 1905, 81 were under chloroform anæsthesia. All the six deaths in Ireland were under chloroform. Again, of the total of 318 deaths in England and Wales, in the case of 48 in 1904 and of 57 in 1905, the nature of the anæsthetic is unrecorded. As chloroform is probably the most common anæsthetic agent in use in England, it is fair to assume that it was the agent in the great majority of these cases. As the population of England and Wales is about ten times that of Ireland, and the number of deaths under anæsthetics some fifty times as many, there is a difference to be explained. Assuming that the figures are equally trustworthy in the two countries, and that the incidence of operation on the population is approximately the same, then only one explanation of the disparity is possible. In Ireland ether is the anæsthetic of choice, chloroorm being rarely used except where there are definite indications for it. In England the use of the latter is still very common.

Railway Carriages and Dirt

EVIDENCE of an important character in regard to public health was given a week or two ago before the Railway Commission in Ireland by representatives of the Commercial Travellers' Association. These gentlemen, among other matters with which we have no direct concern, drew the attention of the Commission to the filthy condition in which railway carriages are kept on many of the lines in Ireland. Spitting is practised everywhere, and not only the floors, but the doors and windows of the carriages are contaminated. The carriages are seldom, if ever, thoroughly cleansed. Heating and lighting are insufficient, and ventilation is entirely at the will of the passengers. We have often drawn attention to the part played by railway carriages in the spread of disease, and we think the Commercial Travellers' Association has done a service in pointing out the risks to which its members and the travelling public generally are exposed by the neglect of common cleanliness on the part of the railway managers. We cannot but think, however, that some body claiming to speak with authority on matters of public health should have brought forward evidence on the subject, and not have left it to a lay association.

A Chinese Medical College.

THERE is hardly any more marvellous chapter in the history of science than the way in which Japan brought herself into line with modern Western medical knowledge. The other great nation of the Far East, China, still hugs an ancient system of medicine founded on barbaric superstition and ignorance. In various directions, however, China is beginning to follow, *longo intervallo*, in the wake of her Japanese neighbours. The Union Medical College of Pekin appears to be at last making a real impression upon the national mind. Lord Overtoun, who presided at a recent meeting in Glasgow of the promoters of the College, gave various interesting details concerning the Institution. A year's work has been completed and the work is being run by a combination of five missionary societies. Perhaps the most significant fact connected with the movement is its recognition by the Dowager-Empress, who not only gives her sanction to the work, but couples it with a considerable donation. It is perhaps somewhat to be regretted that the precepts of modern medical science cannot be instilled into the mind of a great nation without the accompaniment of religious teaching; both are undoubtedly excellent things in their way but there is no obvious correlation between them.

Another Martyr to Science.

ANOTHER medical man has lost his life at the post of duty. Dr. Macfadyen, one of our most distinguished bacteriologists, by an accident, inoculated himself with the poison of Malta fever, in the preparation of which he was engaged. Even the most cautious and skilful workers are exposed to a certain irreducible margin of risk when handling specific pathogenic cultures. In the particular disease mentioned the fever usually runs a chronic non-fatal course, but in the case of Professor Macfadyen its unfavourable issue was no doubt influenced by the lowered resistance of a frame taxed for some time past with anxiety and overwork. In his death we recognise another added to the long list of medical martyrs to science.

PERSONAL.

ON March 9th Her Majesty the Queen and the Empress Marie paid a private visit to the London Hospital, of which the Queen is president. Attended by members of their suites, their Majesties drove down to the hospital from Buckingham Palace, arriving at midday, and spent several hours in inspecting wards and patients.

LAST week, Her Majesty the Queen, attended by the Marchioness of Lansdowne and the Hon. Charlotte Knollys, paid a surprise visit to the offices of the Queen's Victoria Jubilee Institute of Nurses in Victoria Street, London.

THE Imperial Association of Physicians in Vienna resolved, on March 8th, to hold the usual annual ceremonial sitting this year in honour of Lord Lister. The inaugural speech, dwelling upon his merits and achievements as a member of the medical profession, will be given by University Professor Dr. Fraenkel.

LIEUT.-COL. L. A. IRVING, R.A.M.C., it is stated, has resigned his appointment as recruiting medical officer in the London District. Capt. P. J. Bodington, R.A.M.C., is to be appointed to the Royal Horse Guards. Major T. B. Beach, from Chatham, has been appointed to the Royal Arsenal, Woolwich, for duty.

DR. F. G. HOPKINS, Senior Medical Officer of Southern Nigeria, has been promoted Deputy Principal Medical Officer, and Dr. E. H. Read, Medical Officer, becomes Senior Medical Officer.

LIEUT.-COLONEL W. BABTIE, C.M.G., V.C., has been selected for the appointment of Inspector of Medical Services under the new Army plans.

THE DUKE of DEVONSHIRE has been elected Chancellor of the Victoria University, Manchester.

THE Gold Medal founded by the late Sir Gilbert Blane, Bart., to be given biennially, has been awarded by the Medical Director-General of the Navy and Presidents of the Royal College of Physicians, and the Royal College of Surgeons, to Staff-Surgeon James W. W. Stanton, for his Journal of H.M.S. *Suffolk*, 1905, and to Surgeon Bernard Ley, for his Journal of H.M.S. *Algerine*, 1904.

THE DUKE of ARGYLL has consented to preside at the festival dinner of the Royal Waterloo Hospital, to be held at the Savoy Hotel on May 14th.

MR. LEONARD BIDWELL, Dr. Rolleston, and Mr. WARING are to continue on March 19th the debate opened last night at the Chelsea Clinical Society on "Gall-Stones, their Diagnosis and Indications for Operation.

DR. BEATTIE, Lecturer on Bacteriology at Edinburgh University, has been elected Professor of Pathology at Sheffield.

13) 5
13

A CLINICAL LECTURE

ON

SOME PNEUMOCOCCAL AFFECTIONS REQUIRING SURGICAL TREATMENT.

By E. W. SCOTT CARMICHAEL, M.B., F.R.C.S.E.,

Assistant Surgeon, Royal Hospital for Sick Children, Edinburgh.

GENTLEMEN,—The subject which I wish to bring before you to-day is one which has been illustrated by several cases recently admitted to hospital. It serves to show how increasingly widespread infections by Frænkel's pneumococcus have become since more thorough bacteriological investigation has isolated the specific organism in acute infective conditions. This organism has been shown to affect serous membranes throughout the body, not only in association with a lung affection, but also independently as far as clinical evidence and post mortem examination can determine.

Pneumococcal infection of the meninges of the brain, peritoneum, synovial membranes of joints and tendons are more frequently recognised than formerly.

The following case, gentlemen, illustrates well a pneumococcal affection occurring independently of any pulmonary condition :—

A female infant, æt. 6 weeks, was brought up to the out-patient department of the hospital on December 24th, 1906, with the history that it seemed to suffer pain when it was moved, especially when the mother tried to straighten its legs when washing it. Swelling of the left wrist was also noticed three days before.

On examination the child was fairly well nourished, there was general swelling of the wrist joint and an abscess over the lower end of the radius on its dorsal aspect. The child lay with both thighs and knees flexed. Attempts to extend the hip joints showed considerable fixation of the right. The hollow behind the trochanter on the right side was filled up with an elastic swelling, giving a sense of deep fluctuation. The temperature was 101° F.

The history, age of the infant, and clinical examination justified the diagnosis of an acute arthritis of the right hip and left wrist, and the child was admitted to Mr. Kay Smith Ward.

On the following day the hip joint was explored, and drained by a posterior incision. No primary bony focus could be found either in the neck or upper epiphysis of the femur, and we therefore had to deal with a primary acute synovial infection of the joint.

Drainage of the wrist joint was also carried out. I think, if one considers the state of development of the structures entering into the formation of the wrist joint in a child of this age, we may consider that we had here also to deal with a primary synovial infection.

The centres of ossification of the lower ends of radius and ulna, and of the first row of carpal bones have not yet appeared at this age, nor has the epiphysis of the head of the femur. The ossific centres for the acetabulum are present at this age, but are so small as to preclude the probability of a primary bone affection.

We have therefore to deal here with a primary synovial affection of both joints. What, then, is the probable cause ? What organisms are most likely to affect the synovial membrane by means of the blood stream with acute symptoms as presented by this case, and suppuration ?

We have either to deal here with a pneumococcal or streptococcal infection. Clinically, the child does not present the severe toxic symptoms of a streptococcal infection, and I was inclined to think that we had a simple pneumococcal infection of both joints. Bacteriological examination of the fluid from both joints gave a pure culture of Frænkel's pneumococcus.

This, therefore, gentlemen, is a fairly typical case of a generalised pneumococcal infection with local manifestations in the hip and wrist, or, in other words, the child suffers from a mild form of pneumococcal septicæmia. This case also illustrates the fact that we may have a general pneumococcal infection without any local manifestation in the lung, as far as can be ascertained clinically.

I wish, therefore, now to consider pneumococcal arthritis in general.

AGE AND SEX.

It may occur at any age, but is probably much more common in children than any other period of life. When it occurs in children it is most common during the first year, at the time of dentition.

Of eight cases which have been treated in this hospital during the last three years, five were under the age of one year, two were æt. 13 months and 14 months respectively, and one was æt. 7.

Thus a large proportion of cases of acute suppurative arthritis in infants are due to the pneumococcus.

It seems to affect male children more frequently than females. All the eight cases above referred to were males, although the case presented to you to-day is that of a female, æt. 6 weeks.

GENERAL CONDITION.

This child, though obviously ill, did not present that extreme degree of toxæmia which might be expected when two large joints are the seat of acute sepsis, and in many cases this is somewhat typical of the condition.

The general disturbance does not correspond to the degree of the joint affection. This child eats and sleeps fairly well, and does not present the restless, poisoned appearance of one suffering from a strepto or staphylococcal infection. The temperature varies from that of a typical affection of the lung in the more severe forms to one in which it is somewhat irregular, but does not extend higher than 101° F. When one joint is affected the temperature chart may resemble that of an acute lobar pneumonia, with a marked crisis, but in many cases, especially when there is more than one joint affected, the fever shows no such regularity.

In only one of these nine cases was there any affection of the lung or pleura associated with the involvement of the joints. In adults a joint infection is much more frequently secondary to or coincident with a lobar pneumonia, but in children the arthritis of one or more joints appears to be more frequently the primary local manifestation.

The blood reaction is as a rule well marked, as shown by a high leucocytosis, a distinct glycogen reaction, while in severe cases pneumococci may be cultivated from the blood.

CONDITION OF JOINTS.

The disease is essentially one which affects the larger joints and in about 50 per cent. of cases affects more than one joint.

In those cases treated in this hospital, the order of frequency of the various joints has been the hip, knee, shoulder and wrist, and in all probability the knee is the joint most frequently affected.

The joints present all the signs of an acute inflammation as shown by tenderness, swelling, and pain. There is one sign, however, which is occasionally striking, though not always reliable, and that is the absence of periarticular œdema. In the case of the child shown to you to-day, however, the infection has spread beyond the joint into the surrounding cellular tissue and formed an abscess outside the joint, and this is the stage at which the condition is generally met with by the surgeon, especially in the case of the hip joint, in which it is difficult to detect a distension of the joint until an abscess has formed under the gluteus medius, and maximus and filled up the natural hollow between the great trochanter and the dorsum ilii.

It is important to remember the character of the pus as seen in pneumococcal joints. It is met with in two forms, either it is thick, and of a greenish yellow colour, or like somewhat thin cloudy serum. In both instances it is odourless, and the one variety may occur in one joint and the other in another joint in the same individual.

It seems probable that the serous fluid occurs in an early stage of the disease, although some authorities believe that this thin turbid pus is evidence of a more virulent infection. In one case, however, of a baby, æt. 7 months, with acute pneumococcal arthritis of the hip, the joint contained somewhat turbid, almost gelatinous, looking fluid having a slightly greenish tinge and with no odour, the joint subsequently recovered with almost no limitation of movement.

The recuperative power of joints in infants and young children after septic infection is much greater than that of the adult, so that even after drainage for some considerable period the power of mobility of a joint is not seriously interfered with. This is not infrequently the case in pneumococcal infection of a joint in which the prognosis is rather more favourable as regards mobility than in other septic conditions.

It is not necessary to drain the joint for a prolonged period, and in two cases drainage tubes were removed after the third and fourth day. The purulent effusion into the joint does not apparently persist so long as in other septic conditions.

Prognosis as to life becomes more unfavourable the greater the number of joints affected. In three cases in which more than one joint was affected, two ended fatally, while in six cases where only one joint was involved, one died, the cause of death being meningitis.

As compared with most septic conditions in joints, the prognosis as to the future function of the joint itself is much more favourable.

Before passing on to the next series of cases, gentlemen, I would have you consider the following points, which a review of these cases teaches:—

(1) That a large proportion of acute infections of joints, more especially in infants under one year, are due to the pneumococcus of Frænkel.

(2) That such infection is often evidence of a general septicæmia.

(3) That in the majority of cases there is no evidence of a primary infection in the lungs as far as can be ascertained clinically.

(4) That the degree of toxæmia is relatively less, and the prognosis therefore more favourable, than in other acute infections.

I wish now to consider more briefly several cases which we have recently had under observation, illustrative of another serous membrane infection, namely pneumococcal peritonitis.

Like the joint affection, it is more common in childhood than in later life. It tends, however, to affect older children, and rarely infants. Thus of 11 cases treated in the hospital, one only affected a baby of 13 months, the remaining cases being, with one exception, in children over six years of age.

It is generally believed to occur more frequently in the female than in the male, but of the 11 cases above referred to 7 occurred in males and 4 in females. It is probable that in the adult the female is more often attacked than the male, the source of infection being in these cases by means of the Fallopian tube, although this channel cannot be overlooked even in the case of the young child. Whether this is so or not can only be determined by more careful pathological examination, as it has been shown (Armand and Bowen) that where the peritonitis has been secondary to a lung infection, the female is affected in 67 per cent. of cases.

In the cases above referred to three were secondary peritonitis, in that there was also a pulmonary affection. Of these two were females.

One cannot help thinking that if pneumococcal peritonitis is more common in the female, its greater frequency cannot be entirely laid at the door of a tubal infection.

Clinically we may consider two varieties of pneumococcal peritonitis, the generalised and the localised or encysted. The former is the more common variety. Of the 11 cases referred to two were localised.

A localised pneumococcal abscess is generally situated below the umbilicus, is often lateral and tends to occur more frequently on the left than the right side. If untreated it may burst in any direction, but the point of election is at the umbilicus. Localised abscess of the peritoneum is more frequently a secondary affection than the generalised form, for when the latter occurs it is usually one of many lesions in a pneumococcal septicæmia.

In the localised form, the general condition of the patient is often good, but if left untreated wasting becomes a marked sign, until the abscess bursts into the bladder, vagina or rectum, or at the umbilicus. The child when seen at this stage often presents the appearance of one suffering from a tuberculous condition; especially is this so when an umbilical fistula is present.

In generalised peritonitis the onset is acute, and the symptoms severe, terminating in death in many cases in forty-eight hours. There is evidence of gastro-enteritis, as shown by vomiting and diarrhœa, and marked general toxæmia in cases resembling the galvinating form of appendicitis. All degrees of severity are met with down to that in which the patient presents chiefly gastro-intestinal symptoms without marked toxæmia. There is tenderness of the abdomen without any degree of distension, and were it not for the somewhat marked abdominal tenderness, the presence of diffuse peritonitis might be unsuspected.

Diarrhœa is a symptom which is more constantly present than in any other form of general peritonitis.

How does infection take place; is it by the blood stream, or by direct intestinal infection? The fact that vomiting and diarrhœa are such prominent symptoms in most cases, would seem to point to a spread from an intestinal infection, but it is possible that where generalised peritonitis is present with other lesions the infection has occurred by means of the blood stream.

The diagnosis of the condition is not always easy. When general peritonitis is present, especially in a child, the vermiform appendix is in the majority of cases the cause. If on palpation there is no swelling in the right iliac fossa, pneumococcal peritonitis or a pelvic appendicitis becoming generalised offer the most probable explanation. A rectal examination is often unsatisfactory owing to the extreme tenderness of the pelvic peritoneum in both cases, but under an anæsthetic a localised swelling would suggest the appendix as the more probable cause.

When a localised abscess is present the case often does not come to the surgeon till the patient has been treated for some weeks.

The history will as a rule serve to distinguish it from a tuberculous condition, although the appearance of the patient may be similar in both conditions. Where a fistula is present palpation will reveal masses if the condition is tuberculous.

What, then, would justify a diagnosis of pneumococcal peritonitis, apart from the clinical history? One of the most distinctive features of the condition is the character of the pus as revealed at operation.

On opening the abdomen, a clear somewhat fibrinous fluid, sometimes even jelly-like in consistence and mixed with a somewhat yellowish green pus, escapes. It is always, when a pure infection, odourless, which serves frequently to distinguish it from pus of appendix origin.

In localised abscesses the pus is not so characteristic, but it is probable that many of these encysted abscesses result from a less severe generalised infection, which has cured except for the local collection. The want of odour and fibrinous character of the pus is even in these cases a distinctive character of a pneumococcal infection.

The prognosis in general peritonitis is grave, while that of the localised form is relatively good. It is better in cases where the peritonitis is a secondary lesion.

The successful treatment depends, gentlemen, on an early diagnosis. It is not, however, easy to diagnose this condition in its early stage, but fever, abdominal tenderness and diarrhœa are strong indications for operative interference. Multiple drainage without washing out the abdominal cavity gives the best results.

I have tried, gentlemen, to bring before you the salient features of these two conditions, which illustrate the greater frequency of what up till recently were unrecognised affections as far as their bacteriology was concerned.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by T. K. Monro, M.A., M.D., F.F.P.S.G., Physician to the Glasgow Royal Infirmary and Professor of Medicine in St. Mungo's College, on "Diabetes."*

ORIGINAL PAPERS.

THERAPEUTIC NOTES.

BY PROF. WILLIAM CARTER, M.D., B.SC., LL.B., UNIV. LOND., F.R.C.P.LOND.,

Professor of Therapeutics, Liverpool University; Physician to the Liverpool Royal Southern Hospital.

IN the art of medicine as well in that of govenment the application of abstract principles is often less successful in effecting cure or relief than the employment of remedies that are sometimes condescendingly spoken of as merely empirical.

In the few notes which I propose to write, it is rather to the application of some practical remedies that I shall ask attention than to any of the theories of modern therapeutics, useful and suggestive though some of these undoubtedly may be.

"Do you consider trypsin of any value in the treatment of cancer?" is a question that has more than once been put to me. By way of reply I will transcribe verbatim the notes kindly forwarded to me by Dr. McAfee of the case of a lady, who, when I saw her in consultation with him, seemed to be in a hopeless condition—merely premising that I was led to suggest the use of trypsin owing to a report which had been given to me, on the occasion of one of his visits to England, by my friend Dr. Albert Chalmers of Ceylon, of its beneficial effects in two cases of uterine cancer that seemed from his description closely to resemble the one now to be related.

Dr. McAfee's Report.—"Patient, æt. 51, unmarried, had panhysterectomy performed for adeno-carcinoma of the uterus. The left ovary was found to be seriously involved, considerable infiltration had taken place into the tissues around, and from soon after the time of operation—in July, 1900—up till the beginning of 1905, it was evident that the disease was making progress in the pelvic region; a considerable mass could be felt in the left groin, and a large ulcer formed in the posterior wall of the rectum. This soon necessitated colotomy, which was performed in March, 1905. The patient was much relieved by this operation up till August of that year, when several alarming syncopal attacks occurred, and there was much exhaustion; pain in the pelvis was intense, and frequent discharges from the rectum took place with symptoms of septicæmia.

"The patient became steadily worse; increasing weakness, with symptoms of absorption and constant distress from the activity of the rectum, notwithstanding the injection of local sedatives, pointed to a rapidly fatal termination.

"On February 19th the use of trypsin was commenced. Two drachms of the liq. trypsin co. (Allen and Hanbury) made up to one ounce with water were injected daily, and one drachm three times a day administered by the mouth.

"There was an immediate improvement in both the local and general condition. At first the rectal injection was only retained from ten to twenty minutes, but the relief was remarkable after a few days. The discharges from the bowel which had necessitated the use of the slipper ten or twelve times a day, were reduced to twice. The sense of urgent pressure ceased, and the general increase of comfort was most gratifying. Sleep returned, the digestion improved, and wasting was checked. The abdomen became less tender, and a marked diminution of the resistance in the left groin became evident; in a month the patient was able to get out of bed to a chair, and several times during the summer she has been able to take drives of considerable length.

"The period of the retention of the trypsin has been increased to two or three hours, when a considerable discharge has returned by the opening in the side. This is far in excess of the bulk of the injection and is often of a gelatinous character, occasionally very offensive.

"The patient is now more free from pain and discomfort, sleeps more soundly, and is better nourished than at any time since the colotomy was performed. An injection of 20 minims of liq. Battley twenty minutes before that of trypsin has allowed the latter to be retained longer; and in the month of June the trypsin caused some nausea, and a slight erythematous rash appeared. This led to the omission of its administration by mouth for one day of the week, and has probably conduced to toleration of the drug."

Such is Dr. McAfee's report, and, in order to learn whether the improvement continued, I telephoned to him for information as these notes were being prepared for the Press. The reply was in the affirmative, and that the patient shortly before had had an hour's carriage drive, not only without discomfort, but with pleasure and apparent benefit. When it is remembered that the act of sitting up in her bedroom even, much less of going downstairs, and less still of driving out of doors, would not have been thought possible ten months previously, and, moreover, that a microscopic examination had determined beyond question that the growth was an adeno-carcinoma, this case seems to point to the possible power that may be possessed by trypsin of differentiating between one form of cancer and another.

In a recent volume of the Liverpool reports I published the case of a lady, æt. 36, from whom it had been decided to remove by operation a very large tumour of the left side of the upper jaw, involving all the adjacent tissues and protruding the left eyeball. All the medical gentlemen who had been consulted, and they were numerous, considered the growth malignant; and it was probably in despair of any supposed rational hope of relief by other means, that operation had been suggested. Yet, in the course of two or three months, under the influence of X-rays, all trace of the growth had disappeared. But if I had been asked why I had recommended the application of X-rays in one of these cases and treatment by trypsin in the other, I could have given no other reply than that both had been proved to be beneficial in some—though it must be admitted only in some—apparently similar cases. What we want to know is when, and on what grounds, we can rationally anticipate success. To elucidate this very obscure subject there should be a close co-operation between the clinician on the one side and the physiologist (including, of course, the microscopist) on the other. I am reminded in this connection of some wise words written by Pawlow. "My belief," said he, "extends to this: that it is only by an active interchange of opinion between the physiologist and the physician that the common goal of physiological science and medical art will be most quickly and securely reached."

It may perhaps be added that the matter discharged after the injection of trypsin (a portion of which I had the opportunity of examining), besides the physical characters mentioned by Dr. McAfee, had a sp. gr. of 1033, was alkaline in reaction, very albuminous, and contained trypsin; but as 20 fl. oz. were sometimes discharged while only 1 fl. oz. of the trypsin solution was injected, it obviously contained very much more. Whether the additional fluid discharged was the result of any solvent action produced by the drug upon the cellular or other elements of the growth, must be matter of conjecture. What is not matter of conjecture, however, is the very great improvement in the patient's condition which followed, and, as we think, was caused by, the treatment.

Not long since I drew attention, in a clinical lecture published in the *Lancet*, to the prompt relief which followed the administration by the mouth of 10-minim doses of oil of turpentine in a case of rapidly recurring hæmorrhagic effusion into the left pleural cavity, where other means, including the intrapleural injection of adrenalin solution, had signally failed. A more recent, and in some respects a more remarkable case, which seems to teach the same lesson, deserves perhaps to be placed on record. The patient, a gentleman, æt. 41, whom I had seen on June 20th, 1906, at St. Anne's-on-the-Sea, in consultation with Dr. O'Connor, suffering from hepatic disease of a serious character, was the subject, a few weeks later, of an enormous effusion into the left pleural cavity. The amount of fluid was greater than I remember ever to have seen, reaching, as Dr. O'Connor informed me on the following day, between nine and ten pints. The flow continued so long that I was compelled to leave before the measurement could be made. Re-accumulation took place rapidly, and when I saw him three weeks later the left pleural cavity was again full. I was agreed, therefore, to replace the iodide and acetate of potassium, which had been given internally, and the 10 per cent. oleate of mercury in oleic acid, which had been applied to the chest-wall, with 10-m. doses of oleum terebinthinæ, and the application of moderate-sized blisters. The report on August 24th was: "There is friction all over the left side." And during September and October there was still no reaccumulation. Of course, it may be said that credit should be given to the blisters. Truly, and the wise plan will be to use both agents. Still, severe counter-irritation by means of a strong solution of oleate of mercury had not been followed by relief—which was, however, at once experienced on the administration of the oleum terebinthinæ.

I have more than once drawn attention in these columns to the practical advantage of that complex—that curious complex, as many think it—of remedies known as Warburg's tincture in the treatment of cases of malarial fever that resist quinine, as well as other remedies, such as arsenic, methylene blue, etc., when administered in any of the ordinary ways. An illustrative example has just occurred in the tropical ward of the Royal Southern Hospital, and its relation may encourage those who are not as yet practically acquainted with the effects of the drug to employ it in obstinate and chronic cases, where strength is becoming exhausted by the fever. The main symptoms were daily recurring fever—the temperature on one occasion reaching 106.8°—profuse sweating, frequent rigors, vomiting, and steady emaciation. The patient, a highly intelligent male, æt. 31, was greatly depressed by the persistence of his illness, which, with a few small fluctuations, had continued from August 23rd, 1906, to September 23rd, 1906, when, on Warburg's tincture, of which an isolated dose had previously been occasionally administered, being steadily given twice daily, the temperature speedily fell to normal and remained so for sixteen days, when he was transferred to a surgical word for the treatment of a fistula, and there was no further rise during the remainder of his stay in hospital.

Among the methods of rapidly curing severe cases of chorea, none perhaps are so useful as the administration of large doses of strychnine or arsenic, the former of which drugs has, unfortunately, as I venture to think, fallen out of use lately. Having had ample practical experience of both of these methods, I propose to say a few words concerning them. As the late Dr. Murray, of Newcastle, pointed out in his very useful little book, entitled "Rough Notes on Remedies," doses of from 15 to 20 minims of liquor arsenicalis can often be borne three times a day for a week by even quite a young child, at the end of which time the patient is not unfrequently cured. But sometimes the drug cannot be borne.

An even better remedy is found in strychnine in those very severe cases where life seems to be in immediate danger owing to the severity and persistence of the symptoms. I am aware that the employment of the drug was urged in such cases by Trousseau, but I am equally aware that it is falling into disuetude notwithstanding the advocacy of that prince of clinicians, as well also as that of such men as Dr. Hammond, of New York, and the late Dr. Murchison. The kind of case where its best results are shown will now be related. A. R., æt. 16, had been ill for five weeks before admission under my care into the Liverpool Royal Southern Hospital. He had been unable to speak at all for three weeks, and could speak but very indistinctly for ten days previously. His pupils were widely dilated. He lay in an apparently idiotic condition, noticing nothing and scarcely able to swallow; liquid placed in his mouth having to trickle back to the fauces before feeble effort at deglutition was made. Both hands dropped at the wrists. The right leg seemed to twitch more than the left. The movements were quite as strong during sleep as when he was awake. The boy was extremely emaciated, and a strong and very peculiar odour was given off from the skin. The temperature oscillated between 100° F. and 100.5° F.; the pulse was very variable, ranging from 80 to 112. Urine and motions were passed into the bed. As soon as a little of the former could be collected its sp. gr. was found to be 1046, but it contained neither sugar nor albumen. Chlorides were present in abundance. When, on the day but one after admission, he was asked to hold out his hand, he appeared to make a feeble effort, showing apparently that he understood what was said, but that he was unable to carry out his intention. I think this was as bad a case as I have ever seen. Nothing but constant care on the part of the ward sister and nurses prevented the skin of the back and elbows from breaking down owing to the incessant chafing to which it was subject. As it was, it became very hot and angry-looking. In order if possible to quiet the extremely violent movements, several enemata, of which each contained one drachm of bromide of potassium and a little tincture of Indian hemp, were administered; but, from the first, strychnine was given, commencing with $^1/_{30}$ gr., and quickly increasing the dose till, on April 8th, he was taking $^1/_{16}$ gr.; on the 10th, $^1/_{13}$ gr.; on the 18th, $^1/_{10}$ gr. and on the 28th, nearly $./_{6}$ gr. During the whole time—after the first few days—the improvement was steady. The power of speech slowly returned. He could answer questions on April 18th, and speech seemed quite restored by May 1st. The twitchings ceased before the 13th of April, but he was miserably weak and emaciated, and was on this account retained in hospital for some weeks longer. With the subsidence of the movements his temperature became, and for a long time remained, subnormal; often continuing throughout the entire day as low as 95.6°, the pulse at the same time ranging between 48 and 60. The sp. gr. of the urine fell to 1014. He continued to take large doses — gr. three times a day—until his discharge on June 30th. He wrote his name in a very fair hand, free from tremor, on June 27th. Until the choreic movements ceased he did not appear to notice the bitter taste of the medicine; so soon, however, as they had ceased he required something to take after each dose.

My belief was that the strychnine was the means of saving the boy's life.

The amount of strychnine that can be advantageously taken in some other conditions, such, for example, as post-diphtheritic paralysis or the paralysis of beri-beri, is very great. I have now under treatment in the tropical ward of the Royal Southern Hospital, a Chinaman suffering from beri-beri, whose dose three times a day is at present ¼ gr. of the hydrochloride. From being absolutely paralysed he is now able to walk, and that without the aid of a stick, when not being observed—though he always wants more or less support from his stick when we are watching him. But, on the other hand, some people are so susceptible that much less than half that dose will cause spasm of voluntary muscles. Such was the case lately with a married lady, where a dose of 5 m. of the liquor strychninæ hydrochloridi was prescribed, to be cautiously increased at intervals of two days up to 10 m.; beyond which there was to be no increase, but a reversion slowly to the original dose. The third dose of 10 m. was followed by closure of the jaws, inability to open them, difficulty of breathing and a sensation of suffocation. Such was the description of her condition sent to me by the doctor who saw her, and all this when she was taking hardly more than one-third of the dose given apparently with great advantage to the man with beri-beri.

SOME POINTS IN THE TREATMENT OF ENLARGED PROSTATE.

By L. G. GUNN, M.D.,

Assistant Surgeon to the Adelaide Hospital, Dublin.

It is hardly possible to read the current British and American medical journals without finding every week one or more papers on the treatment of enlarged prostate; most of these seem to have been written with this purpose—to demonstrate that the author's plan of operating on the gland is the best method, and that he and he only was the inventor of the operation.

It seems to be taken for granted that some form of operation is the only possible treatment. The non-operative treatment is seldom mentioned, yet I venture to think that there are more patients at the present time treated by non-operative measures for enlarged prostates, and with a large measure of success, than there are patients who are treated by operation.

To-night I wish to deal with the broad general lines, rather than with the details of treatment, to avoid any discussion as to which operative procedure is the most useful, to remain silent on operative technique, for these points are to the surgeons present already familiar, and to those who are not engaged in operative work their recital can only be wearisome.

During the past two years I have had some opportunity of seeing enlargement of the prostate treated at three different centres of learning—at London, at Paris, and at Berlin—on diverse lines by men who had specialised at genito-urinary work. I propose now to give you an outline of these three methods and then, very briefly tell you the plan I try to carry out myself in the treatment of such cases.

At Prof. Hartmann's clinic the diagnosis was made from the symptoms, the urine examined for pus and albumin, a rectal examination, sometimes followed by the passage of a soft catheter to find out the amount of residual urine. The treatment is carried out on general hygienic lines; the patient is handed a paper bearing the following instructions: wine, beer, liqueurs, coffee, tea, all spicey foods, tomatoes, asparagus, must be avoided. Take a teaspoonful of bicarbonate of soda and dissolve this in a litre of filtered water; take a wineglass of this at each meal. Take short brisk walks; do not remain more than seven hours in bed; let the bed be a hard one. Make each morning a dry friction with a rough cloth on which has been sprinkled a few drops of spirit or eau de cologne over the entire surface of the body. Do not try to pass water oftener than is natural.

As long as the patient can pass water nothing further is done unless the urine contains pus, and the patient shows signs of septic absorption. Under these circumstances a soft catheter is passed daily and the bladder washed out with 1-5,000 oxycyanide of Hg. Should the patient be unable to pass water, he is taught to clean and pass a gum elastic catheter, and told to wash out the bladder each time the instrument is passed.

The male patients attending this clinique averaged about 150 per diem. A fair proportion of these cases suffered from enlarged prostate, yet during four weeks there I saw no case advised to have his prostate removed.

In Berlin, at Frank's Clinique, the number of patients was not so large, but the methods of examination were far more thorough. The symptoms were taken in the usual way, the urine submitted to a careful micro and macro-scopic examination; if bacteria were present, they were, as a rule, planted out. The rectal examination was followed by a cystoscopic examination of the interior of the bladder, the amount of residual urine being measured at the same time.

The treatment in cases where the urine was aseptic consisted in passing occasionally, about once a month, a full-sized metal bougie and leaving this distending the prostatic urethra for five minutes. Purgatives were freely given, and great stress was laid on this, but no attempt was made to stop beer or alcohol.

If the obstructive symptoms were severe prostatectomy was advised in all cases with aseptic urine.

In cases with septic urines a partial operation, such as Bottini's, was performed.

If the sepsis was very severe the bladder was washed out by catheter for a few days and then perineal drainage was established.

Of the treatment adopted in London I can speak with less certainty, as the time there at my disposal was very limited. The diagnosis was made by taking the symptoms and a rectal examination; microscopic examination of the urine did not seem to be the rule. The residual urine was tested by passing a soft catheter.

The treatment recommended in every case seemed to be prostatectomy.

In looking at these three methods of treatment I felt that a less severe treatment than that adopted at London might have sufficed in some of the cases, that the Berlin method of treating the more septic cases did not seem satisfactory, while some of the Paris cases would undoubtedly have been benefited by an operation.

I try to apply the following principles in the treatment of enlarged prostate:—

Let the examination of the patient be as complete as possible. Examine the urine macroscopically and microscopically, the rectum, the urethra, and the interior of the bladder, by this finding out the extent the gland is enlarged up into the bladder, the appearance of the prostate, whether suggestive of malignancy or not, the presence of calculi, the condition of the bladder walls, if sacculated, the discharge of pus from either ureter, for on these findings the treatment of the case must largely depend.

In mild cases, where the bladder wall is healthy, where the urine is aseptic, and the patient able to pass water, though not empty his bladder, I stop all alcohol, keep the bowels free, promote the healthy action of the skin, warn the patient against exposing himself to wet or cold, pass once a month, if necessary, a full-sized metal bougie. In such cases the indications for operation would be the pain being severe, the presence of calculi, the possibility of the gland being malignant. In cases where a mild chronic cystitis is present I adopt the same treatment with the addition of internal urinary antiseptics. The indications here for operation are sacculation of the bladder or signs of infection spreading to the kidneys.

In septic cases which require catheterization, wash the bladder for a week before doing a prostatectomy; the contra-indications to operation are—extreme age, great weakness, or a double pyalitis. In acutely septic cases with much fever I drain the bladder for a few days before doing a radical operation and give stimulants freely during this time.

It is possible you may think from my remarks that I am not in favour of prostatectomy. This is not the case. The operation is often admirable in its result and in many cases the only way in which a patient can be relieved from his distress, but at the same time I do think that many medical men hold mistaken ideas about this operation of prostatectomy. It is looked upon as an operation easy to perform, uniformly successful in its results and having almost no mortality. Quite lately a patient informed me that his doctor told him that the operation consisted in making a small opening into the bladder and picking the gland off the floor, the operation only lasting a few minutes. This gentleman had not seen, as I have, a urinary surgical specialist struggle for forty minutes before he succeeded in "picking the gland off the floor of the bladder." Again, after this operation a stricture may form, or if the compressor urethra is injured, incontinence may occur, leaving the patient in a very miserable condition, a supra-pubic or perineal fistula, as the case may be, sometimes persists for a long time, and causes much discomfort. Lastly, as to the risks of the operation, I would put the mortality at about 8 to 10 per cent., in spite of lengthy statistics showing almost no mortality. When I think of the age at which this operation is usually performed, the amount of sepsis often present, and the extent to which the patient's kidneys are sometimes diseased, it seems impossible to me that prostatectomy should not have a considerable mortality, and this mortality must be borne in mind in recommending a patient to submit to the operation. On the other hand, I do not think that the risks of a prostatectomy can ever be so great as those incurred by the constant use of a catheter.

PSYCHORHYTHM AND RECURRENT PSYCHOSES. (a)

By THEO. B. HYSLOP, M.D., M.R.C.P.,

Senior Physician, Bethlem Royal Hospital; Lecturer on Insanity, St. Mary's Hospital.

PART II.

(*Conclusion*).

I now pass to the consideration of some recurring psychoses which are coincidental to or alternating with metabolic processes, and for convenience I propose to discuss briefly, seriatim—

(1) Alternations;
(2) Recurring insanities of metabolic origin;
(3) Recurring insanities due to bacterial toxæmia.

Alternating conditions are always of great interest to alienists. It has long been known that nervous and mental disorders may be relieved by acute bodily disease. Acute mania, melancholia and even delusional insanities have been temporarily or even permanently relieved by some intercurrent inflammatory condition. We have in Bethlem now a general paralytic of nearly thirty years' standing whose disease was arrested by an extensive inflammation and abscess of a limb. Savage has described alternations as occurring between hysteria, epilepsy, headache, asthma, chronic bronchitis, rheumatic fever, gout, eczema, diabetes and insanity. These alternations may recur several or many times before health is re-established. The presence of a definite bodily affection is in itself sufficient guide for the treatment and most of these cases yield sooner or later to systematic treatment.

(2) Insanities of metabolic origin are, of course, due to auto-intoxication by reason of defective metabolism. They may be classified as follows:—

(*a*) Auto-intoxications from the suppression or disturbance of the functions of an organ—

Thyroid—Myxœdema, cachexia strumipriva.
Pancreas—Diabetes.
Liver—Acute yellow atrophy.
Supra renal capsules—Addison's disease.

(*b*) Auto-intoxications which occur from anomalies in general metabolism without any definite localisation—

Gout—Oxaluria.

(*c*) Auto-intoxications caused by retention of the physiological products of metabolism in the different organs—

Carbonic acid in defective respiration.
Uræmia.
Eclampsia gravidarum.

(*d*) Auto-intoxications due to over-production of physiological and pathological products of the organism—

Hydrothionæmia, ammoniœmia, acetonuria.
Diaceturia, cystinuria, also diabetic coma.
Coma carcinomatosum, etc.
Basedow's disease.

In all these metabolic forms of insanity when there is a tendency to periodicity or recurrence at more or less definite intervals, there is usually also an hereditary taint. The development and decline of the periods are comparatively rapid. The commonest forms are—

(1) *Recurrent or periodical melancholia.*
(2) *Recurrent or periodical mania.*
(3) *Circular insanity* (*folie circulaire*).

Space will not permit me to describe these types in detail. I prefer rather to refer to some of the latest clinico-pathological investigations.

Typical periodical melancholia usually begins mildly although somewhat suddenly. Recovery is followed by a lengthy period of comparatively good health until the second attack, which is more severe, and followed by a shorter period of health. The second attack may be similar to the first, and each subsequent periodical attack exhibits but few deviations. There is one form of periodical melancholia occasionally met in the male, and coinciding with a diminished output of uric acid. It sometimes recurs as frequently as at monthly intervals, and each attack may last a week or ten days. I have seen hallucinations of hearing with desperate suicidal impulses recurring time after time in one such case now under my care.

Periodical mania is more frequent than periodical melancholia, particularly in females. It is sometimes synchronous with menstruation. Sometimes these mental attacks may tend with advancing years to merge into each other, and there is diminution of mental debility without true dementia. Some observers believe that dementia is a very rare termination.

Circular insanity consists essentially of an alternation of maniacal and melancholic conditions, which either follow one another immediately or are separated by an interval. A typical case of mild form runs as follows:—Without being regarded as insane the individual passes his entire life in a periodical alternation of moderate excitement and depression. When excited, there is merely a slight change of character, and at times unusual activity. His condition may pass unnoticed by persons who do not know him well. This state passes slowly or suddenly into one of depression with reticence, general malaise and loss of appetite. Not infrequently it runs in families and it is generally to be found in individuals with hereditary taint. The female sex is more prone to it than the male. In the more severe cases the depression may pass into actual stupor, and the excitement into acute mania, with impulsive violence. Hallucinations seldom occur except in the severest cases when the change coincides with the period of menstruation. Hitherto the prognosis has been regarded as rather unfavourable, but in some cases the climacteric starts a decided improvement. In view of the recent researches by Bruce and others there is hope that more enlightened treatment may lead to better results than hitherto.

Macpherson divides the causes of toxæmia into:—

(*a*) Auto-intoxication as the result of—

(1) Physiological instability.
(2) Defective metabolism.
(3) Defective gland secretion.
(4) Auto-intoxication from the alimentary tract.
(5) Auto-intoxication from the liver and kidneys.

(*a*) **Read before the Harveian Society, February 14th, 1907.**

(*b*) Intoxication from micro-organisms introduced into the system.

(*c*) Voluntary intoxication by alcohol and drugs.

Bruce believes it is highly probable that they all depend on some degree of hepatic insufficiency, the liver failing to arrest or destroy toxines produced by any of these causes; and, secondly, renal insufficiency through the kidneys failing to excrete the toxines by the urine. Certain it is that perversions of the functions of the kidneys are very frequent in insanity and although much has already been done in this direction, there is still open a very wide field for research.

Whilst recognising that maltrutrition and deficient excretion of the waste products may cause almost any of the types of insanity other than those already referred to as being due to deprivation, the greatest interest centres around the recurrent melancholias and manias and the condition of folie circulaire. Failure in the secretion of the thyroid gland gives rise to the well-known condition of myxœdematus insanity. Excessive or altered secretion may be followed by maniacal outbreaks or other mental symptoms. The chief interest in these conditions rests in their tendency to periodicity or recurrence, and one attack, for obvious reasons, is unable to confer immunity against further attacks. In some of the very acute infective conditions, such as acute delirious mania, acute delirious melancholia, however, it is not infrequent to have no recurrence of the disease, and this in itself is in some instances suggestive not only of bacterial toxæmia, but it also suggests that immunity may be conferred in this way.

I have seen two cases of very acute delirious mania which were apparently of bacterial origin, and after careful investigation it was ascertained that in both instances the infection was derived from contact with diseased sheep. The details of these investigations are not yet completed, so I am unable to lay them before you. It must suffice for the present to say that we are merely on the threshold of lines of research which will ultimately bring the work of the bacteriologist and the alienist into very close contact.

I will now refer briefly to some of the results of the investigations undertaken by Bruce, who has carried further the work of Macphail, Krypsiakiewicz, Kroumbmiller and others.

Starting on the hypothesis that a leucocytosis between 6,000 and 10,000 per cm. of blood is what one might expect to find in health, he examined blood taken from the lobe of the ear as nearly as possible at the same hour every day just before the midday meal. The numerical counts were made with Thoma Zeiss' hæmocytometer according to the method of Coles, and never less than 40 fields were counted at each examination.

In acute mania, if examined early, there was in every case a leucocytosis of from 18 000 to 20 000 per cm., and sometimes even higher. The percentage of polymorphonuclear cells was never below 70 per cent. This lasted only a few days, then the leucocytosis fell sometimes as low as 10 000 per cm., but never lower. More generally the leucocytosis was 14,000 or 15,000 per cm. Along with this change the percentage of the polymorphonuclear cells fell, but there was a corresponding rise in lymphocytes. Any subsequent increase in excitement was attended by a further increase in the leucocytosis with a mild degree of eosinophilia of 3 to 5 per cent. With convalescence the polymorphonuclear cells diminished to between 60 and 70 per cent., whereas in many cases the leucocytosis persisted for weeks or months after complete recovery. This leucocytosis Bruce believes to be a protective leucocytosis, favouring the supposition that acute continuous mania is an acute infective disease with subsequent establishment of immunity.

In those cases which do not recover the leucocytosis tends to fall and the percentage of polymorphonuclear leucocytes may fall below 40 or even 30.

There is much to be said in favour of his theory that cases of recurrent mania might be described as conditions of continuous toxæmia with recurrent attacks of mental excitement and confusion.

Similarly the variations in the amount of leucocytosis and in the percentage of polymorphonuclear leucocytes occurring in association with the different stages of folie circulaire are highly suggestive and may lead to a more comprehensive grasp of the true nature of the morbid processes. Treatment undertaken to modify the amount of leucocytosis is up to the present uncertain and of little value.

I have avoided any discussion upon the question of the presence of bacterial agglutinines in the serum of cases of insanity. The facts at hand are insufficient to justify any definite statement.

I have avoided detailed descriptions of the features of folie circulaire, and I have not entered into any discussion as to whether it may be regarded as a distinct disease as did Falret and Baillarger, who first described it. Kraepalin describes this great class of diseases under manic-depressive insanity, and folie circulaire is now included under periodic or recurrent insanities. The practical outcome of the observations of late years may be summed up very briefly as follows:—Most of the recurrent psychoses which formerly were regarded as inexplicable are now within a measurable distance of elucidation by means of the clinico-pathological evidences of defective metabolism.

CLINICAL RECORDS.

A CASE OF RENAL CALCULUS SIMULATING APPENDICITIS.

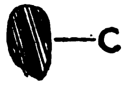
By S. J. ROSS, M.D.Vict.,

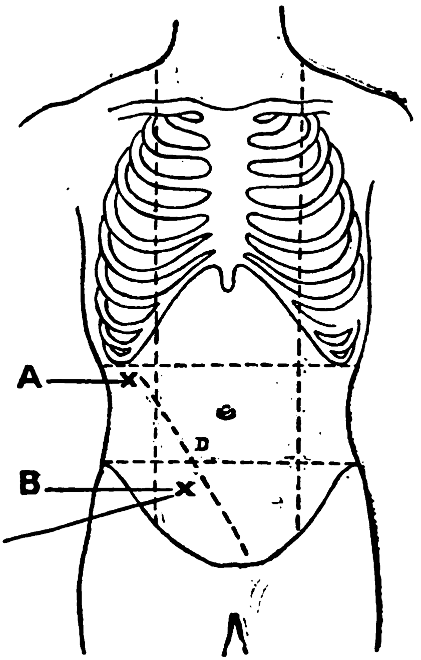
Surgeon Out-Patients, Bedford County Hospital.

I WAS called on January 15th of this year to see a youth, æt. 20, who was said to be suffering from appendicitis. He had had three similar attacks during the past twelve months.

C—Calculus passed per urethram.

Actual size.





A.—Region of pain on Jan. 6th.

D—direction

B—Region of pain on Feb. 2nd.

The present attack began on January 14th and was ushered in by shivering, vomiting and fever.

When I saw him on January 15th I found that his temperature was 101 degrees. He complained of acute pain over his right kidney. Percussion over the back of the right kidney increased the pain. There was marked retraction of the right testicle. The pain radiated downwards towards the symphysis pulvis. His urine on the previous day was very high coloured, but now was white and turbid with a white sediment.

Specific gravity 1019 alkaline phosphatic, a trace of albumin. I placed him on milk diet, told him to drink plenty of barley water, and gave him a diuretic mixture. I also told him to watch his water carefully for any sign of a stone.

On January 16th his temperature was normal and he was free from pain. On January 27th his urine was quite clear, acid and having had no recurrence of pain he determined to get up, and on January 31st returned to work. On February 2nd I was called to see him on account of intense pain situated in the region of the right iliac fossa, 1½ inches from the middle line and radiating towards the right pulvic spine. I thought that the calculus was in the right ureter and had been stopped at the narrow part of the conduit where it crosses the pelvic brim. The pain, relieved by occasional doses of morphia, finally disappeared on February 12th. On February 17th the patient passed a phosphatic stone, the exact size and shape of which are indicated in the diagram.

The previous attacks of appendicitis so called were doubtless attacks of renal colix.

There appears to be no doubt that the stone was found in the renal pelvis, and the time occupied from the first appearance of symptoms to the final liberation of the stone per urethram was 34 days.

Finally, we may note that not every pain which is referred to the iliac fossa has its origin in the appendix.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

Operation for Chronic Middle Ear Disease, Suppuration, Necrosis of Posterior Labyrinth, Facial Paralysis, Large Parotid Swelling and Pus tracking down to the Soft Palate and Tonsil.—Mr. **Arthur Cheatle** operated on a man, æt. 22, who came to the hospital on December 3rd, 1906, complaining of pain in the left temple and below the ear. He had had suppuration from the ear for a year and nine months, six months constant headache in the left temple and pain in the face; for fourteen days he had experienced some giddiness and enlarged tonsils, a limp in walking, constant high-pitched whistling tinnitus in the left ear which for four days had been very great. For six weeks there had been a large swelling in the face in front and below the left ear which had increased gradually; for one week the patient had been unable to swallow owing to pain in the act; for four weeks he had noticed that the face was drawn up on the right side; he had been unable to sleep for four nights on account of the pain; there had been no sickness. The man had been doing his work within four days of coming to the hospital. On examination there was a large tender swelling in the parotid region in front and below the left ear; there was complete facial paralysis on that side; a large polypus blocked the meatus; there was no tenderness or œdema over the mastoid or outer antral wall. There was difficulty in opening the mouth, but it could, however, be seen that the left side of the soft palate appeared full and the left tonsil was pushed downwards and inwards. The temperature was 97 and there was no mystagmus, optic neuritis, or paralyses. At the operation on the day after admission the outer wall of the antrum was dense and the cavity contained degenerated lining membrane and cheesy pus. The mastoid process was diplœtic and free from disease. On removing the polypus and granulations from the middle ear the upper and back part of the inner wall were found to be absent and the whole led upwards, backwards and inwards to a large cavity which should have been occupied by the vestibule and semi-circular canals. The cavity was freely exposed and was found to be full of granulation tissue among which was lying a sequestrum, consisting of part of the vestibule and parts of the opening of the semi-circular canals. The cochlea was intact. The anterior inferior meatal walls, both bony and cartilaginous, were represented by a ragged opening. On passing the finger through this opening it was found to lead to a cavity running down behind the jaw to the soft palate and tonsil which cavity was full of fœtid pus. In order to drain this cavity, an aneurism needle was passed to the bottom, its point after being turned up in the neck in a line with the mastoid process was cut down upon; the intervening structures were then carefully divided until the instrument was free. The cavity was well stuffed with iodoform gauze, and hot fomentations applied to the parotid swelling which, Mr. Cheatle said, was probably glandular in origin. Mr. Cheatle remarked that the case was interesting from several points of view:—(1) The absence of symptoms of labyrinthal disease in the whole history of the patient, and the fact of the man having been at work four days before admission; (2) the fact that there were no gross mastoid signs due to the anatomical condition, *i.e.*, the dense outer wall and the diplœtic mastoid process, also the intervening layer of dense bone between the cavity of the antrum and the mastoid process, a common anatomical condition which prevents suppuration reaching the surface, this condition being simply a continuation of that found in early infancy; (3) the track of the pus into the soft palate was unusual, having evidently come from the meatus behind the jaw to the soft palate. The patient's recovery was uneventful; the temperature never reached 100°, and he left the hospital at the end of January with everything quite healed. He reported himself at the end of February, having resumed work in the meanwhile. He experienced no inconvenience beyond facial paralysis and he was found to have some hearing in the left ear; the conversational voice was heard at fifteen inches, the watch at two inches and the acoumeter at four inches, demonstrating, as Mr. Cheatle pointed out, the interesting fact that the vestibule and semi-circular canals can be removed without complete loss of hearing.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

Meeting held February 8th, 1907.

The President, Mr. Clutton, in the Chair.

MEDICAL AND SURGICAL TREATMENT OF CONGENITAL PYLORIC STENOSIS.

Dr. G. A. Sutherland read a paper on

THE MEDICAL TREATMENT OF CONGENITAL PYLORIC STENOSIS.

The details of the treatment were given in connection with three cases. The aim of the treatment was to remove any source of irritation in the stomach that might maintain pyloric spasm and to keep the stomach free from any irritating food material which might excite pyloric spasm. For this purpose small feeds, frequent feeding, and food capable of being digested in the stomach were necessary. Fat was more irritating than any other constituent of food. Gastric lavage should be carried out daily at first, to prevent any retention of irritating food materials in the stomach. Progress was indicated by a cessation of vomiting, by the return of normal intestinal evacuations, by a diminution in the stomach peristalsis, by the disappearance of signs of distress and discomfort in the patient, and by improved nutrition. He had not found any benefit from treatment by sedatives, such as opium or the bromides, but advised the use of saline injections, both subcutaneously and per rectum, to supply the great need of water in the tissues generally.

Dr. A. F. **Voelcker** read a paper on

SOME CASES OF PYLORIC STENOSIS IN INFANTS.

He gave a brief description of seven cases that had been under his care in the past two years; five died. There had been altogether 39 cases in Great Ormond Street Hospital since 1897. Thirty-five of these were in males, four in females; in no instance had more than one case occurred in the same family; nine out of 34 were first-born children. Other congenital malformations occurred in only two cases. In 70 per cent. of the cases symptoms began between the second and fourth week; 21 out of 37 cases (56 per cent.) were in breast-fed children. Brown fluid was sometimes vomited, never bright blood. The gastric contents were acid and contained pepsin; 34 of the 39 cases (87 per cent.) died. Five were operated on; they all died. Vomiting was not an important point in either prognosis or pathology. He suggested that the condition might be an acquired one, due to some congenital perversion of the gastric juice.

Mr. F. F. **Burghard** read a paper on

THE SURGICAL TREATMENT OF CONGENITAL PYLORIC STENOSIS,

based upon 16 cases that had come under his own care. He pointed out that the chief difficulty at present was to know in what proportion of cases medical treatment alone might be expected to suffice. Whereas in former years most of the cases came under the surgeon's hands at an early date, the tendency at present was to delay operation as long as possible in the hope that medical measures alone would succeed. This hope was justified in a certain number of cases, and the debate would probably do much practical good by enabling surgeons to form some idea of results that were likely to follow medical treatment alone, as hitherto no extended experience had been published. Dealing with the question of operative results, 16 cases in all had been operated upon by the same method, namely, dilatation of the pylorus, and of these 11 had recovered satisfactorily from the operation, 10 remaining well, whilst one case died of convulsions within three months of the operation. The total operative mortality had been therefore 31.25 per cent., whilst the total mortality had been 37.5 per cent. The chief danger of the operation was shock, which could be minimised by careful preliminary preparation and operating rapidly in a well-warmed room. Two accidents that had happened in the series of cases quoted were rupture of the pylorus in two cases and wound of the duodenum in one. These accidents could be treated by immediate suture and were not necessarily fatal. Prolapse of the omentum and small intestines was a very troublesome complication, as it tended to prolong the operation, and this might quite well cause it to prove fatal. It was best avoided by making the incision high up in the middle line over the liver, which was hooked up to allow the pylorus to be pulled out of the wound and allowed to fall back into place at the end of the operation, so as to keep the omentum and intestines in place. The child was fed per rectum for twelve hours after the operation, after which feeding by the mouth was gradually resumed. Dilatation of the pylorus was contrasted with pyloroplasty and gastro-jejunostomy, and compared favourably with these on account of its simplicity and rapidity. No recurrence of symptoms occurred after any of these cases.

Dr. **Ashby** (Manchester) had treated 11 cases; they all died. Only one of them had been operated on. He had usually seen temporary improvement as a result of medical treatment, and had found whey of the greatest service in the feeding. The condition might deteriorate after all vomiting ceased. At the autopsies he had been struck by two points especially, first, the constant presence of marked gastric catarrh, and, secondly, the fact that the hypertrophy rarely caused complete obstruction. He thought that operative measures should be directed to the pylorus rather than to anastomosis.

Mr. **Clinton Dent** said that of 120 collected cases, including a number of unpublished ones, that had been operated on, the mortality was about 50 per cent. Surgeons rarely saw cases until the classical picture was fully established. He was against the performance of gastro-enterostomy, but thought that we should not confine ourselves to any one operation. He had a specimen in a seven months' fœtus, showing the condition well marked.

Dr. G. F. **Still** had seen 27 cases personally. Three had not been treated at all. In one the issue was unknown. Of the remaining 23, 14 recovered. Of these 14, 8 had been operated on, 5 of which were mild cases that he had passed on direct to the surgeon as had formerly been his routine custom; the other six had been treated medically, five by lavage, one by dieting only. Of the nine that died, three were untreated (moribund), three had been operated on, and three treated medically. He pointed out that the question of surgical treatment was not to be decided only by statistical mortality tables. He raised a query as to the late results of operative measures; on the other hand, lavage twice daily for months might be impracticable.

Mr. **Makins** had operated on two cases, and they both recovered, but one died later from enteritis.

Dr. **Edmund Cautley** considered that physicians were too optimistic in their views. He thought that many cases were diagnosed as hypertrophic pyloric stenosis that were really due to spasm and other conditions. In true hypertrophy nearly all the cases died unless operative measures, which therefore were absolutely imperative, were undertaken. Why was the condition never found at autopsies apart from cases recognised during life? Of twelve of his cases, nine had been operated on by Mr. Clinton Dent; none died, except for accidental occurrences, such as pneumonia, &c.

Dr. **Robert Hutchison** had seen nine cases in private practice. One was operated on and recovered. Of the eight treated medically, only one died. He thought that hospital cases did not do so well.

Mr. **Burghard**, in reply, said that in his experience hospital cases had done decidedly better.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, FEBRUARY 15TH, 1907.

The President, J. F. O'Carroll, M.D., F.R.C.P.I., in the Chair.

URINARY TUBERCULOSIS.

Dr. L. G. **Gunn** exhibited a specimen taken from a man of about forty-five years of age, who had been admitted to hospital with the usual symptoms of urinary tuberculosis. As far as they could diagnose, he had a large right kidney, from which it was thought the pus in the urine was probably proceeding. The bladder was small, contracted, and tubercular. A cryoscopic examination led to the conclusion that the patient was on the borderland of insufficiency, and the right kidney was thought to be a bag of tuberculous pus. On operating, a large kidney was found having a great deal of apparently healthy tissue in it. On exploring the pelvis of the kidney, tuberculosis was found present. He presumed he had been wrong in thinking the other kidney healthy; he therefore did not take the kidney out. The patient died two days afterwards, and the post-mortem showed that the cause of death was extensive miliary tuberculosis affecting the liver, lung and spleen. The other kidney was a tiny structure, apparently congenitally small, but perfectly healthy, though incapable of sustaining life. The primary tuberculous focus was a small chronic abscess in the prostate.

The **Chairman** said the fundamental interest in the case was the difficulty of making out whether one or other or both kidneys were involved. For many years attempts had been made to settle the matter. An observer had stated that the mere palpation of a healthy kidney was sufficient to produce some degree of albuminuria; a larger amount was produced if the kidney had been damaged previously; but if it were an utterly insufficient thing like a tuberculous mass it did not produce any. If that were established, it might give them a further and pretty commonplace test for which of the two kidneys was involved.

Professor **McWeeney** said the large kidney was a beautiful specimen of compensatory hypertrophy; the other was the smallest he had ever seen which bore no evidence of organic disease.

Mr. **Gunn** replied.

(1) LIVER WITH CIRRHOSIS AND CARCINOMA; (2) A CASE OF LYMPHATISM.

Dr. A. R. **Parsons** showed specimens of above. The first was the liver of a woman, æt. 42, who had been admitted to hospital in November last complaining of considerable swelling of the abdomen and also of the legs. The swelling of the abdomen, which had commenced three months previously, had not interfered with her until some six weeks before admission. Her previous history threw practically no light on the nature of the swelling, excepting in the one point that had a slight bearing on it—viz., that five years previously she had had a slight attack of hæmorrhoids. She was the mother of twelve children, of whom six had died in infancy. She was rather a sallow woman, but not jaundiced. Opinion differed on the ante-mortem diagnosis as to whether the condition was malignant; he held the view that it was cirrhosis, basing his opinion on the facts that the patient gave an ill-defined history of alcoholism; the liver was uniformly enlarged; the spleen was considerably enlarged; there was a history of hæmorrhoids; and the fluid obtained on tapping was clear and non-sanguineous. On the other hand, the rapid emaciation and short history of the case were supposed to suggest malignant disease. No primary focus could be palpated in any part of the abdomen. She vomited, but no hydrochloric acid was present. There was no symptom to suggest primary disease of the stomach. On opening the abdomen after death they found the liver considerably enlarged, and it was perfectly manifest she had malignant disease of the liver. It was equally certain she had advanced cirrhosis of the liver, usually attributed to alcoholism. A careful examination was made of the stomach, pancreas, intestines, uterus and ovaries; there was no evidence whatever of primary malignant growth in these organs, and the naked eye appearance of the liver, and the microscopic sections, showed that the growth was primary in the liver. There were secondary nodules in the lung. The case represented an unusual combination of primary malignant disease and advanced cirrhosis of the liver.

Dr. A. R. **Parsons**, in presenting his second specimen, said that in 1892 he had met with several cases of sudden death in children from one to five years of age, in which the only abnormal post-mortem appearance was great enlargement of the adenoid tissue of the intestines. Dr. Peacocke had described two or three cases which were identical with his own cases, and referred to a valuable paper by Dr. Ewing, of New York, who, following Paltauf, called the condition lymphatism. The cases were characterised by sudden death, frequently, but not always, preceded by convulsions; and the post-mortem revealed nothing sufficient to account for death. In the cases which he (Dr. Parsons) had met, he noted considerable enlargement of the solitary follicles and Peyer's patches; considerable enlargement of the mesenteric glands; the spleen was slightly enlarged, and a section of it showed some enlargement of the Malpighian bodies. Dr. Peacocke observed in his cases extreme enlargement of the thymus gland. Since Dr. Peacocke observed his cases no others had been reported in Dublin, and there was little information available in English literature. It was not until recently that he had had an opportunity of seeing another case of lymphatism. This was a child of seven months. He was perfectly well until the Saturday; he was brought to hospital on the Sunday at 12.30, and died at two o'clock. Simultaneously he (Dr. Parsons) had a child in hospital suffering from pneumonia. He was the same age as the other child. The viscera of both children formed a striking contrast. In the one the thymus gland was in its presumably normal condition; in the other there was an enormous enlargement covering quite a large part of the heart. It was, he thought, quite possible that a large number of cases succumbed to the condition of lymphatism, and not to convulsions.

Dr. **Pringle** and Dr. **Farnan** cited similar cases.

Dr. **Peacocke** said that when he was observing his cases he was anxious to get comparisons similar to what Dr. Parsons had got, as he felt that exaggeration was possible. He had never found any enlargement of the external lymphatic glands. He had, however, found a slight patch of congestion at the base of one or both lungs, although there was no evidence of there being anything wrong before, except a slight cold. He was sure a great many cases occurred which were ascribed to convulsions, which, however, was only a symptom of disease—not a disease itself.

Dr. **McWeeney** recalled a case similar to Dr. Parsons' first exhibit. As regards the subject of lymphatism, he did not think they had good scientific proof that death was due to the lymphatic condition.

Dr. Parsons, in replying, admitted they were not able to trace the connection between the lymphatism and sudden death, but the fact remained that the condition was found present in the cases of sudden death which he had cited, and as cases accumulated there would be fair reason to believe that there was some connection.

ORGANISMS FROM CEREBRO-SPINAL MENINGITIS.

The **Secretary** (Professor White) exhibited specimens of organisms obtained from cases of cerebro-spinal meningitis. From the first case reported he had, he said, made direct cultivations from spinal fluid obtained aseptically by lumbar puncture in broth, human blood serum, glycerine agar and litmus milk. The broth next day was barely clouded; tiny discrete grey colonies developed on the serum; the glycerine agar remained sterile. Subsequent examination showed these growths to be pure cultures of a diplococcus, sometimes seen in tetrad form, staining irregularly with simple stains like Loffler's blue and negative to Gram's stain. Microscopic examination of the cerebro-spinal fluid showed very many pus corpuscles and numerous organisms seen mainly as diplococci, but there were many tetrads and a few short chains. A considerable number of these organisms were inside the pus cells. Some of them appeared to have capsules, and like those in the cultures all were decolorised by Gram's method. He inoculated further cultures from the originals, and continued the inoculation to the fifth generation, which was still alive. The fourth and fifth had grown very well on ordinary agar, although the original inoculation on the glycerine agar was without result. He had done animal inoculations with negative results. The same organism in pure culture was obtained from later cases of the disease, but a smaller number of pus cells and fewer organisms were present, although the cases were more severe clinically. The diplococcus now exhibited had many of the characters of the organism described by Weichselbaum under name, *diplococcus intracellularis meningitidis*, but apparently differed from it in having a capsule, and in forming short chains. He was not quite satisfied that the organism was a distinct entity, but inclined rather to the opinion that it was a modified *pneumococcus*. That, however, was difficult to prove. In a previous outbreak he only got the pneumococci from a great many cases, and during that outbreak in only one case did he get an organism which, like those now exhibited, might be classed with Weichselbaum's.

Dr. **Day** gave the clinical history of four cases, the curious thing about them all being, he said, that they were perfectly clear in their intellect.

Professor **McWeeney** had observed two meningitis cases within the last few days from the Children's Hospital, Temple Street. A post-mortem was obtained in the first case, and revealed the tubercular form, limited to the cerebral pioarachnoid. From this numerous T. B. were obtained in smear preparations. A curious fact was that whilst engaged in searching through preparations of the membranes of the cord he came across a single polynuclear leucocyte, containing a few typical "biscuit-shaped" diplococci. Was it a case of mixed infection? In the second case, which was regarded by Dr. D. Farnan as typical cerebro-spinal meningitis, there was no autopsy, but he had examined about 5 cc. of fluid obtained from the child (æt. 3) by lumbar puncture. The microscopic result was negative, but he had succeeded in growing from it, as the only organism present, a gram-staining diplococcus tending to form tetrads, and growing well in the form of small whitish colonies on ordinary agar, serum-agar and blood-agar. He felt sure this could not be the organism described by Weichselbaum and found by Professor White. The speaker concluded by referring to the probability that the organism obtained access *via* the posterior fossæ of the nose, to its propagation by contacts, to its low resisting power, and to the small numbers in which it occurred even in severe cases. He could only suppose that it must be highly toxic, though of this there was no experimental evidence.

Dr. **Farnan** read the clinical history of the cases mentioned by Dr. McWeeney from notes by the house surgeons.

Dr. Parsons and the Chairman also spoke, and Professor White replied.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, February 28th, 1907

The President, Mr. **Frank T. Paul**, F.R.C.S., in the Chair.

CLEIDO-CRANIAL DYSOSTOSIS.

Dr. **J. Hill Abram** showed a typical case of the disease described by Maire and Sainton under the name of cleido-cranial dysostosis. The patient was a boy, æt. 16. The clavicles were absent, the cranium typically brachycephalic and the anterior fontanelle still largely open. The distorted vertex with the deficient development of the facial bones led to a superficial resemblance to cretinism; the absence of any solid œdema in the subcutaneous tissue and the considerable standard of intelligence attained showed that cretinism might be excluded.

Dr. **A. G. Gullan** said that certain features led him to believe that the lad was to a certain extent a cretin, viz., the full face, arched eyebrows, thick neck, short stature, lordosis of the spine and the typical waddling gait, full abdomen with unfolded umbilicus, undeveloped genitals, and absence of hair from the pubis, the coarse hair of scalp, and characteristic broad hands all pointed to a degree of athyroidism. The lad, though intelligent, was certainly emotional. Dr. Gullan considered that the combination of cretinism and the absence of the clavicles made the case even more interesting.

RECURRENT PARALYSIS OF OCULAR MUSCLES.

Mr. **R. J. Hamilton** showed a case of recurrent paralysis of the ocular muscles in a man, the subject of hæmophilia. The condition was always preceded by severe headache which lasted for some hours, and the paresis lasted from four to six months. The first attack occurred four years ago and followed a very severe and almost uncontrollable hæmorrhage, the result of tooth extraction. Mr. Hamilton suggested a neuritis, induced by the severe anæmia as a possible explanation of the paralysis.

Dr. **K. Grossmann** agreed with Dr. Hamilton that the case was one of peripheral (neuritic) origin. He had recently observed a similar case occurring after influenza, recovering and reappearing after a second attack of influenza. The second attack of paralysis recovered and recurred finally got gradually well. Similar post-influenzal neuritic attacks followed by alternate improvement and relapse had been observed in other parts of the body.

Sir James Barr and Mr. T. H. Bickerton also spoke.

CATARACT EXTRACTION.

Mr. **Richard Williams** read a note on cataract extraction mainly in reference to suppuration in the wound, and reported the case of a gentleman, æt. 88, in which the suppurative process had been arrested by the application of a 1 per 1,000 solution of perchloride of mercury after a weaker solution (1 in 3,000) had failed. He suggested that these cases were not due to the introduction of infective material from without, but to abnormal activity of the ordinary micro-organisms of the conjunctiva in certain abnormal conditions of the nervous system.

Dr. **K. Grossmann** said suppuration was fortunately very rare and when it did occur there would always be a suspicion that that infection had come from without. An inspection of the wound six hours or so after operation was generally desirable, especially after extraction without iridectomy.

Mr. T. H. Bickerton, Mr. E. M. Stockdale, and Mr. R. J. Hamilton also spoke.

MALARIA.

Dr. **J. Lloyd Roberts** read a paper on malaria, based on the study of 124 consecutive cases under his care in the tropical wards of the Royal Southern Hospital. He gave a brief historical survey of the advance in knowledge of this disease during the last twelve years, and gave proofs of the correctness of the mosquito-malaria theory. The ætiology of malaria was then considered and the life history of the various kinds of parasites met with in man was described, with lantern illustrations of each at varying stages of its existence. The correlation between their life-cycle, and the clinical symptoms was demonstrated. Lantern slides were shown of the temperature charts of the different kinds of malarial fever—benign tertian, quartan, malignant tertian and malignant quotidian—and the diagnostic differences between the benign quotidian and the malignant quotidian charts were pointed out. The symptoms of the disease were next described, and the diagnosis considered with reference to the history, source of infection, physical examination, type of fever, anæmia, leucopenia, great proportional increase of the large lymphocytes and particularly the discovery and recognition of the parasites and of the pigmented leucocytes. Cases were mentioned illustrative of the differential diagnosis between malaria and such diseases as phthisis, suppuration, ulcerative endocarditis and hepatic abscess.

Dr. **W. Carter** thought that the time had come when the word "malaria" which kept the superstition that bad air caused the disease should be abandoned for a name more in accordance with absolutely established facts. Among the unsolved problems of the disease were:—(1) the occurrence of attacks years after removal from mosquito-infected areas; (2) the apparent immunity of exceptional individuals, even after repeated bites; (3) the impossibility, in some cases, of administering quinine owing to its effects being more poisonous than those produced by the parasites. Among the more troublesome symptoms were (1) the occasional occurrence of persistent vomiting, rendering it necessary to administer the quinine by rectum or hypodermically; (2) the supervention of coma, which in his experience was best relieved by freely blistering the shaved scalp, unless (3) it was accompanied by a continuous and very high temperature, when cold baths were in addition required. In some cases of chronic cachexia, with acute exacerbations, the utmost benefit followed a course of Warburg's tincture when quinine in other forms could not be borne or failed to relieve.

Dr. C. J. MacAlister, Dr. Bradley Hughes, Dr. W. T. Prout and Dr. Wyley also discussed the paper.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT LIVERPOOL, FEBRUARY 15TH, 1907.

The President, Dr. E. O. CROFT (Leeds), in the Chair.

CARD SPECIMEN.

DR. A. STOOKES (Liverpool) showed a mixed adenoma and dermoid of the ovary, weighing 9 lbs. co-existing with a small dermoid of the opposite ovary.

SPECIMENS.

Drs. BRIGGS and EMRYS-ROBERTS exhibited (*a*) the Fallopian tubes and ovaries from a case of acute gonorrhœal salpingitis, occurring in a woman æt. 25, who had suffered from repeated attacks of pelvic pain since marriage, 5 years ago. (*b*) Cancer of the cervix uteri coincident with unilocular cyst of one ovary, and fibroma of the opposite ovary, removed from a patient, æt. 67, iv.-para, who had suffered from a sanious vaginal discharge for two years. Abdominal hysterectomy was performed. Microscopically the growth was an epithelioma.

Dr. GEMMELL showed a double pyosalpinx. The tubes were each 4 inches long and 1 inch in diameter. There were only a few peritoneal adhesions. The ovaries were unaffected.

Dr. A. STOOKES (Liverpool) exhibited an ovarian cyst with the adherent vermiform appendix successfully removed by abdominal section from a nulliparous woman, æt. 41, who had suffered from pain in the right side and menorrhagia for 6–7 years. The Fallopian tube was thickened by chronic salpingitis, and was stretched over a thin-walled cyst of apparently inflammatory origin. Beneath this lay the cystic ovary the size of an orange. The adherent vermiform appendix was also removed.

Dr. F. W. BAKER YOUNG (Liverpool) showed a safety-pin removed from the vagina of a girl, æt. 8. It had been there for two years and had caused continuous hæmorrhage.

Dr. DONALD (Manchester) described a case of ectopic pregnancy co-existing with uterine pregnancy in a woman æt. 40, iv.-para. Previous to this pregnancy, menstruation had been regular every four weeks, lasting one to fourteen days. She was delivered of a 7-months living child, eight weeks prior to admission to hospital. Three days after the confinement, her doctor noticed an abdominal swelling which increased in size and was accompanied by intermittent cutting pain in the left side. During the eight weeks following delivery there were two menstrual periods lasting seven and fourteen days respectively, the, latter accompanied by the passage of two large stringy lumps. There were no symptoms of severe pain, fainting, or other signs of hæmorrhage. An irregular swelling occupied the hypogastric and both iliac regions, and per vaginam was found to be distinct from the uterus. Abdominal section revealed a sac composed of the left Fallopian tube, containing a decomposing fœtus measuring 13 inches and weighing nearly 3 lbs. The sac was adherent to intestine, and was therefore stitched to the edges of the abdominal wound, and packed with gauze. The patient was discharged convalescent at the end of six weeks. The extra-uterine was probably synchronous with the uterine pregnancy, death of the fœtus occurring when the uterine fœtus was born.

Drs. GEMMELL and LEITH MURRAY showed a tumour of the right ovarian ligament weighing 2 lbs. and the size and shape of a cocoanut. There was a double twist of the pedicle, and the surface and substance of the tumour was deeply mottled with hæmorrhage. Microscopic section proved it to be a pure fibroma.

Dr. STOOKES (Liverpool) also described a case of fatal vomiting in a woman ii.-para, who was seven months pregnant. From the second to the sixth month the vomiting was not excessive, but for the fortnight preceding admission to hospital it was continuous and "coffee ground" in character. She was so ill that induction of premature labour was deemed inadvisable. Rectal salines were administered. Death occurred on the second day after admission from cardiac failure. At the autopsy partly digested blood was found in the stomach and small intestine, and the kidneys were congested, the other organs were normal.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 10th, 1907.

FIRST SIGNS OF PHTHISIS.

THE difficulty in diagnosing phthisis in its germinal period is well known and frequently impossible for the general practitioner. It is true some methods, such as Rontgen Ray diagnosis, the chemistry of respiration, modifications of the humours, cyto- diagnosis, etc., have been tried by some new lights, but they are beyond the reach of the multitude. However, Dr. Barot has made a study of certain clinical signs that are sufficient to reveal tuberculosis at its inception, and these he divides into two groups. The first are composed of what he considers cardinal signs, and are constant. They are four in number:—(*a*) Wasting. This sign is not absolutely pathognomic, but it is supported by the presence of the three others. (*b*) The second sign is a sensation which also belongs to neurasthenia, but is nearly always present in incipient pulmonary tuberculosis. It consists in an invincible lassitude experienced in the morning. Instead of being refreshed from the night's rest the patient feels more tired getting up than when he laid down. (*c*) The third sign to which M. Barot calls particular attention because it is new and seems to be special to the disease is a painful sensation to pressure, localised at two distinct points: along the line of the spinous processes, the apophyses, and in the sterno intercostal spaces. The vertebral sensitiveness involves one or more apophyses; under moderate pressure the sensation provoked is disagreeable, under stronger pressure it is acute enough to make the patient cry out. M. Barot attaches considerable importance to this sign, as he found it in no other affection, acute or chronic, foreign to the baccilli of Koch. The painful sternal points correspond exactly to the vertebral points. (*d*) The fourth sign, like the third, is important as well as new, and consists in an abnormal and rough resonance of the voice when the patient speaks in a low voice, and can be heard over the vertebral painful points; it differs from the same sounds in the healthy individual which are soft and similar to the vesicular murmur. Such are the four clinical signs considered by M. Barot as constant and sufficient to establish the diagnosis of consumption in its germinal period, and should be sought for in every suspicious case, and the more so as it is at this stage that a well-ordered dietary and an enlightened treatment are attended with the best results.

CAUSES OF SUDDEN DEATH.

For press reporters—and for doctors sometimes—the diagnosis of heart disease or congestion of the brain is always sufficient to explain sudden death. Yet out of 1,000 post-mortems, says Professor Duise, scarcely one real case of heart disease is found, while cerebral congestion is frequently the outcome of a fanciful imagination.

In reality the cases in which sudden death occurs are numerous. In the absence of traumatism, sudden death may occur in the course of maladies unaccompanied by any marked symptoms.

Sudden death, said M. Bruardel, is the rapid and unforeseen termination of an acute or chronic malady developing frequently in a latent manner. It is an unexpected end to an ignored or unknown disease. An individual dies from the heart, the lungs, the brain and, above all, from the kidneys.

Microscopic examination of the viscera will not explain the real cause of death in 10 per cent. of the cases.

The classification of the multiple causes of sudden deaths adopted by Prof. Duise embraces the circulatory, cerebro-spinal, respiratory, digestive and genito-urinary apparatus.

Heart.—Chronic disease, arterio-sclerosis of the coronary arteries, aortic and mitral insufficiency, fatty degeneration and sclerosis. Paralysis of the heart in convalescence from diphtheria or croupous pneumonia.

Arteries.—Congenital narrowness of the aorta. Rupture of aortic aneurism, arterio-sclerosis of the encephalic arteries (apoplexy) or thrombosis (softening).

Veins.—Rupture of a pulmonary vein near the auricle, rupture of the azygos into the right pleura, of the inferior cava (the result of a violent struggle or effort).

Phlebitis(clots passing into the circulation and producing mortal thrombus of the pulmonary artery). Latent thrombi of the meningeal sinus and venous thrombi after fractures.

Cerebro-spinal apparatus.—Thrombi of the large cerebral arteries, cerebral tumour, latent abscesses of the brain revealed by post mortem. Epilepsy, slight violence over the epigastric or laryngeal regions.

Pulmonary apparatus.—Bursting of a large vessel in hæmoptysis. Granular phthisis without any special symptoms, producing sudden death from œdema of the lung.

Ambulatory pneumonia with decrease of temperature (aged persons and hard drinkers). Thrombus of the pulmonary artery. Ambulatory diphtheria: patients found dead in the morning who seemed to be but slightly indisposed the preceding evening (croup descending the bronchi), œdema of the glottis in the course of tonsilitis; bronchial catarrh of young children.

Digestive apparatus.—Abundant hæmatemesis from round ulcer of the stomach. Perforation of the ulcer with acute peritonitis. Mortal hæmorrhage from latent tumours of the stomach. Tuberculous or cancerous ulcers of the intestine or hæmorrhage. Perforating syphilitic ulcers of the rectum (women). Strangulated hernia not recognised by the patient, invagination and volvulus discovered at the autopsy.

Genito-urinary system.—Vesical tumours hydronephrosis producing acute uræmia.

Of all sudden deaths that by the kidney, according to Prof. Bronardel, is the most frequent, and the exciting cause is to be found in the different forms of uræmia: pulmonary form (dyspnœa, œdema), gastro-intestinal form (cholera nostras), alcoholic form in drunkards.

Sudden death has been observed in the course of extra-uterine pregnancy or in abdominal collapse after a few hours.

GERMANY.

Berlin, March 10th, 1907.

At the Verein für Innen Medizin, Hr. Litten spoke on

CONTUSIONAL PNEUMONIA.

He said that he had introduced the subject twenty-five years ago at the Medizinische Gesellschaft, and based it on fourteen cases. Liman then expressedhis satisfaction that this had been done, and said that by these clinical observations pathologists were in a position to take up a more precise ætiological standpoint, and Falk reported on pneumonia resulting from maltreatment of the thorax. Since that time the subject had not been again discussed at the Medical Society.

The speaker had then discussed the matter clinically only; he now proposed to discuss it from the point of view of professional opinions by the medical referee. He had not since then made any fresh observations, but he had thoroughly exhausted the teaching of the facts that had been sent to him for the purpose of obtaining expert opinion. The immediate reason for the present paper was two cases that were recently observed. The history of one case was as follows:—A man fell from a ladder from a height of some metres, striking his thorax on a piece of wood in the fall. Immediately afterwards he became pale and giddy and vomited. Brandy and water was given him and he recovered enough to be able to go home. He felt ill that and the next day, and on the following one had a rigor, and the same evening was seen by a medical man, who diagnosed pneumonia. On the fourth day the symptoms were grave, and on the fifth the man died. The club surgeon gave the opinion that it was remarkable that a young man should die so rapidly of pneumonia; it might have been a case of contusional pneumonia. The trade society demanded an opinion from an official surgeon,who gave the opinion that there was no connection between the accident and the pneumonia, that no external signs of the accident were visible. The pneumonia arose from other causes and the pension to the man's representatives was refused. This decision was contested, and the speaker was appealed to for a superior opinion. This was given to the effect that a connection between the accident and the pneumonia might be assumed with certainty and that the claim of the deceased's representatives was a proper one. This was the decision of the Court.

He preferred the expression contusional pneumonia in place of that of traumatic pneumonia, as the physical force was a "dull" or "blunt" one that led to compression of the pulmonary tissues. In these cases marks were scarcely ever seen externally, even when the lung tissue or heart was lacerated. The pneumonia did not occur where the contusion had taken place, not even on the same side. It was to be observed that tuberculous infiltration formed a place of lesser resistance. Contusional pneumonia affected people of younger years, who by preference had to perform heavy tasks. As regarded the immediate cause it was always a fall, a blow, being run over, injury from kneeling on the thorax, etc. The second case was specially noteworthy ætiologically. A carriage weighing 30 to 35 cwt. was off its frame and was being lifted on again by four men. One of the men immediately afterwards fell (March 20th) and had to be carried home. On the 22nd he had pneumonia, and on the night between the 23rd and 24th he died. The medical attendant had conceded in his report the connection between the injury and the death and admitted the claim for compensation on the part of the relatives. The official medical referee had, however, denied that there was any connection. The speaker was appealed to for a superior opinion (obergutashten). He was for the connection and confirmed the first opinion. He did not know then what the judicial decision had been. He had had three other cases before that of fatal pneumonia which had followed in a short time on the lifting of heavy weights. In one case the man had hæmoptysis immediately afterwards. For the rest it was not always a pneumonia, strictly speaking, but rather a hæmorrhagic infarct was formed. A case of importance was recorded as the Berlin Medical Faculty had given an "opinion." The case was that of a temperate young man. On May 25th, 1901, a heavy stone flag, weighing 5½ cwt., was being lifted. One of the workmen suddenly dropped his lever, complained of pain in the chest, and spat up blood. On the 27th pneumonia had developed and the patient died soon afterwards of gangrene of the lung. Two "opinions" had been given that there was no connection between the lifting and the inflammation. A "higher opinion" of Revers was to the effect that there was no bruising of the chest, and that the possibility of the healthy lung tearing could not be conceded. The Berlin Medical Faculty was now called on for its opinion. This was given by V. Leyden and Kraus, and was to the effect: (1) That other cases were already known in which pneumonia had followed the carrying of heavy weights; (2) the case must be looked upon as one of contusional pneumonia and a connection between the lifting and the pneumonia was in a certain degree probable. The speaker confessed that he did not understand this expression. After the premisses the strict concession of a connection would have been logical. As regarded the circumstances under which in lifting heavy weights tearing could occur he was of opinion that it could easily take place on deep inspiration. He had claimed that the earlier the pneumonia came on after the straining the more likely was the connection between the two; he had fixed the intervening period at two days. Aufrecht and Buch-Hirschfeld had given eighty hours in one case. He had himself now lengthened the period to four, five, or six days. Later occurring cases had been reported. One patient after an injury was brought home, felt ill the first day or two, but was not confined to bed, and even worked a little. On the sixth day he had to take to bed, and on the ninth a doctor was called in, who found pneumonia of a whole lung; which on the tenth day proved fatal. In another case a block of stone weighing 10 to 12 cwt. fell against a man's chest. He went pale, was taken home, and again did a little work. Ten days afterwards pneumonia and pleursy were diagnosed, and four days afterwards he died. Senator gave the opinion that the pneumonia had already existed four or five days when the man was first seen, and that the disease was certainly connected with the accident. Senator added that even in a less probable case the death must be attributed to the accident happening to an already weakened body. V. Leyden went farthest, however. A workman fell from a ladder, he still worked a fortnight, then got pneumonia and died. V. Leyden assumed a connection between the accident and the disease. In the speaker's experience pneumonia already present was influenced for the worse by the traumatic shock. As no certain day could be named as that on which contusional pneumonia would arise, each medical referee must decide for himself. But it was necessary in coming to a decision not to satisfy one's self with a *non-lignet*; the judge would then not know where he was. As regarded the man's doings between the accident and the disease, there was no normal condition; one man worked on, another ceased work, another worked with interruptions.

As regarded symptoms, they did not differ from those of ordinary pneumonia. Hæmoptysis was perhaps a characteristic. This was often very diffuse and arose from the laceration of lung tissue. Recovery generally took place. There was one death in his fourteen cases.

AUSTRIA.

Vienna, Mar. 10th, 1907.

Tænia Cucumerina.

At the Gesellschaft, Pollak showed a six months' child which for the last four months had been passing by the bowel daily small reddish white bodies about 1 centimetre long, and two broad, having all the appearance of miniature gherkins. The microscope revealed their nature to be segments of the Tænia Cucumerina, which is often found in the alimentary canal of the dog and cat, but rarely to be met with in the human being. The etiology in this case is somewhat interesting. When the child was five weeks old the mother with the infant went to visit a friend of the family who had a cat that lay in the bed with the infant. Three weeks after this occurrence the first segment was observed to pass from the child, which Pollak considers the necessary period for the growth of the worm from the ovum. The presence of the entozoon had no untoward symptoms, the infant remaining healthy and well. With the object of removing it from the canal he proposed to use kamala the dose of which is from 0.5 to 2.0 grammes; failing in this he may try Ext. Filicis Maris in cautious doses.

Digital Malformation.

Homer next produced a patient with a malformation of the left hand, that led to a wrong diagnosis of the initial stage of tabetic paralysis from the thickening of the left thumb. It appears that the patient was born with an abnormally long index finger, which gave trouble and was partially removed 28 years ago, owing to its excessive length. The cicatrix can yet be seen. The thickening of the thumb, which is only in the soft tissue, seems to be connected with this cosmetic operation.

Functional Treatment of Pes-Varus and Valgus.

Semeleder treated the members to a long and comprehensive method of treating flat-foot and club-foot without any surgical operation. He presented examples, very wonderful in themselves which had been corrected by his functional or automatic method and the assistance of a shoe which he has ingeniously devised for this purpose. The body weight is the chief factor in the production in the pes valgus and varus. Remove this, he affirms, and you prevent the deformity. With this origin in view, he arranged a boot with a lever at the sole of the foot and another in the upper part of the leg, making the angle of projection the fulcrum. In the standing or walking posture the weight bears on the horizontal bar, which turns on the "hypomochlion" that adjusts the distortion.

The first patient was a heavy person of 120 kilograms, or 18.8 stones, who had suffered, according to photo, very badly from pes valgus but now by this functional method was quite restored and lay in the normal position. The second patient was one that had been quite unable to walk without great pain. With this shoe he was able to move about without the slightest pain after a few days. At the same time, the twisted foot was adjusted and within six weeks was almost restored to its normal position and could move about without an instrument, free from pain. The third was a paralytic form of talipes valgus, which had been corrected by the same method. Eiselsberg thought this method of treating talipes was an excellent form of therapy and hoped that all the results would be verified by other favourable results. Handek thought this was Baly's idea improved on, the principle of twisting the deformed part into position. He was of opinion that the tests exhibited were not sufficient. Hovorka remarked that three years ago the "supinationsbrett" was introduced with great benefit in talipes, but Semeleder's instrument had the advantage of turning the foot into the correct position at every step the patient took. Friedländer expressed great satisfaction with Semeleder's method, which he had practised in Wilhelm's hospital with excellent results.

The Commission of Inquiry into the health of Belfast, appointed by the Local Government Board for Ireland, commenced sittings on March 5th, under the presidency of Colonel Harding, ex-Lord Mayor of Leeds. The other members of the committee are Dr. L. W. Darra Mair, one of the medical staff of the Local Government Board, England; Dr. K. Chalmers, medical officer of health of Glasgow; Mr. P. C. Cowen; and Colonel Dr. E. Selim, of the British Local Government Board, with Dr. T. P. Nolan as secretary.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Presentation to Sir Henry D. Littlejohn.—An interesting ceremony took place in the Hall of the Royal College of Surgeons on March 8th, on the occasion of the presentation to Sir Henry Littlejohn of his portrait, painted by Sir George Reid, R.S.A. In making the presentation, Lord Stormonth Darling said that the confluent streams of medicine and of law met that afternoon to do honour to their old friend and teacher, Sir Henry Littlejohn. Those of them who had been law students had reason to look back with satisfaction to the days they spent in the little room in the Police Office under the tuition of Sir Henry. Personally, he had never learned so much in so short a time from any other teacher. They all knew the extraordinary vivacity and humour, and, above all, the clearness with which he explained the subjects he dealt with. In the discharge of his duties as Police Surgeon and Medical Officer of Health, Sir Henry had won golden opinions, and had come to be looked upon as a leading medical expert. Dr. John Smith, speaking as the oldest medical friend of Sir Henry, referred to the esteem in which the latter was held. It was unnecessary to do more than recall the eminent services Sir Henry had rendered both in a civic and academic capacity, and to contrast the sanitary condition of the town now with its condition when the medical officer of health first took up his duties. Virtue was doubtless its own reward, but this was an occasion for showing in a tangible form their appreciation of services rendered. Sir Henry Littlejohn in reply said that the present was a most flattering incident in a busy life passed amidst those keen critics, his medical and legal brethren, in a great centre of medical and legal education. He had lived, so to speak, in the open air, and he had to acknowledge the unvarying indulgence shown him by his medical brethren in the discharge of the delicate duties of police surgeon and medical officer of health. On looking back over a long series of years, he was not conscious of ever having made an enemy. Sir Henry then spoke of his alarm when he had heard that he was to have his portrait painted, and his pleasure when he found that the distinguished artist made the twelve sittings a pastime with his varied talk and vivid memories of the great men who had sat to him. He was proud in possessing such a portrait, and should have pleasure in passing it down to his family. Amid great discouragement he began the practical teaching of forensic medicine, and for forty years taught it with increasing success in one extra mural school. He could easily recount the changes he had witnessed in the Courts of Law and Municipality during a long life, and he had often been asked to write reminiscences of life and character in his native city. But, alas! he found that he, too, often had to deal with the painful and tragic in domestic life, and that the events were too recent to justify him in drawing aside the veil that must, for a time at least, be left untouched. He solaced himself with memories of friends whose cheerful intercourse had gladdened his life and had left him the pleasant heritage he could maintain in his old age—a pleasant demeanour and a cheerful countenance. Old age, did he say? He would rather repeat the words of Sir William Turner—"perpetual youth." He had enjoyed an unusual spell of long life and good health; but thrice (would they believe it?) had the startling words *mene mene, tekel, upharsin* been thrown on the screen of his life to his saddened gaze. On three occasions he had been sentenced to death by distinguished medical men, who had reported to their respective insurance companies that that poor fellow Henry Duncan Littlejohn was a bad life and would soon shuffle off this mortal coil. He had had the melancholy satisfaction of following the remains of these doctors to the grave. The meeting had given him a fresh lease of life, and he hoped with cheerful heart, God willing, to live on to the end of his natural life. The ceremony was attended by a large number of Sir Henry's friends and admirers, including the President of the two colleges, many of the Lords of Session, members of the bar, the university, and the legal and medical professions.

BELFAST.

The Samaritan Hospital.—The annual meeting of this institution was held last week, the Lord Mayor (the Right Hon. the Earl of Shaftesbury, K.C.V.O.) presiding. Dr. John Campbell read the medical report, which showed that during the year 526 patients attended the extern department, and 176 were admitted to the wards. The operations numbered 144, and there were seven deaths, six after operation and one from inoperable cancer. The surgeons regretted to report that on several occasions they had to refuse patients admission owing to lack of funds.

The Health Commission.—During the past week the much-talked-of Health Commission has begun its sittings, and has continued on four days to inquire into the health problems of the city. The Commissioners are Colonel Harding, ex-Lord Mayor of Leeds; Dr. Chalmers, medical officer of health, Glasgow; Dr. Mair, a medical inspector of the English Local Government Board; Surgeon-Colonel Flinn, who holds a similar post under the Irish Board; and Mr. P. C. Cowan, chief engineering inspector under the Irish Local Government Board. Day by day the large committee room of the City Hall has been crowded with City Councillors, Water Commissioners, members of the Citizens' Health Committee, and others interested in the inquiry. Counsel have been employed by some of the bodies interested, but will not be allowed to cross-examine witnesses. The examination is on oath. The first witness was the Registrar-General for Ireland, who gave evidence regarding the population of Belfast and the death-rate. Owing to the rapid increase of population it is uncertain what the exact population is, and, of course, the death-rate varies with the different estimates made. It is probably about 380,000. After Mr. Meyer, the assistant town clerk, had given some formal evidence, the Chairman of the Public Health Committee, Dr. King-Kerr, was examined at length. This is the gentleman who has had the most acute differences with his professional brethren during the past year, as they consider that he is largely responsible for the appointment of the present medical officer of health. He gave evidence regarding the distribution of insanitary areas in the city, the working of the refuse destructor, the provision of hospital accommodation for infectious cases, and some minor points. No doubt he will be heard again, as much of his evidence will be traversed by medical and other witnesses representing the Citizens' Association, the Ulster Medical Society, and other bodies. For three days Dr. W. H. Bailie, the medical officer of health, was submitted to a searching examination, and even those who most strongly opposed his appointment to his present post last year were sorry for him in his most unenviable position. Of course the first points brought out were that he had been a general practitioner and a member of the City Council, and had no previous experience of his special work. Question after question was put to him by Dr. Chalmers regarding the sanitary state of the city and the means used to discover and deal with breaches of the city by-laws, and as he bravely struggled with his difficulties the Chairman asked him if it would not be better simply to say he did not know. Asked about the by-laws of the Corporation, he said he had no time to read them, and it seems as though most of them were not worth the paper on which they were printed, for all the attention anyone pays to them. For instance, though there are nearly three hundred schools in Belfast, all subject to the by-laws regarding overcrowding, and though it is admitted that many, if not most, are far over-crowded, no record was forthcoming of anyone ever having been prosecuted for such breach of these by-laws, and this is only one instance out of many. On the fourth day, Mr. H. A. Culter, City Surveyor, formerly of Leinster and Cork, was examined, and gave evidence regarding the frequent flooding of parts of the city, and also regarding the building by-laws. He explained that the floods were caused by the rapid draining of the rainfall on the hills through the city, and estimated the cost of proper flood works to prevent such floods at from £60,000 to £100,000. The building by-laws were not at all up-to-date, he said, and were often difficult to apply to special cases. He made the significant admission that in many cases the would-be builder appealed from his decision to the Corporation or one of its Committees, and might obtain leave from them to put up some building which did not, in his opinion, conform to the by-laws. As property owners and jerry-builders are largely represented on the Corporation, it is easy to see the effect of such manœuvres! The Commission will not sit again till March 19th, their arrangement being to sit four days a week on alternate weeks. Professor Symmers will give evidence at an early date regarding the water supply, and it is expected that his predecessor in the Chair of Pathology and Bacteriology, Professor Lorrain Smith, now of Owen's College, Manchester, will also give evidence on the same subject.

CEREBRO-SPINAL MENINGITIS.—During the past week 32 new cases of cerebro-spinal meningitis have been notified in the city, and 15 deaths have occurred. The total number of cases now reaches 162, with 90 deaths.

LETTERS TO THE EDITOR.

THE QUACK MEDICINE TRADE.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The letter from Mr. Henry Sewill in your last issue is direct and cogent, and is a pleasure to read in these days of dilettante selfishness. Probably some of your readers, however, will think with me that the remedy for the present state of things does not lie altogether in the hands of the medical profession. I very much doubt if the passage of the various Medical and Public Health Acts in this country were directly due to medical organisation, although doubtless they had a say in the matter. Surely Mr. Sewill credits statesmen and politicians with very little acumen when he says that they are "ignorant of the nature and extent of existing evils." It must surely be evident to any man of culture and enlightenment, for instance, that a quack cannot cure locomotor ataxy or elmsei, and that one medicine cannot be a specific remedy for a hundred diverse ailments, let alone the difficulty of first diagnosing the nature of the trouble. But when Mr. Sewill comes to the question of a Royal Commission as the only effectual way of informing "statesmen and politicians" as well as the general public, of the gross evils of quackery, then we are with him. Obviously and clearly it is "the only way." It would be a great service to the medical profession as well as to the public if you, sir, were to adopt this idea as a policy to be pressed to the front at all times and at all hazards. If I may be allowed to say so it requires somewhat of the powers of a Hercules to attack this hydra-headed monster, representative as it is of so many wealthy vested interests. Worst of all, the purity of the British press is daily defiled by the insertion of quack advertisements that are for the most part deliberate and patent frauds. Surely the least paternal of governments would be galvanised into action by the report of a Royal Commission. I trust, sir, as a true friend of the medical profession, you will resume your powerful advocacy of what I for one believe to be the only way of opening the door to much-needed reform.

I am, Sir, yours truly,
A COUNTRY CORONER.

Wales, March 11th, 1907.

[We have no intention of letting this matter drop. —ED. M.P. & C.]

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is rarely I am tempted to take up my pen and write to the journals, for a lifelong experience as a general practitioner hardly tends to develop the habit of literary expression. However, I am moved in the present occasion to enter my emphatic approval of Mr. Henry Sewill's proposal to demand a Royal Commission upon the subject of quackery. How else can the public get at the facts of the case? The newspapers are gagged by the quack advertiser. Can Mr. Sewill show the medical profession how to organise? Can he give us a plan of campaign, as he has furnished us with a war cry? My mite will be forthcoming, if wanted, for the war chest.

I am, Sir, yours truly,
WESSEX.

March 12th, 1907.

OBITUARY.

WILLIAM H. PEARSE, M.D.

IN recording the death of this gentleman, we do it with grief as that of an old friend. For upwards of forty years, Dr. Pearse has been a subscriber and contributor to this journal, and many valuable contributions from his pen may be found in its past volumes. He was, moreover, personally known to us as a large-hearted man, courageous in his opinions, and extremely courteous to those who differed from him. It may be said of him that he literally worshipped his profession, and anything he did or wrote of medical import was done with the sole object of throwing light on some obscure subject, or of furthering the advancement of medical science. Deceased was of commanding presence and possessed a robust constitution, having travelled extensively and occupied Government posts in Australia, the West Indies, &c. Up to a few weeks since he was apparently in the best of health, but caught a chill during the recent severe weather, gastritis supervened, and he died of exhaustion on Thursday last in the 77th year of his age. Dr. Pearse, after retiring from Government service, settled in private practice in Plymouth thirty-five years since, and enjoyed from that date until his death the ungrudging respect of his fellow townsmen, an extensive practice, and the veneration of the poor, by whom he was regarded as "the good Samaritan." Dr. Pearse was twice married, and leaves a widow, a son, and two daughters, for whom the deepest sympathy of a very wide circle is felt. The son, Dr. W. W. Pearse, holds a medical appointment under the Government at Hong-kong, and is at present at Plymouth.

WILLIAM HEATH STRANGE, M.D.ABER. M.R.C.S., L.S.A

WE regret to record the death of Dr. Heath Strange, for over fifty years one of the best known and most highly esteemed medical practitioners of Hampstead. Dr. Strange was educated at St. Thomas's Hospital and Aberdeen University, and after taking the diplomas of M.R.C.S. and L.S.A., graduated M.B. and C.N. in 1865. The next year he proceeded to the M.D.. Settling in Hampstead, he was eventually elected on the staff of the Hampstead General Hospital, and also to the Hampstead Provident Dispensary, both of which institutions he served for many years. The chief contribution to the medical literature was the article on "Diseases of the Rectum and Anus" in "Pirrie's Surgery."

ALLAN MACFADYEN, B.SC., M.D.EDIN., F.I.C.

WE regret to announce the death of Dr. Allan Macfadyen, who died on March 1st. at the age of 46. He was born in Glasgow, and was educated at the Collegiate School, Edinburgh and at Edinburgh University, and in London, also studying at Göttingen, Berne, and Munich. From 1889 till 1892 he was Sanitary Research Scholar of the Grocers' Company. He was formerly professor of bacteriology in the College of State Medicine, Great Russell Street, and afterwards bacteriologist at the Lister Institute of Preventive Medicine at Chelsea. He had been Fullerian Professor of Physiology at the Royal Institution, and was a Fellow of the Institute of Chemistry and of the Royal Medical and Chirurgical Society. Dr. Macfadyen was a contributor to the Proceedings of the Royal Society and to professional publications, and was the author of a paper on the "Chemical Action of Bacteria on Albumens and Peptones," published in the Local Government Board Reports, 1889.

HON. ALAN HERBERT, M.D.

IT is with deep regret that we announce the death of the Hon. Alan Herbert, M.D., which occurred on March 9th, at his residence in the Rue Duphot. The news of his death will come as a blow to the British colony in Paris, of which he was the doyen, and to friends in France and England, as no one could have been more universally beloved. The brother of the late Earl of Carnarvon, Alan Molyneux Herbert was educated at Harrow and at Christ Church, Oxford, and came to Paris for the purpose of studying medicine, where he took a brilliant degree. After a competitive examination he became house physician at one of the Paris hospitals in 1865, and soon afterwards he entered on the active practice of his profession. When the war broke out between France and Germany Dr. Herbert remained doing splendid service with the ambulances, and in 1871 he was appointed physician to the Hertford British Hospital, a position which he retained until a few years ago, when he retired. For the many valuable services which he had rendered during the siege of Paris and afterwards, Dr. Herbert was created a Knight of the Legion of Honour and only lately he was promoted to the rank of officier of the Order. Dr. Herbert was a little over seventy years of age, but until recently there had been every hope of his continuing in health and strength for a long time.

SPECIAL ARTICLE

THE UNIVERSITY QUESTION IN IRELAND.

THE important issue as to the form the Government proposals with regard to University Education in Ireland should take is being warmly debated and it is now known from an announcement made in Parliament that the promised legislation will not be introduced till after Easter.

Although no official report has been published of the attitude adopted by the General Assembly of the Presbyterian Church towards Mr. Bryce's proposals, it appears from a paragraph which has been going the round of the press that, while there was practical unanimity as to the amendments necessary in order to bring the proposals into harmony with the recognised non-sectarian policy of the Presbyterian Church, there was at the same time a very substantial minority of those present opposed, on academic expediency as well as on grounds of public policy, to the solution of the question by means of the establishment of one National University. The minority also considered that while Dublin University and Trinity College required large reforms it would not be in the interests of higher education in Ireland to deprive them of autonomy by merging them into a University governed and controlled by divergent and antagonistic educational ideals.

A meeting of the Catholic University School Union was held last week under the presidency of Professor E. J. McWeeney, M.D., at which the following resolutions were adopted. :—

On the motion of Sir A. Chance—

"That this meeting of the Catholic University School Union hereby welcome the declaration of the Government's intention to deal immediately with the question of University education in Ireland."

On the motion of Dr. O'Carroll—

"That no scheme for University Education in Ireland providing a College acceptable to Catholics can be satisfactory unless such College be within the University of Dublin, with endowment and autonomy on a par with those enjoyed by Trinity College."

It may be remembered that Professor McWeeney, who is a Fellow of the Royal College of Physicians, gave evidence before the late University Commission, in which he strongly criticised the attitude which he maintained was adopted by the Royal College towards Roman Catholics. This criticism naturally caused a great deal of indignation amongst the Fellows of the College, and was especially remarkable coming, as it did, at a time when the President of the College was a Roman Catholic. We understand that the College have registered a strong opinion to the effect that there was no justification for Dr. McWeeney's evidence.

A meeting has been summoned by the Provost of Trinity College, on the requisition of the Dublin University Defence Committee, which all graduates and past and present members of the College are invited to attend. It is to be held on March 22nd, in the Examination Hall of the College, and admission will be by ticket. All who propose being present are requested either to sign their names (with address) in the porter's book, or to send a postcard to the Committee so that proper arrangements can be made.

Those who are opposed to the proposals should note that the President of Queen's College, Galway, is against the scheme, not merely because his own College is omitted, but on general grounds as well.

An interesting illustration of the principle that blood is thicker than water is to be found in the fact that a largely attended meeting of graduates of the University of Cambridge was held at Caius College, Cambridge on March 2nd, to support their brethren of Trinity College, Dublin, in resisting any encroachments on their interests. Sir Robert Ball presided, and among those present were the Master of Trinity, Cambridge, the Masters of Christ's, Pembroke and Corpus, the Vice-Chancellor, Mr. S. H. Butcher, M.P., and Mr. J. F. P. Rawlinson, M.P. (the members for the University), Professors Sir George Darwin, K.C.B., Ridgeway, Howard Marsh, Bonney, Clarke, and many other distinguished men. After an eloquent speech by the chairman, Dr. Butler, Master of Trinity, moved the first resolution :—

"That we desire to protest against any legislation which would transform the University of Dublin into a University comprising colleges identified with different religious denominations and animated by conflicting educational ideals; such change must be attended by the introduction of sectarian division into the administration of the University, and must subject teaching and research to limitations injurious to liberal education and free inquiry. This protest is not made on any political grounds, but solely in the interest of liberal education."

Dr. Butler said that he begged to say that he sympathised with all his heart with every word in the resolution he had moved. If the Roman Catholic laity of Ireland desired a University in Dublin controlled by their Hierarchy, he thought English statesmen ought to grant it, and not be deterred by the Protestant feeling of England, Scotland or part of Ireland. But it was one thing to give to Roman Catholics a special form of higher education, to be conducted by their own faculty if they wished it, and a totally different thing to them when they asked for the pulling down of the large part of one of the noblest and most ancient of the institutions in Ireland.

The Master of Christ's (Dr. Piele) seconded the proposition.

Professor Joly supported the resolution and thanked the members of Cambridge University in the name of Trinity College, Dublin, for their kindness in coming there that day in their support.

The resolution was carried unanimously.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Management of Bowel of Doubtful Vitality in Operations for Relief of Strangulated Hernia and Intestinal Obstruction.—Hall (*Amer. Jour. Obstet.*, February, 1907). There is a group of cases in hernia and obstruction operations where the surgeon is in doubt as to the vitality of the injured portion of bowel, and it is to the treatment of this uncertain condition the writer wishes to call attention. He has devised a means which has proved eminently satisfactory in a number of cases. The method consists in employing a single layer of iodoform gauze about three inches broad, placing it against one side of the mesentery and carrying it over the diseased bowel until it rests upon the mesentery of the opposite side, extending a couple of inches beyond the bowel of doubtful vitality upon each side, and placing this loop of bowel surrounded by the gauze just inside of the abdomen. The wound is dressed in the usual way, leaving the end of the gauze surrounding the bowel projecting out of the wound a foot or more. Immediately after operation the peritoneum commences the process of walling of the gauze, which fixes it by adhesive inflammation, and by the end of three or four hours it is thoroughly walled in with a layer of lymph. The perforation is not likely to occur for three or four days, or later, and by that time the gauze is thoroughly walled off, and if leakage of pus or fæces occurs, there is a ready exit for it along the strip of gauze through the open wound, and a temporary anus is established. Within a day or so after this occurs the gauze can be removed and replaced by a drainage tube.

F.

Abdominal Sinuses.—Pierce (*Amer. Jour. Obstet.*, February, 1907). Upon examining several of these discharging pockets, we find a ready means of classifying them by the character of the discharge. (1) The serous sinus, (2) the mucous sinus, (3) the true fistula. The serous sinus is essentially an unhealed abscess, tubular in form, the walls of which are lined with granulations exuding serum and kept open because of the inability of the deeper portions to cicatrize. The predisposing causes are constitutional diseases, tuberculosis, cancer, or syphilis, and among the local causes are drains of gauze or tubes, silk ligatures, calculi, clamps, needles, suture ends, &c. In the treatment a bacteriological examination of the discharge to determine if infection be present should first be done. If absent germicides are of no use, examine for foreign material, and if present, remove, and then direct attention solely to increase the reparative powers of the tissues. Mild stimulants, such as balsam of Peru, or emulsion of Aristol, or 1 in 500 solution of formaldehyde used daily, have proved successful. Mucous sinuses are not unlike the foregoing, but examination of the discharge proves it to be mucous, broken down mucous membrane, and pus. There are three organs which may furnish it—a gall bladder with occlusion of the cystic duct, an appendix with occlusion of its proximal end, and a fallopean tube occluded at or near its isthmus. There is one other source of a pseudo mucous sinus, and that is a ruptured ovarian cyst or a remaining portion of cyst wall. The prognosis in mucous sinus is bad, unless operated upon, no other form of treatment being of any avail. Fæcal fistula, considering the grave lesion and character of the organs involved, the prognosis is surprisingly good. Spontaneous healing occurs in 55 per cent. of cases, and Hirst says, "the majority of fæcal fistula close spontaneously in a few days; if not the case should be treated expectantly for nine months. If it does not close in a year it probably never will." Secondary laparotomy for closure has a mortality of 25 per cent. As soon as the leakage occurs the fistulous track should be cleaned thoroughly at frequent intervals with some antiseptic, and the canal closely packed with iodoform gauze saturated with balsam of Peru, stopping just short of the intestine. The dressing should be removed daily. When this opening has become quite small the bowels should be thoroughly cleared out by some cathartic; then the peristalses should be checked by morphia and kept at rest for one week, giving concentrated food, and then the bowels should be moved by enemeta. This procedure may have to be repeated several times.

F.

Pyelitis Complicating Pregnancy.—Meek (*Amer. Jour. of Obstet.*, February, 1907. The pyelitis to which the author refers is an acute inflammation which develops during pregnancy, and is dependent in some way on the pregnant condition for its causation, in some cases partially subsiding before completion of gestation, and where usually all signs of the inflammatory process pass off in a few weeks after delivery. The symptoms consist of history of pain in right kidney region, running down the ureter coming on rather suddenly, and accompanied with chills, fever, sweats, digestive disturbances, emaciation and urinary irritation. Examination of the urine shows it to be acid, containing pus and epithelial cells, quantity of urine is not diminished and micturition is not painful though frequent. It should be kept in mind that at the very onset of the disease no pus may be found in the urine—nothing, perhaps, but a trace of albumin and a few hyaline casts. Pus, however, soon appears. The etiology of the condition, according to Vinay, depends on two factors:—(1) compression of the ureter by the pregnant uterus; (2) infection of the urinary track above the point of compression. In all reported cases in which a bacteriological examination was made of the urine, with one or two exceptions, the infecting organism was found to be the colon bacillus. From personal experience the author agrees with Cragin, "that the interruption of pregnancy is seldom if ever necessary." The medical treatment consists of rest in the recumbent posture, fluid diet, largely of milk and large quantities of water, laxatives and saline purgatives, with urothropin in 5-grain doses largely diluted every four hours.

F.

The Influence of Disinfection of the Vagina on Puerperal Morbidity.—Since the statistics concerning antepartum douching of the vagina contradict each other, and the question is still undecided, it has been taken up again by Baisch under the supervision of Döderleim (*Archiv. fur Gyn.*, Bd. lxxix., Hft. 2). Firstly in order to exclude all other sources of infection' indiarubber gloves were always used during examination, cleansing and disinfection of the vagina and the external genitals. Secondly, in order to exclude extra-genital diseases a bacterial examination of the lochia was made in all fever cases. Thus, through recognition of the microbes, it was also possible to separate the infection on an actiological basis. In a thousand spontaneously delivered women five hundred were douched at the beginning of labour, five hundred were not. Corrosive sublimate solution 1:1000 was used. First it must be mentioned that the results showed that there was no difference whatever between those cases in which internal examination were not made at all and those in which they were made with gloves. Among the five hundred who were not douched 40 got fever (8 per cent.); among the five hundred who were douched 64 got fever (12.8 per cent.). If one divides the lying-in periods of those who got fever into disturbed, that is—a single rise of temperature over 38.5° in the rectum—and diseased, it is found that severe and moderate disturbances were about twice as frequent in those who were douched as in those who were not douched. The very important bacteriological examinations demonstrated that true streptococcal infection was present in 38 per cent. of those who were douched and in only 23 per cent. of those who were not douched. The fact, therefore, is that the corrosive douching instead of removing the cause of the puerperal sepsis favoured its settlement and propagation. Finally, the author analysed the different fever cases with regard to the problem of autoinfection, and he concludes that this occurs in only a very few cases.

G.

Cysts of the Corpora Lutea.—Grouzdew (*Archiv. fur Gyn.*, Bd. lxxix., Hft. 2) reviews the literature dealing with the serous cysts, hæmatoma of the corpus luteum, and the so-called degeneratis luteinalis polycystica. He describes three cases, and comes to the following conclusions. Cysts of the corpora lutea may attain considerable dimensions and very great practical importance. They often deviate from the original type and resemble follicular cysts. Still they keep the folding of the lutein layers. The multiple development of hæmatomata in the corpora lutea with typical lutein celled layers is a particular form of multiple degeneration. The dimensions which the hæmatoma can attain are also of great practical importance. The contents of the hæmatomata may arise from hæmorrhage from the capillaries of the lutein layer, which open directly into the cavity. In some cases the so-called epithelium which lines the interior of the cystic lutein structure is nothing else than morphologically altered endothelium of the capillaries of the lutein cell layer. One cannot regard the excessive development of lutein tissue in the ovaries as specific of hydatiamole and syncytioma. The author lays particular stress on the lining endothelium. He observed it in cylindrical cell and goblet cell form, and also as syncytium. These facts, he says, makes one think that perhaps the authors are right who look upon many tumours which are described as chorio-epitheliomata as being nothing other than endotheliomata.

G.

MEDICAL NEWS IN BRIEF.

Edinburgh Royal Asylum—Dr. Clouston's Report.

Dr. T. S. Clouston, the physician-superintendent of the Edinburgh Royal Asylum, has presented his report for 1906. The admissions during the year were 385, of whom 169 were men and 216 women. The number under treatment during the year was 1,269. The close connection of mental disease with bodily ill-health and weakness was, he said, well brought out by the fact that only thirty-five of the 385 patients admitted were in really good bodily health, and that twenty-five of them died within a month of admission. The number of cases of general paralysis—that dread and hitherto incurable disease—sent to them was fifty-five, or nine less than last year. Last year the number of women general paralytics exceeded that of the men, which was a unique and unprecedented fact for any asylum, and had not been repeated this year, for there were thirty-five men and twenty women. Even that, however, far exceeded the proportion of female to male general paralytics in any institution in Scotland. Dr. Ford Robertson, the superintendent of the Scottish Asylums Laboratory, had, with Dr. M'Rae, the pathologist of the Edinburgh Asylum, made distinct progress towards a knowledge of the true nature of this disease, its definite diagnosis, and, they thought, of its treatment, with a view to cure. Their success would be of such service to humanity as would mark an era in medical science. The great hope lay in the fact that the new treatment was on the lines of modern pathological experience, being virtually on the same principles as the mode of treatment now commonly adopted in regard to diphtheria and such diseases as were caused by specific microbes. Alcohol, continued Dr. Clouston, was, as usual, the commonest of all the outward causes of the disease in those admitted. As yet the prevention of mental disease was in its infancy. In no department of human effort to benefit humanity was the modern spirit of optimism more helpful or more needed than in the treatment of the mentally afflicted.

Extension of Lewis's Medical Library.

Mr. H. K. Lewis's well-known firm have just completed a considerable extension of their premises in Gower Street by the inclusion of 24, Gower Place, adjoining. The two shops have been made into one, the older portion being retained as the Second-Hand Department. The new shop faces Gower Street and Gower Place, and affords greater convenience to customers for inspecting the latest books in all branches of medicine, surgery and general science. The library is entered from the end of the shop, and has three windows facing Gower Place. Subscribers are able to examine the books on the shelves when making exchanges, and convenience for writing or making extracts is also provided, the idea being to make this department a reading-room for subscribers, especially those residing in the suburbs or the provinces. The telephone in this room is free for subscribers' use, so that clients from the country may arrange appointments conveniently. Lavatory accommodation is also provided for the necessary "wash and brush up" after a journey, or a prolonged inspection of books. The address will still be 136 Gower Street, and as is generally known the premises are within a minute's walk of the Metropolitan Station, whilst the new Tube station at the junction of Tottenham Court Road, Euston Road and Hampstead Road is only a few minutes distance. The termini of the Great Western, Great Central, London and North Western, Midland, Great Northern, and Great Eastern, are thus within easy access, while the new north and south Tubes, and the numerous lines of 'buses bring the South Western and Southern Districts within comfortable reach.

Important Midwifery Proposals at Bath.

The Town Clerk of Bath recently submitted certain recommendations suggested by the Midwife Committee. The proposals included the formation of a Midwife Committee, consisting of 21 members—14 being members of the Council and seven co-opted. They also suggested that they be given power to deal with all matters coming within the meaning of the Midwives Act. The Town Clerk also read a letter from Mr. H. A. Hope, hon. secretary of the District Nursing Institute, in the course of which he stated that his institution had under consideration the possibility of extending the midwifery work done by their nurses. The committee felt that the charitable public could not be called upon to support more than two nurses, and that if more nurses were to be employed the cost must be guaranteed from some other source. Having suggested that the cost of a nurse, which was from £80 to £90 a year, could be partly covered by a fee payable by the patients, the letter went on to say the committee wished to ask the Council to consider the expediency of giving a sufficient annual grant to enable them to engage a nurse to live on the south side of the river, who would undertake the midwifery work in that neighbourhood. Owing to lack of funds the institution could not now take midwifery cases for less than a fee of 10s. 6d., but if they could lower the charge they were sure it would be an immense boon to the poor patients all over Bath, and they could then obtain thoroughly skilled attendance for the same fee as they now obtain a woman who had no hospital training nor passed any examination. The health of the future generation, as well as that of the mothers, was so immensely affected by the sufficiency of midwifery work that they hoped it might be possible for the Council to consider it a legitimate expenditure. The Local Government Board had sanctioned a grant being given by the Somerset County Council of £150 to the County Nursing Association for which they undertook to train pupils in midwifery. Alderman Phillips: It is necessary that people coming into the world should have as much care bestowed upon them as those who are going out. Dr. King said it was quite right that steps should be taken to prevent the loss of infant life. He would suggest that the matter be adjourned for a fortnight to give the committee an opportunity of thinking the matter over. Dr. Paton supported the idea, and in the course of his remarks declared that such institutions did much to promote thrift and reliance among the working classes. Further consideration of the matter was accordingly adjourned for a fortnight.

Infant Life Protection.

Mr. Staveley Hill's Amending Bill for the Protection of Infants is backed by Sir John Kennaway, Mr. Arthur Lee, Mr. Hay, Mr. Walrond, Mr. Ramsay MacDonald, Mr. Hills, and Mr. Nicholls. It is an amending Bill, and must be read in conjnnction with the Act of 1897.

The Act of 1897 was tentative, and the Society for the Prevention of Cruelty to Children have always held that it did not go far enough. By its terms a person receiving for hire or reward more than one infant under five years of age for the purpose of nursing or maintaining such infants apart from their parents for longer than forty-eight hours, or receiving an infant under two years of age, to bring up in consideration of a sum of money not exceeding £20 paid down, was obliged to give notice to that effect to the local authority within forty-eight hours.

Thus, if people took in one child only at a time they were exempt from official supervision, although it is evident that such a child runs a greater risk of ill-treatment, since the wholesale adoption of children is likely to attract attention, and neighbours may exercise a surveillance. Mr. Staveley Hill proposes to extend the Act to cases where only one child is taken, and to any child received in consideration of a sum of money paid down, whatever the amount may be, and to raise to seven years the age limit of children. There are other useful provisions, too, to strengthen the law dealing with professional baby farmers.

National Hospital for Consumption—Annual Meeting.

The fifteenth annual meeting in connection with the Royal National Hospital for Consumption for Ireland, was held on March 7th, at the Royal College of Physicians, Kildare Street, Dublin, Mr. R. O'B. Furlong, C.B., Chairman of the Board of Governors, presiding. The annual report was read, and the Chairman, in proposing its adoption, said that since the opening of the hospital they would be interested to hear that 2,100 patients had passed through their hands. Last year there were 498 patients treated, or 28 more than in 1905; 402 were discharged, being 24 more than in 1905, and four died. Of those discharged, 38 were very much, 138 much, and 134 simply improved. That showed a total of 310 patients improved as compared with 277 in 1905. In 342 cases the tubercular bacillus was discovered—a percentage of 83.8, as compared with 81.4 per cent. in 1905, and 75 per cent. in 1904, which rather pointed to greater care in admission of the cases or possibly more accurate observation. The Registrar-General followed with an important speech in which he discussed the mortality rate of tuberculosis in the British Isles and in other countries. The meeting shortly after terminated.

Viceregal Commission on Poor Law.

The General Council of the Royal Academy of Medicine in Ireland have passed the following resolution on the report of the Viceregal Commission on the Poor Law:—

Resolved—That the Royal Academy of Medicine in Ireland desires to express its approval of the suggestion contained in the report of the Viceregal Poor Law Commission to convert the entire Poor Law Medical Service in Ireland into a National Service, to be paid by the State, to be entered by a competitive examination, the members of such service to be jointly controlled by the central body and the local bodies, and that the medical profession should have representation on the central body.

The Opium Traffic.

In the House of Commons on the 7th March Mr. Smeaton (Stirlingshire) asked the Prime Minister whether, seeing that crime in Burma had increased during the past twenty-five years with the growing consumption of opium, that the report just issued shows how far opium was a predisposing cause of the crimes committed by Chinese in the Transvaal, and that the opium habit was being fostered among the Kaffirs, he would take into consideration the urgency of the steady suppression of the opium traffic in and from India, which was the principal source of supply. Mr. Morley (Montrose, &c.), who replied, said:—I am not sure that crime has increased in Burma owing to the greater prevalence of the opium habit. The percentage of opium consumers to the total gaol population of Burma is less than it was in the past. The subject, my hon. friend may be certain, is receiving the closest attention of his Majesty's Government from every point of view.

Attack on a Medical Man.

At Southampton last week a man named Edward Williams was charged with attempting to murder Dr. Russell Bencraft, the medical officer of the union and a well-known Hampshire county cricket captain. When an inmate at the local workhouse Williams was brought before the doctor for examination, and he suddenly produced a heavy bludgeon, but was promptly overpowered. It was said Williams was insane, and, whilst committing him for trial at the assizes, the magistrates directed him to be placed under strict supervision.

A Portable Form of Beef Tea.

A convenient and portable form of beef-tea has been introduced by Messrs. G. Foster Clark and Co., of Maidstone, who, under the name of "Ju-Vis," are preparing gelatine tablets composed of extract of beef and certain vegetable bodies. It is only necessary to cut the tablet into four pieces and add boiling water to secure a cup of beef-tea. The preparation will doubtless become popular in the household, and especially among tourists and travellers; and the fact that each tablet which is enough for a cup, costs but one penny will doubtless ensure to the manufacturers the encouragement such enterprise merits.

Royal College of Surgeons, England.

A course of three lectures will be delivered at the above College on Monday, Wednesday and Friday of next week by Professor Cecil F. Beadles (Hunterian Professor) on "The Cerebral Arteries," illustrated by specimens, drawings, and lantern-slides. The lectures will commence at 5 o'clock each day and are free to members of the medical profession and students.

The epidemic of enteric fever in Kirkintilloch is still spreading. Hitherto the cases have been all from one street, but the infected district is enlarging, and of the cases removed yesterday three were from Freeland Place. The sanitary authorities are looking to the milk supply as the source of infection. A special meeting of the Town Council has been held, at which tne doctor laid the results of his investigations before it, and preventive measures were considered.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

Asepsis.—It is always difficult to be sure of catgut. One of the best methods is Macewen's, which consists in keeping catgut in a mixture of chromic acid (20 per cent. solution) 1 part and glycerine 5 parts, till the required degree of hardness is obtained. This may be obtained in an hour or two, or not for four days. The gut is then washed in sterile water, dried on a sterile towel, and finally wound on glass rods, which are preserved in 20 per cent. carbolic acid in glycerine. After a fortnight the gut is ready for use.

Yeast.—There is very little known about the pathology of mucor moulds. They have been found growing in the inflammatory states of the external ear, and also post-mortem in internal organs. We should be glad to have any particulars you can furnish us with.

Dr. H. L.—There is no such appointment as you mention, but work of that kind is usually performed in the sanitary department; that is, if it is undertaken at all. It is obviously a duty that should be performed by a medical man acquainted with pathology, but an inspector often without training is generally detailed for it.

DEATH'S REHEARSAL.

'Tis sad, we every day rehearse
One act of the primeval curse.
Death sentence, passed on all.
We practically die each night,
And either wake to morning light,
Or wait the "Trumpet's Call."—A. D.

Metastasis.—If A was engaged for the confinement but could not attend, and B was called in by the friends, it would be impolitic in the extreme to charge a fee, except for the purpose of paying B. This should be made clear. The correct course would have been to have called on B at the earliest moment and thanked him for his services, as this would have given an opportunity for explanations. We may say it would be difficult to convince a jury that he had done you a wrong, as jurymen always look at things from a strictly commercial point of view. But we are not sure that B ever knew that you had been positively engaged. It is a wise plan to ask for half the fee when booking a confinement, as this gives you the opportunity of naming your own substitute should you be unable to attend.

R. H.—An excellent antiseptic mouth-wash with a not unpleasant taste is that used at the Dental Hospital, containing formaldehyde and creolin. The formula is as follows:—

℞ Creoline - - - - -	♏xv
Formaline - - - - -	ʒi
Ol. Gaultheriae- - - - - Ol. Bergamot - - - - -	} āā ♏v
Sp. Chlorof. - - - - -	ad. ℥i

Misce. A few drops to half-a-tumblerful of water.

Meetings of the Societies, Lectures, &c.

Wednesday, March 13th.

Hunterian Society (London Institution, Finsbury Circus, E.C.). 8 p.m.: Short Discussions on Diseases of Children. Short Papers:—Dr. G. Carpenter: Nephritis. Dr. D. Lees: Administration of Salicylates. Mr. H. Barnard: Intussusception.

Dermatological Society of London (11 Chandos Street, Cavendish Square, W.).—5.15 p.m.: Meeting.

Medical Society of London (Whitehall Rooms, Hotel Métropole).—7 p.m.: Anniversary Dinner.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. M. Collier: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. G. N. Pitt: Brachial Paralyses.

North-East London Post-Graduate College (Tottenham Hospital, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Thursday, March 14th.

Ophthalmological Society of the United Kingdom (11 Chandos Street, Cavendish Square, W.)—8 p.m.: Card Specimens. 8.30 p.m.: Papers: Dr. W. C. Rockliffe; I., Acute Septic Meningitis with Thrombosis of Cavernous Sinus; II., Sympathetic Irritation occurring after 18, 22, 28, and 50 Years. Mr. A. R. Brailey: Cysts of the Ciliary Body.

Society of Arts (John Street, Adelphi, W.C.).—4.30 p.m.: Sir James Thomson: The City of Madras.

British Gynæcological Society (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Mr. Spanton, Dr. Macnaughton-Jones, and Mr. Jessett. Paper:—Mr. S. Bishop: Mobile Kidney, with a Description of an Operation for Anterior Hepatopexy.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Mr. F. C. Wallis: Suppuration in Bone—Non-tuberculous.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m.: Lecture:—Dr. G. F. Still: Some Medical Aspects of Physical and Mental Development in the Child.

Friday, March 15th.

Society for the Study of Disease in Children (11 Chandos Street, Cavendish Square, W.).—5 p.m.: Papers and Clinical Evening followed by Discussion. Patients in attendance from 4.30 p.m.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. R. Lake: Clinique. (Ear).

North-East London Post-Graduate College (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

Manchester, Township of.—Assistant Medical Officer. Salary £110 per annum, with furnished apartments, fire, light, washing, and attendance. Applications to James Macdonald, Clerk to the Guardians, Poor-Law Offices, New Bridge Street, Manchester.

Aberdeen University.—The McRobert Fellowship for Cancer Research.—Fellow. Salary £200 per annum. Applications to Secretary of the Medical Faculty, the University, Aberdeen.

Cornwall County Asylum, Bodmin.—Third Assistant Medical Officer. Salary £140 a year, with furnished rooms, rations, laundry, and attendance. Applications to Medical Superintendent.

Warwick County Asylum, Hatton.—Junior Medical Officer. Salary £130 per annum, with apartments, board, washing, and attendance. Applications to the Medical Superintendent.

Lewes Dispensary and Infirmary and Victoria Hospital.—Resident Medical Officer. Salary £120 per annum, with furnished apartments, board, coal, gas, washing, and attendance. Applications to the Hon. Sec.

Wandsworth Union Infirmary, St. John's Hill, near Clapham Junction.—Junior Assistant Medical Officer. Salary £100 a year, board, lodging, and washing. Applications to the Medical Superintendent.

Saint Andrew's Hospital for Mental Diseases, Northampton.—Third Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Warneford Hospital, Leamington.—House Surgeon. Salary £100 per annum, with board, washing, and apartments. Applications to the Secretary.

Saint Pancras Parish Infirmary.—Assistant Medical Superintendent. Salary £120 per annum, with furnished apartments, rations, and washing. Applications to the Medical Superintendent.

Somerset Hospital, Capetown.—Chief Medical Officer.—Salary £450 per annum, with house. Applications to Davis and Soper, 54 St. Mary Axe, London, E.C.

Durham University, College of Medicine, Newcastle-upon-Tyne.—Head Laboratory Attendant in the Bacteriological Department. Applications to the Secretary. (See advt.).

Appointments.

Beattie, James Martin, M.D., C.M.Edin., to the Chair of Pathology in the University of Sheffield.

Clark, R. L., M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Maryport District of the county of Cumberland.

Harrison, A. T., L.S.A., Medical Officer of Health to the Durham Rural District Council.

Lacey, Hugh Kirbell, L.R.C.P.Lond., M.R.C.S., Honorary Physician to the Rosehill Children's Hospital, Torquay.

Rushton, Charles Chapman, M.B., B.S.Lond., L.S.A., District Medical Officer and Public Vaccinator of the Macclesfield Union.

Marriages.

Foster—Beveridge.—On March 6th, at Our Lady of Lourdes Church, Uxbridge, Rowland J. Foster, R.A.M.C., second son of J. R. Foster, Esq., Greenhithe, to Phyllis Victoria, second daughter of Mr. and Mrs. Henry Beveridge, of "Rostrevor," Southall.

Deaths.

Macauley.—On March 7th, at 17 Nevern Road, London, William Robert Macauley, M.R.C.P.I., aged 64.

White.—On March 8th, at 6 Southwell Gardens, Queen's Gate, London, Helen Jane, wife of the late Joseph White, F.R.C.S.E., D.C.L.

West.—On March 8th, Charles West, L.D.S., R.C.S.Eng., of "Fernville," Fortis Green, East Finchley, N., and 41 Finsbury Square, E.C.

HARLEY STREET.—To MEDICAL MEN.—One of the best Houses in the Centre of the Medical Profession, with stabling, for Sale, having a lease of 33 years unexpired, at a very low ground rent.—For detailed particulars apply to W. Burnell Tubbs, Surveyor, 68 and 69 Shoe Lane, E.C., and 37 Barbican, E.C. Phone. 3,755 Central.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

Boston "Culture."

DURING the last few days there has been some agitation at the stupendous results achieved in Boston by "five reputable physicians," who have been weighing people immediately before and after death. These gentlemen, under the leadership of a Dr. Duncan MacDougall, have discovered the interesting fact that the soul weighs about half an ounce, and that at death it takes longer to leave the body of a large fat man than that of a small thin one. These reputable physicians are said to be upset because their researches, like those of Koch with regard to tuberculin, have been prematurely disclosed to the public, and they fear that ridicule may be forthcoming from medical colleagues, and other carnally-minded folk. This task of soul-weighing is said to have been one of extreme difficulty, which we are quite prepared to believe, but that every allowance was made for bodily secretions, excretions, and moisture, and some commentators have already taken the results so seriously as to write articles on them, deprecating undue scepticism and arguing that it is absurd to adopt the *a priori* view that the soul is imponderable. At the risk of offending the five reputable physicians and their partisans, we beg to express the view we are sufficiently prejudiced to conclude *a priori* that such experiments do as little credit to the 'investigators'' intelligence as to their good taste. Boston is generally supposed to pride itself on its culture; we are unable to decide whether this evidence of it savours more of fatuity or ghoulishness.

Exit Dowie.

THE death of John Alexander Dowie is more a matter for pity than exultation. The wretched creature will live in the minds of men as example of how every reasonable and decent instinct in human nature may be sacrificed on the altar of self-deception and love of distinction. The character-complex of persons of the Dowie type is so far removed from the experience of the ordinary man of the world that he has only such words as impostor, liar, and humbug wherewith to describe them. These certainly are the nearest suitable terms in the language, but they do not precisely cover the ground. Dowie was not a humbug in the sense that (for example) Mr. Winkle was. Mr. Winkle was a pure humbug; he knew he could not skate, but feared to lose his character as a sportsman if he acknowledged his impotence. Dowie was a moral pervert who drew no distinction between his power to deceive himself and his power to deceive others. He suffered from grandiose hallucinations, and the admiration of his followers converted these into *idées fixes*. No doubt Dowie was as much convinced that he was Elijah as that prophet himself was of his own existence, but Dowie's influence lay in his ability to impart this preposterous notion to others.

General Paralysis.

OF course he was a heartless scoundrel, but then so are many of the inmates of Broadmoor and other prisons and lunatic asylums; but his swindling of the sick was not of the cold-blooded type of Professor Richard. Everything that consorted with his own depraved mind was merely a means of exalting his conceit, and the pitiable ease with which he found dupes doubtless intoxicated him with ideas of his power and splendour. No doubt among the lists of cures were to be found many cases of real faith-healing of a more or less permanent character, and, indeed, such healing powers are really not to be marvelled at in a man who could fleece money out of his followers to the prodigious extent that he did. For many years Dowie must have been in the incipient stages of the malady which has just closed his miserable existence, and his whole career is bitter sarcasm on the common-sense of the quack-ridden American race. Medical men can only shrug their shoulders and wonder what is in store for a country which allowed such a pernicious lunatic to swindle and dupe its citizens for so long. Australia and, happily, London, would have none of him.

Anti-vivisectionists and Honesty.

A propos of some remarks we made last week on the falsehoods by which the antivivisection cause is kept going, we have received a letter from Miss Kidd, Secretary to the British Union for the Abolition of Vivisection, which will be found in our correspondence columns. In it we are said to appear to feel no scruples when attacking antivivisectionists. We should like to point out that we were not attacking but defending. An absolutely false accusation had been made against the medical profession, and though it had been categorically refuted, no apology, so far as we could make out, had been made in the journals in which the accusation was made. Conduct of that character we have become accustomed to in the antivivisection movement—reckless assertion and absence of shame on exposure. Miss Kidd says that a little consideration will, she hopes, induce us to withdraw the remark "the honest man has no place in any of the antivivisectionist organisations of our time." By that we did not mean that there are no honest men in the antivivisection movement; there are, and that is where the danger lies. What we meant was that such should withdraw themselves from the leadership of the protagonists, and if they were convinced of the moral wrong of experiments on animals, seek by moral methods to make their convictions known.

Humanitarianism and Discretion.

There are people who say that they would rather their children should die than purchase life at the price of animal experiment, just as there are people who say they would rather their children had small-pox than were vaccinated. Such a position is conceivable even if not comprehensible on ordinary rational and humanitarian grounds, and people who occupy it have the right of all free citizens to make their views known so long as they do so fairly and straightforwardly. But when there are a number of societies of similar aim competing for public favour, such as the four antivivisection societies, it is not wonderful that each should trip over the other in its desire to dish up horrors and pillory experimenters. There is, we believe, a Society for the Abolition of Capital Punishment, which advocates the abrogation of the extreme penalty of the law. That society, so far as we know, is content to pursue its object by unostentatious moral suasion. We do not read lurid letters sent to the papers from its officers every time a prisoner is sentenced to death, accusing judges of nameless barbarity, gaolers of foul glee, or executioners of blood-lust. On the contrary, these officials are treated with respect and regarded as the agents for the expression of the will of the community. Their duties are such as the public can understand, and calumny would be generally resented. The scientific experimenter must, from the nature of his work, be more or less "caviare to the general," and false statements and insinuations about him and his motives are far less easily exposed to public reprobation. There is no body of men more humanely disposed than the medical profession, and none who would resent cruelty to man or animal more keenly. Those who honestly wish to protect animals from hardship would do well to be guided by its expert advice.

Health Visiting and Medical Treatment.

The creation of a new office, such as that of a female health-visitor, is certain to be surrounded with unforeseen difficulties, as we have already said in this column. Not the least of these is the possible clashing of her work with that of medical practitioners. We are all the more pleased, after what we have said, to notice this point is safeguarded in a code of instructions for duty to a female health visitor, whom it was decided to appoint at Beckenham last week. The Council passed these instructions, drawn up by a small committee of which one member was a medical man, with general approval, and they are likely to be most helpful to the officer and to all connected with her work. But the chief point that we are concerned with is that in all cases of absence from school on account of illness, it is specifically stated and printed in italics that she is to offer her services *under the directions of the medical man in attendance*. That is as it should be, but we are considerably less satisfied with another instruction, namely, that where "in her opinion any case seen at school would be benefited by her services at the child's home, she is to attend at the home and offer her services or advice to the parents *under the direction of a medical man, if one is in attendance*." This gives the health visitor even greater latitude than the midwife, for the latter, at least, is under statutory obligation to advise that a medical man should be sent for in certain eventualities. In our opinion, in the interest of the Beckenham children, the clause ought to be considerably modified. No health visitor should undertake medical treatment of any kind except under the supervision of a qualified doctor.

LEADING ARTICLE.

THE BITTER CRY OF THE NOSTRUM VENDOR.

There is a pretty proverb which asserts with terse emphasis the advantages accruing to honest men when rogues fall out. From the medical point of view, all persons who claim to cure manifold or incurable diseases by means of a single specific are rogues. It follows, therefore, that our readers are likely to be interested in the occurrence of a quarrel among the patent medicine vendors that is assuming the dimensions of a pitched battle. The war cry is "Substitution," a term that may, of course, be used by honourable firms who find out that other wares are being palmed off on intending customers instead of their own legitimate products, which receive the sanction of the medical journals and are often largely used by the medical profession. The substitution to which we allude, however, is another and a totally different matter. It is the substitution of one rogue's particular roguery in place of another. To take a concrete instance, A, although untrained in medical matters, conceives that he has discovered a cure for cancer, and proceeds to advertise his "Anticancrum Fluid," which, by dint of the application of keen business methods, attains a large sale. B, wishing to purchase some of A's famous specific, goes to a vendor of patent medicines and asks for a bottle of the "Anticancrum Fluid," for which he is prepared to pay the exorbitant sum fixed by its proprietor. Then the substitution begins. In the most suave manner the seller excuses himself for not having the desired article in stock, but he recommends another potion, that of C, "Cancerdeletor, K88," which is "far better in every way," which not only alleviates but cures the malady in question, "gets at the roots of it," so to speak, and is used by many of the crowned heads of Europe. In this hypothetical case, it is clear that the misdirected enterprise of A is shorn of its profits by the equally misdirected and more circuitous roguery of C. It is the old, old story of the—

"Big fleas have little fleas upon their backs
to bite 'em,
These fleas have other fleas, and so *ad infinitum*."

Let us for a moment examine B's position in the matter. He is simply the credulous victim, duped by A and C, who buys the worthless stuff and pays the penalty of deluded hopes, often with unutterable pain and anguish, and of the lost opportunity of early surgical interference. If he can be snared into the belief that an uneducated farm labourer can find a cure for cancer where scientific medicine has hitherto failed, it is plain that B's judgment is defective and that his information as to the disease itself and the results of orthodox medical treatment must be inaccurate and incomplete, to say nothing of the impossibility of his controlling the statements of the quack. Yet B comes from all ranks of Society, from duke to chimney-sweep. It is common for a testimonial to come from Lord this or Lady that, saying that Smith's elixir or Brown's panacea has cured locomotor ataxy, or epilepsy, or cancer, and the writer wishes the world to be informed of the great boon that is thereby conferred upon humanity. Clergymen and dignitaries of the Church are notoriously given to write puffing testimonials for nostrums, thereby proving what everyone knows already, that a mind that may be accurate enough in a special limited province of work may be hopelessly at fault in the elementary principles of reasoning in outside matters. In a certain limited sense we submit that the amateur cancer curer, be he university professor or farm labourer, is, for all practical purposes, an ignorant and dangerous quack, from whom B should be protected by any modern State anxious to protect her subjects. For if B cannot protect himself against the snares of the fowler, it is the duty of the State to intervene in his behalf. That is the inevitable position in any properly constituted scheme of Government. Apparently nobody knows and nobody cares what is put into the nostrum. The newspapers and the proprietors reap a golden harvest, while the credulous public and the incredulous medical practitioners pay the piper. The extent of the evil can only be guessed at, but its proportions probably exceed the wildest estimate that can be formed by the average man in the street. To gain the data for a more accurate knowledge of the extent of the patent medicine trade and its attendant evils a Royal Commission of enquiry is urgently needed. In our opinion it is worthy of being placed in the forefront of medical politics as an object of first importance. Not only would a Royal Commission secure a basis of accurate fact, but it would serve to educate the public as to the incalculable evils wrought upon the community by quacks and quackery. Meanwhile it is not a little amusing to hear the bitter cry of the successful charlatan at finding his wares ousted by those of a later quack. The sale is effected under the excuse that the one is "just as good" as the other; but, as a correspondent has kindly pointed out, this is clearly the reverse of what should have been expressed for a very short acquaintance with the composition of quack remedies would convince the most sceptical that one is just as bad as another, while the majority are absolutely unfitted for the routine purpose for which they are sold.

CURRENT TOPICS.

Another Imposition.

ONE of the great problems of civilisation is to secure equal justice to the rich and poor. Although it is a common boast that all classes are equal in the sight of the law, in practice this is far from being the case. A fine of forty shillings may mean a month's imprisonment for a labouring man, though to a well-to-do one it does not even mean the deprivation of one cigar. In the same way, when a rich man sustains wrong or injury he has no difficulty in setting all the legal machinery of the land in motion, whilst his poor brother has to grin and bear it. It is a real hardship that the poor who sustain injury are dependent on the mercy of the speculative solicitor, and it is more than a hardship, it is a gross injustice, that medical witnesses in such cases should be kept hanging about courts to the detriment of their practice and patients if expert evidence is required. Some proper provision, with adequate safeguards, should be made to meet such cases. Last week, the father of a child who had been bitten by a dog brought an action against the owner, and a medical man was subpœnaed to give evidence on his behalf. The medical man in question objected to be sworn till his fee had been paid, and after an unedifying plea *ad misericordiam* had been made by counsel for the plaintiff, the doctor adhered to his decision. Of course, counsel did not lose such an opportunity for sarcasm at the expense of medical charity, nor for gaining sympathy for his client; but the real point was untouched. There was no real gravity about the case, but the plaintiff had cause for action, and ultimately recovered forty shillings damages. In any properly organised legal system, it should have been possible to obtain medical aid at a proper remuneration.

Starch in Cream.

IN his last monthly report Dr. Collingridge, the energetic medical officer of health for the City of London, drew attention to the pernicious custom of adding starch to cream. There is, he says, no legal definition of cream, the fat present in any sample depending upon various factors and varying from 15 to 55 per cent. The public naturally form their opinion of the value of cream by the only standard available to them—*i.e.*, by the thickness. The addition of starch or gelatine gives a fictitious appearance of thickness, which bears no relation to the actual amount of fat present. A departmental committee as far back as 1901 reported "that the artificial thickening of cream by any addition of gelatine or other substance shall raise a presumption that the cream is not genuine," and Section 6 of the Sale of Food and Drugs Act, 1875, makes it an offence to sell any article of food to which any matter or ingredient not injurious to health has been added fraudulently to increase the bulk, weight, or measure, or "to conceal the inferior quality thereof." Now that attention has been drawn to the point there will be no excuse in future for sanitary authorities in various parts of the Kingdom if they do not take precautions to ensure the purity of the cream supplied to the public within their jurisdiction.

Trypsin and Cancer.

PROTEST was made by the reputable medical journals when, some months ago, the trypsin treatment of cancer became the subject of sensational articles in lay papers. The evidence on which Dr. Saleeby and others relied for their extravagant statements was easily seen to be insufficient, and in the light of further information has vanished altogether. Dr. Bainbridge, of New York, has published in a contemporary a full and evidently careful account of the case described by Dr. Morton as "a most remarkable atrophy of an entire cancerous breast," the same case which furnished Dr. Saleeby with the basis for his excited gospel to the public in the pages of the *Pall Mall Gazette*. As a matter of fact, the breast in question, undoubtedly affected with carcinoma, had been treated not only by injections of trypsin, but by repeated exposure to X-rays. When examined by competent pathologists the tumour was found to show in its central parts degeneration of the cancer cells with increase of connective tissue, and toward the surface increase of both tumour cells and stroma. Peripherally, however, the tumour showed columns of tumour cells in good condition, extending into the lymph spaces. In other words, as one of the pathologists says, the tumour had "the typical appearance of scirrhous carcinoma." The "conquest of cancer" will have to be substantiated by more solid evidence than is supplied by this one less than dubious case.

Mr. Haffkine and the Indian Government.

A LONG letter from the vigorous pen of Professor Ronald Ross appeared in *The Times* of March 15th on the subject of Mr. Haffkine and his treatment by the Indian Government, and we fancy it will be heartily endorsed by medical feeling throughout the country. Professor Ross points out that Mr. Haffkine went to India in the darkest days of its sanitary administration, when, in spite of the light that sanitary science was shedding on social problems in every civilised country, India remained sunk in the depths of that stereotyped officialism which knows of nothing but seniority and pension. The inroads of scientific teaching were, he says, scoffed at and opposed by officialism of that type, and Mr. Haffkine's anti-cholera vaccine was coolly received. In 1896, however, cholera gave way to plague, and in Bombay, through want of proper care on the part of the authorities, got so vast a hold that nothing could stop it. Mr. Haffkine, by his bacteriological knowledge and ingenuity, elaborated his anti-plague prophylactic, which Professor Ross thinks has saved more lives than any discovery save Jenner's. Everyone knows about the Mulkowal incident; how the persons, nineteen in number, who were inoculated from a particular bottle of a consignment of prophylactic, died of tetanus. A Commission which inquired into the matter came to the conclusion that the contamination of the bottle was due to a mistake in Mr. Haffkine's laboratory, whereas it now seems the contamination occurred after the bottle was opened, and that Mr. Haffkine's directions as to its use were not followed. At any rate, it seems that on the Commission's report Mr. Haffkine was deprived of his position, and beyond his salary while in India, and the doubtful compliment of a C.I.E., he has nothing to show for half a lifetime of scientific work and discoveries of the greatest value in the saving of human life. Even if the contamination occurred in the laboratory—which is denied as impossible—Mr. Haffkine was only technically and not personally responsible, and without him there would have been no prophylactic at all. As Professor Ross says: "Unless the verdict is amended, such men will hesitate before going to a country where the most meritorious service seems only to lead to neglect and censure."

Dakhyl v. Labouchere.

THE judgment of the Lord Chancellor and the other judges of the House of Lords in the above case last week will come as a great relief to medical men and writers generally. The unanimous judgment of the Court was that the Court of Appeal was right and that the Lord Chief Justice, who tried the original action, was wrong, and that the verdict and damages of £1,000 for libel obtained by Dr. H. N. Dakhyl against Mr. Labouchere must be set aside, and a new trial undertaken. There was clear misdirection on two vital points by the Lord Chief Justice, and it is astonishing how that able man could have gone so far astray. The first was the definition of a "quack," which he only allowed to be interpreted as a "pretender to skill which the pretender did not possess." As the Lord Chancellor pointed out, the word has a much wider meaning, and could with propriety be used of a person, however skilled, who lent himself to a medical imposture. The second point was that the Lord Chief Justice told the jury that there could be no fair comment, which was pleaded by Mr. Labouchere, without justification. This point was set aside by the House of Lords, and quite reasonably. Comment may be fair and designed in the public interest, although through mistake, inadvertence, or minor slip it is not wholly justified. The point is precisely one for a jury. We congratulate Mr. Labouchere on obtaining these important decisions.

Devonshire C.C. and Midwives.

The Devonshire County Council is one of those health authorities which finds itself so gifted by nature with medical knowledge and sanitary acumen that it needs the advice of no mere medical officer of health in the execution of its duties. But though the laws of epidemiology and disease-prevention are to them as an open book, they found themselves somewhat non-plussed at having to take over the supervision of midwives in the very wide area that they govern, and after delegating their powers to the local district councils and finding the arrangement for some reason does not work, they have now taken the unusual step of handing over the inspection to the poor-law medical officers of the various areas. Now, although the poor-law medical officers are undoubtedly capable of inspecting the midwives, bags and dresses, the arrangement seems so much at variance with the practice of other counties that we cannot help wondering if there is not some deeper signification than meets the eye. If it be merely an attempt to evade the awkward question of payment of fees to medical men called in by midwives by directing the attention of midwives to the poor-law medical officers, and hoping that the latter will not claim fees for attendance on labours because of the honorariums they receive for inspections, it strikes us as unfortunate. The matter of these fees must be settled definitely, and that soon, and no compromise can be acceptable or accepted.

Mr. Stead and the Evans Brothers.

The latest phase of quack doctoring and religiosity is that exhibited by the ministrations of the Brothers Evans. These persons are small Cardiganshire farmers of a low standard of education, who have conceived the idea that they are endowed with certain healing powers from on High, and who are treating with extraordinary success (of course) cases of cancer which pour into their "surgery" from all parts of the country. Mr. Stead, with his usual want of co-ordination between sail and ballast, has been investigating *au grand sirieux* this crude manifestation of ecstatic credulity, and is convinced that there is a *prima facie* case for experiment. He is much hurt that the Cancer Research Committee refuse to take any notice of the Evans' methods, because the great brethren will not divulge the "secret" of their preparations, but in order to put the method of healing so unreasonably disregarded by the Committee at the disposal of sufferers, he is undertaking to send patients down to Cardigan on certain conditions. Well, there is no reason except those of common-sense and common humanity why they should not be sent, and there is no doubt that they will be described as wonderfully improved after a week or two, and as little doubt that as they get worse less and less will be heard from them. It has all been done before' under varying sets of circumstances, so frequently that it is extraordinary that even Mr. Stead can be "had." By-the-by, it is significant to notice that that enterprising journalist seems to have given up Julia and her fellow spirits, and now uses hard words about "psychic researchers."

PERSONAL.

Dr. J. H. H. Harrison has been appointed Colonial Surgeon of British Honduras in succession to Dr. C. H. Eyles, with effect from September 1st last.

Dr. A. C. McLean has succeeded the late Dr. J. S. Gibbons as District Surgeon of Prieska, Cape Colony.

Dr. J. C. Budding, an official of the German Government, who is staying in London for the purpose of studying the methods and organisation of the Metropolitan Police, paid a visit to Bow Street Police Court.

The Mayor of Chester on March 13th presided over a meeting at the Town Hall, Chester, convened for the purpose of publicly recognising the services of Dr. James Taylor on his retirement after forty years' service as surgeon to Chester Infirmary.

The Public Health Committee of Edinburgh Town Council on March 12th agreed to recommend that Dr. Cullen, Convener of the Committee, and Dr. Robertson, be sent as delegates to the Congress of the Royal Institute of Public Health, which is to be held in Douglas, Isle of Man.

The Committee of the Dundee Dispensary has decided that the following short list should be presented to the Council:—Dr. Kerr, Dr. Smith, and Dr. Thornton.

Owing to the illness of Lord Selby, the Royal Commission on Vivisection has decided to adjourn until after Easter.

Mr. Noel A. Humphreys, I.S.O., read an important paper before the Royal Statistical Society last night on "The Alleged Increase in Insanity."

The Lord Mayor takes the chair at a meeting at the Mansion House this afternoon to promote the interests of the Second International Congress on School Hygiene, to be held in London next August.

Mr. Edwin T. Hall, R.I.B.A., will read a paper on "Sanatoria," at the general meeting of the Architectural Association on March 22nd.

Professor G. Sims Woodhead has been appointed Representative of the University on the Council of the Lister Institute in place of the late Sir Michael Foster.

Mr. J. Ernest Lane, F.R.C.S., Surgeon to St. Mary's Hospital, has been elected a member of the Court of Examiners, Royal College of Surgeons, England.

Mr. Rickman J. Godlee, Surgeon-in-Ordinary to H.M. the King, Holme Professor of Clinical Surgery, University College, has been appointed Bradshaw Lecturer for 1907 in the Royal College of Surgeons, England.

A CLINICAL LECTURE
ON
DIABETES. (*a*)

By T. K. MONRO., M.A., M.D., F.F.P.S.G.,

Physician to the Glasgow Royal Infirmary and Professor of Medicine in St. Mungo's College.

The Flaw in Diabetes.—In diabetes there is a flaw in the method by which the organism deals with carbohydrates, just as in gout there is a flaw in the method by which it deals with nitrogenous materials, and accordingly diabetes has been termed the "gout of the carbohydrate-eater." Both diseases may show a very marked family tendency. In the case of gout this fact is so notorious as to need no illustration, while with regard to diabetes I may mention that I had recently under my care a boy who recovered for a time, but afterwards relapsed, and who was the fifth child in one family of twelve to perish from that disease. The defect in gout is in the excretion of nitrogenous waste matter, while in diabetes it is in the assimilation of carbohydrates.

Carbohydrate Assimilation.—The principal carbohydrates are divisible into three groups :—

I. Polysaccharides (amyloses), having the formula $(C_6H_{10}O_5)n$, and including starch, glycogen, dextrin, cellulose, and gums.

II. Disaccharides, having the formula $C_{12}H_{22}O_{11}$ and including saccharose (sucrose, cane sugar), lactose (milk sugar), and maltose (malt sugar).

III. Monosaccharides (glucoses) having the formula $(C_6H_{10}O_5)$ and including dextrose (glucose, grape sugar), lævulose (fruit sugar) and galactose.

Now the evidence goes to show that it is only the monosaccharides that can be directly utilised by the body. It is not enough that the carbohydrates should be rendered soluble and thus made capable of absorption by osmosis. The disaccharides and polysaccharides must apparently be hydrolysed or hydrated by the addition of one or more molecules of water before they can become attached to or incorporated in the protoplasmic molecules of the living body. For instance, the polysaccharide starch is hydrolysed by the diastatic enzymes of the saliva and pancreatic juice, through various intermediate stages into the disaccharide maltose. But it appears to be subsequently hydrolysed into the monosaccharide glucose by an enzyme which is found in the intestinal mucous membrane.

Of the disaccharides, again, saccharose or cane sugar, though highly soluble, is yet not suitable for use by the living protoplasm. It is accordingly hydrolysed under the influence of invertase, a ferment which is present in the small intestine, and according to Pavy in the stomach also. The result is the production of invert sugar, which is a mixture of the two monosaccharides, dextrose and lævulose. Similarly lactose, which is a disaccharide, is hydrolysed under the influence of lactase, an enzyme found in the mucosa of the small bowel, and yields the two monosaccharides, dextrose and galactose. So that among the functions of the alimentary tract is the production of enzymes for hydrolysing or hydrating a number of the carbohydrates into the monosaccharide form. Accordingly, when an individual takes saccharose (cane sugar) to such excess as to render the urine saccharine, the sugar that is excreted is glucose ; and when a diabetic patient takes either saccharose or lactose, it is glucose which appears in the urine in consequence. If saccharose is injected into the blood-stream directly, it is of no use to the organism and simply passes out in the urine. Pavy finds, however, that the disaccharides lactose and maltose are not wholly wasted when introduced into the body in this way, and that the monosaccharides, and particularly dextrose, are retained for the purposes of the organism to an even greater degree.

The Fate of Glucose.—Glucose, then, being the end-product of the digestion of carbohydrates, we come now to the question of absorption and distribution, a subject which has given rise to great controversy in the past.

(1) According to the glycogenic theory, which in its original form is due to Claude Bernard, and which in some form or other is still held by a good many authorities, the glucose is conveyed by the portal vein to the liver, where by a process of dehydration it is converted into the polysaccharide glycogen or animal starch $(C_6H_{10}O_5)$. It is further held that after being stored in the liver it is re-converted into glucose and discharged into the blood to be conveyed to the tissues as the latter may require it. In diabetes, therefore, the increase of sugar in the blood may be due to increased production of sugar by the liver, or to inability of the liver to convert the sugar into glycogen.

(2) Pavy, on the other hand, maintains that under normal conditions two lines of defence exist to prevent the carbohydrates from getting into the blood in any quantity. These are the intestinal villi in the first place, and the liver in the second place. He considers that the lymphocytes in the lymphatic tissue of the villi feed upon the glucose (as they probably do also upon the peptone), and as they multiply, proceed through the lacteals to the circulation, giving rise to part at least of the digestion-lymphocytosis which is so well known to follow a meal. Another portion of the starchy food is devoured by the columnar epithelium which covers the villi, and is converted into fat. Any glucose which escapes these two agencies in the first line of defence passes by the portal vein to the liver, where it is converted into either glycogen or fat. Pavy further suggests that when the time comes for this glycogen to be utilised, it is reconverted into sugar, and almost at the same instant taken on as a side-chain by a proteid constituent of the blood, just as oxygen is transported to the tissues linked to hæmoglobin. In support of these views he has brought forward evidence which goes to show that proteid matter is of the nature of a glucoside, a body which, though possessing none of the properties of a carbohydrate, can yet be disintegrated by an acid or an alkali so as to yield a carbohydrate.

One of the most important points in Pavy's teaching is that the glucose derived from the food does not pass through the circulation towards the tissues in the free state, since if it did—and according to the glycogenic doctrine, it does—glycosuria would necessarily result. He goes so far as to say that when sugar reaches the circulation, it shows itself in the urine in a corresponding proportion, so that the urine becomes a quantitative indicator of the sugar-content of the blood. Other observers, however (V. Noorden, Seegen, Naunyn), have not always been able to recognise such a constant relationship between the sugar-content of the blood and that of the urine in diabetes.

It would seem that though the glycogenic theory has still influential adherents, a good deal of the evidence on which Bernard founded it must now be set aside as unreliable. Not only has Pavy been the propounder and powerful advocate of an alternative hypothesis, but he quotes Lépine, a staunch supporter of the glycogenic doctrine, as having recently reported certain

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(*a*) Delivered at the Glasgow Royal Infirmary on Feb. 12th, 1907.

results of a comparison between arterial and venous blood which are utterly opposed to that doctrine. Then, again, V. Noorden, who admits that the sugar in the blood is probably in a loose combination with some other substance, and who at the same time believes that diabetic glycosuria is due to the inability of the liver and muscles to transform into glycogen the sugar which reaches them by the blood, calls attention to the fact that Bernard and others, working with obsolete and inexact methods, estimated the sugar-content of normal blood as 2, 3, or 4 parts per thousand, whereas it barely exceeds 1 part per thousand in man.

Hyperglycæmia.—To pass on now from the region of keen controversy, it may be taken as generally recognised that, apart from one exceptional condition, glycosuria is a result of hyperglycæmia. The exceptional condition is phloridzin diabetes. Phloridzin is a substance which is found in the bark of the cherry tree, and which when introduced into the animal body, whether by the stomach or in any other way, tends strongly to induce glycosuria. In this instance the sugar is apparently formed in the kidneys themselves, probably, as suggested by Pavy and others, by the disintegration of a proteid constituent of the blood. The very slight increase which may be present in the sugar content of the blood is attributable to absorption from the kidneys. In other kinds of diabetes, the sugar of the blood often amounts to 3 or 4 parts, and occasionally to as much as 10 parts per thousand, while the normal is somewhere about 1 per thousand.

Unfortunately, the withdrawal of carbohydrates from the food of the diabetic is not always followed by cessation of the glycosuria. Under these circumstances sugar is formed from proteid matter—probably both from food proteids and from tissue proteids. How this occurs we can partly understand if we bear in mind the glucoside structure of the proteid molecule as already described; but why it should occur is a difficult question which I shall not discuss at present.

Tests for Sugar in the Urine.—For the detection of sugar in the urine numerous tests are available. Some of these, such as Fehling's, Trommer's and the Bismuth test, depend upon the fact that certain metallic salts are reduced on being heated in alkaline solution with saccharine urine. The fermentation test is reliable, though not very delicate. The liquor potassæ and picric acid tests, and the polariscope, need simply be mentioned here. The phenyl-hydrazin test of Emil Fischer, who by its means has been enabled to prepare many new sugars, depends on the fact that the different sugars form characteristic crystals with phenyl-hydrazin, a substance which is prepared from anilin. These crystals consist of osazones which can be distinguished from one another by their form and by their melting point. The osazone obtained from diabetic urine is glucosazone, which occurs in sheaves of bright yellow needle-like crystals. On the whole, Fehling's solution is the most convenient for regular use, and is a reliable guide for clinical purposes. 10 c.c. are reduced by 0.05 gramme glucose. Pavy's ammoniated cupric test is much more delicate, and may be used to demonstrate the interesting fact that a certain amount of sugar is invariably present in normal urine; 10 c.c. of Pavy's solution are reduced by 0.005 gramme glucose.

The Acetone Bodies.—Examination of the urine in many severe cases of diabetes reveals the presence of the acetone series of bodies, viz., β-oxybutyric acid and its two derivatives, acetone and diacetic acid. It has long been generally supposed that these bodies are derived from proteid disintegration, though in recent years it has been considered by some investigators that they are mostly derived from fatty acids. Assuming that they are derived from proteid, we may regard them as by-products in the formation of sugar from that source, and accordingly by testing for the acetone bodies, we may ascertain whether the sugar in the urine is derived solely from carbohydrates, or in part from proteid also. Diacetic acid is recognised by the port-wine colour given to the urine by the addition of perchloride of iron, care being taken to avoid fallacies due to the presence of drugs such as salicyli acid. Acetone is recognised by the fact that when sodium nitro-prusside and caustic soda are added to the urine, a cherry-red colour appears, which on the addition of acetic acid in excess gives place to a carmine red. β-oxybutyric acid can be detected by its lævo-rotatory influence on completely fermented urine, and by the difference between the results obtained when the sugar-content of the urine is estimated by the polarimeter and by Fehling's solution.

Limits of Carbohydrate Assimilating Power.—The essential feature, then, of diabetes is the great diminution in the carbohydrate-assimilating power of the body. But it is to be noted that even in health this power is not unlimited, and there is no doubt that it varies a good deal in normal individuals. It is true that in the case of starch there is no known limit, but this is probably on account of the relative slowness of the process by which it is hydrolysed and absorbed. According to Von Noorden, the limit for glucose and also for cane sugar is 150 to 200 grammes in one dose; for lævulose 140 to 160 grammes; and for milk sugar 120 grammes or less. Hutchison, however, puts the limit for lævulose at 200 grammes. There is reason to believe that individuals with a low assimilation limit are "potential diabetics," *i.e.*, are more liable than normal persons to become the subjects of diabetes mellitus.

Etiology of Diabetes.—The etiology of diabetes, notwithstanding all that has been said and done, remains a mystery. Hereditary and family tendencies, the male sex, the Jewish race, affluent circumstances, the early degenerative period of life, a neurotic temperament, city life, hard brain-work, anxiety, sedentary habits, obesity, gout, excesses in food and drink; malaria, syphilis and other infections; mental shock, with or without injury to the head, abdomen, or some other part of the body; lesions of the nervous system, and disease of the pancreas—all these deserve to be mentioned in a list of possible causes. The rare marital form, in which husband and wife both suffer, may possibly, as in the case of marital tabes, be a late result of syphilis acquired by the husband. The connexion between diabetes and the islands of Langerhans or the ductless gland portion of the pancreas is not yet fully explained; but the hypothesis is a reasonable one that the gland produces an activator or co-ferment which constitutes one element in a double enzyme. The other element, according to Otto Cohnheim, is present in the muscles, and there, he supposes, the carbohydrates are burnt up. Pavy, on the other hand, suggests that the activator supplied by the pancreas is wanted to enable the bioplasm of the intestinal tract to build up the absorbed sugar into the proteid molecule.

Hurtful Effects of Glycosuria.—Persistent glycosuria is hurtful to the organism in at least three primary ways. In the first place, the glycosuria means a waste of so much food, with the correspondingly increased demand on the activity of the digestive organs to compensate for this loss. In the second place, the deposition of sugar on the genitals may give rise to troublesome local symptoms. In the third place, and worst of all, the hyperglycæmia constitutes a toxic state of the blood, which, if it persists for a long time, tends to bring about grave consequences in the tissues: the lungs, the crystalline lens, the skin, the nerves, the spinal cord.

Degrees of Diabetes.—In the alimentary type of diabetes, the glucose of the urine is derived simply from the carbohydrates of the food. But in progressive cases the diabetes tends to become composite, the sugar being then derived from the disintegration of proteids as well as from carbohydrate food. And there is some reason to believe that the constant bathing of the tissues with the excess of sugar, in cases of the alimentary type which are not properly treated, favours the transformation of the disease into the more dangerous composite variety. When this happens there is an additional quantity of energy wasted from the body, since both the sugar, and the acetone bodies derived from the disintegration of the proteid tissues, are eliminated in the urine before being fully oxidised, and therefore before yielding up all the energy they contain.

Acidosis.—A danger of a yet more formidable kind threatens the patient when the acetone bodies are liberated into the system in large quantity. This is due not so much to their poisonous properties, for it is doubtful if they are poisons in the ordinary sense of the word, as to their acid character, whereby they combine with the alkali of the blood and interfere with the latter in the discharge of one of its most important functions. For just as the hæmoglobin of the red corpuscles combines with the oxygen inspired into the lungs, and conveys it from the lungs to the tissues, so in health the alkali of the blood combines with the carbon dioxide produced in the tissues and conveys it from the tissues to the lungs to be expired. But when a condition of acidosis develops, and the alkali of the blood is in great measure appropriated by β-oxybutyric and other acids, the carbon dioxide will accumulate in the tissues, and thus the "air-hunger," which is such a striking phenomenon of diabetic coma, is readily accounted for.

Symptoms of Diabetes.—We need not at present linger over the familiar symptoms of diabetes: the polyuria, the hunger and thirst, the loss of flesh and strength, the dry skin, and the red tongue. The urine is acid and pale, the daily output, in a case of moderate severity, being from 5 to 15 pints, the specific gravity from 1032 to 1045, the proportion of sugar from 8 to 12 per cent., and the sugar output from 15 to 25 ounces. Mild cases, however, are often met with; and, moreover, febrile and other intercurrent illnesses may cause a temporary diminution or arrest of the glycosuria.

Coma.—The most important complication of diabetes is coma, which supervenes in about half the cases, and is almost invariably fatal. Its onset is frequently rapid and occasionally actually sudden. Among the influences which appear to promote its development are muscular fatigue, obstinate constipation, high acidity of the urine, early life, and perhaps a sudden withdrawal of all carbohydrates from the food. The most characteristic form of diabetic coma is the result of acidosis, as already explained; and among its phenomena there is not only air-hunger, but also a sweet odour of the breath and urine, which is due to the presence of acetone. In a few cases the approach of coma is heralded by the signs of collapse, while in others there are headache and disordered gait without air-hunger. In occasional instances the coma is uræmic in its origin.

Phthisis.—Pulmonary tuberculosis, a complication of diabetes which is the cause of death in about a third of the cases, deserves particular mention because pyrexia, cough and other symptoms may be slight or absent, though the changes in the lungs are making rapid progress. There are various other complications which are well known and need not be alluded to now.

Prognosis of Diabetes.—Of all the elements which go together to make up the prognosis, age is the most important. If the patient has passed the prime of life, the tendency is for the disease to be chronic and dietetic, whereas in childhood and early adult life it is pretty sure to become composite sooner or later. Many of the cases in middle life are of considerable severity; and though capable of undergoing improvement under treatment, are likely to prove incurable. Patients of the hospital class are naturally apt to suffer after they escape from strict supervision from the danger attending the use of unsuitable food. Apart from the age of the patient, our principal guide in prognosis is the condition of the urine as regards the absence or presence of the acetone bodies, and the disappearance or non-disappearance of sugar when a carbohydrate-free diet is enforced. Most of the severe cases of diabetes terminate in coma. The slighter forms of the disease tend to bring about death in other ways, viz., by diminishing the powers of resistance against such infections as tuberculosis, pneumonia and influenza; and by favouring the premature development of senility in the arteries, with such consequences as gangrene of the lower limbs, and apoplexy.

Treatment.—In approaching the treatment of diabetes it is manifestly the most important thing to withdraw the carbohydrates from the food, since these are not only wasted by being excreted in the urine, but positively harmful by inducing a toxic state of the blood. It is perhaps putting the same thing in another way to say that when the carbohydrate-assimilating mechanism is disabled, the first indication is to give it a complete rest, just as in neurasthenia we give the nervous system a rest. It is a good practice, when the patient comes under observation, to keep him for a couple of days on ordinary diet (except that sugar is replaced by saccharin), so as to allow of the sugar output being ascertained. Thereafter, the ordinary diet should be replaced by one from which carbohydrates are strictly excluded. If, to begin with, the urine does not give the reactions for the acetone-bodies, the change may be made quite abruptly, although it is perhaps as well to allow two or three days for the transition. But if diaceturia already exists, or if the disease is of old standing, it is necessary to use caution, since a very little disturbance of the general condition may suffice to precipitate the onset of coma. In mild cases the effect of the carbohydrate-free diet is to cause the disappearance of the glycosuria. If it is found after a few days that the urine remains free from sugar, a small quantity of carbohydrate, say a potato or two, or half a slice of ordinary white bread, should be added to the daily fare. As long as the urine continues sugar-free, the starchy food should be very cautiously increased, but whenever the glycosuria reappears, part of the starch should be withdrawn. Having thus ascertained quantitatively the carbohydrate-assimilating power, one should continue to give starchy food within this limit, so as to keep the urine permanently free from sugar, while at the same time giving as much carbohydrate as possible. Under these circumstances, one may look, in a certain proportion of cases, for some, and even for a considerable return of assimilating power, though this may not be for months, or even for more than a year. According to Pavy, we may infer that some such return has taken place if, while the urine is constantly maintained free from sugar, the patient begins to lose weight and experience malaise or a sense of exhaustion without any other change in his condition to account for such symptoms; whereas, so long as he continues to gain weight under a carbohydrate-free diet, we may assume that there is no such return. But as soon as signs of the return appear, carbohydrates should be begun in a cautious way.

In many cases, unfortunately, the exclusion of carbohydrates from the food, though reducing the sugar output very greatly, is insufficient to abolish it. If the glycosuria does not continue to decline, drugs may be tried, and although none can be regarded as satisfactory, one medicine may be found to be of some little service in one case and another in another case. On the whole, opium, morphine, or codeine may be looked upon with most favour, and after these perhaps arsenic and the salicylates. In all cases alkaline drinks may be given freely, and in severe examples of the disease sodium bicarbonate should be given in considerable quantity as long as the urine is acid. Constipation, fatigue and similar unfavourable influences must be guarded against as favouring the development of coma.

I may be permitted to make a few additional remarks on the subject of the acetone-bodies in diabetes.

Whether these are mainly derived from proteids or from fatty acids, their appearance in such large quantities as occur in diabetes is associated, for some reason not yet understood, with the cessation of carbohydrate metabolism in the body. Accordingly, a healthy man, who, under ordinary dietetic conditions, does not excrete more than a mere trace of acetone, will, if he excludes all carbohydrates from his food, excrete a greatly increased amount. But if he perseveres with this special diet the excess of acetone will gradually diminish to its normal insignificant proportions. In the same way, a fasting individual, who is living on the proteids and fat of his own body, manifests acetonuria. According to Von Noorden, the daily consumption of from 80 to 100 grammes of carbohydrate is sufficient to prevent acetonuria. Now, when we withdraw carbohydrates from the food of patients suffering from the slighter forms of diabetes with little or no acetonuria, the acetone-bodies are very likely to appear in the urine; and since diabetic coma depends upon the acetone-bodies, it might be thought that this result of a strict diet would involve increased danger to the patient. But apparently this is not the case, and it may suffice to reassure you when I mention that two such authorities as Pavy and Von Noorden are at one on this question. In cases of this class, if the strict diet is persevered with, the acetonuria often subsides within a few weeks, just as it does in a healthy man. If no such subsidence takes place, the outlook is not promising, whether the glycosuria is slight or severe. In the severe type of diabetes where the excretion of the acetone-bodies is well marked on an ordinary diet, it will probably be found that the presence or absence of carbohydrate from the diet makes very little difference to the degree of acetonuria. These patients are always in a precarious position, but even with them it is most desirable, and especially if they can be kept under close observation, to begin with several weeks of a carbohydrate-free diet. To diminish the risk attaching to this, large quantities of alkali should be given, and it may be well to restrict the allowance of butcher's meat. After a time a small quantity of carbohydrate may be allowed on most days, but not on all, and it may be found on trial that one particular kind of carbohydrate can be assimilated to an appreciable degree while others cannot. It is then, our duty to let the patient take advantage of the assimilative capacity which he possesses, whether that power relates to the oatmeal gruel recommended by Von Noorden, the potatoes recommended by Mossé, or some other variety of carbohydrate food. As part of this procedure, the allowance of meat should be reduced to a minimum. By methods such as these we must do our best to conduct the patient along the narrow path between the dangers associated on the one hand with a persistent hyperglycæmia and on the other with an overwhelming acidosis. Even under conditions so unpromising, very good health is sometimes maintained for a considerable number of years.

If coma threatens, a carbohydrate diet should be given and large quantities of alkali should be administered to render the urine neutral or alkaline. When this formidable complication actually develops, an alkali should be injected into a vein. Naunyn recommends 35 to 40 grammes of sodium carbonate (not bicarbonate) in 1 litre of water (9 to 10 drachms in 1¾ pints). If intravenous infusion is impracticable, 3 or 4 ounces of the carbonate should be given daily in solution by the mouth or rectum.

In conclusion, I would strongly urge you to be careful about the diabetic bread which the patient uses. The trustworthy manufacturers are very few, and bread is sold for diabetics which is simply loaded with starch. If, therefore, you are not quite certain about the manufacturer, you should apply the iodine test to every fresh variety of bread, and every specimen of bread from a new manufacturer, to make sure that it is sufficiently free from starch, before you pass it as suitable for the diabetic patient.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for this week will be by Major Ronald Ross, C.B., DSc. Dub., F.R.C.S. Eng., F.R.S., Professor of Tropical Medicine in the University of Liverpool, on "Points of Interest connected with Tropical Sanitation."*

ORIGINAL PAPERS.

TWO CASES OF SYPHILIS SIMULATING TYPHOID FEVER.

By J. D. ROLLESTON, M.A., M.D.Oxon.,

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The possibility of syphilis being mistaken for typhoid fever has long been recognised. Fournier, in 1873, emphasised the similarity of the two diseases, and introduced the neologism "typhose" to designate the condition met with in certain cases of syphilis, particularly in women, which closely simulates typhoid fever. Illustrative cases have since been recorded by Hirschberg and Raïchline, Balzer, Moutard Martin, and Dieulafoy, in France; by Prentiss, Futcher, and McKenna in America; and by Burney Yeo in this country. The condition, however, is not a common one. Since 1896, out of a total of 3,076 cases admitted to the Metropolitan Asylums Board hospitals wrongly certified to be suffering from typhoid fever, only ten were subsequently diagnosed to have syphilis only. It is not improbable, however, that these figures are too low, and that a certain number of cases that were certified as typhoid fever and diagnosed after admission to hospital as febricula, of which there have been 136 cases since 1896, or even as influenza, of which there have been 186 cases, were in reality cases of syphilis. French syphilologists also testify to the rarity of syphilitic typhosis. Thus Carrière, of Lille, had seen only two cases in ten years; Brocq, of Paris, had seen only five cases in eight years at the Hopital Broca (female lock hospital); while Thibierge had not met with a single case in two years' experience at the same hospital. My chief object in recording the following two cases is to emphasise the importance of bearing in mind the possibility of syphilis in dealing with obscure cases of fever. The patient, especially if a woman, will often deny or be unaware of the existence of syphilis. To anyone who had syphilis in mind the evidence in these two cases was so obvious that it is probable that the existence of that disease did not occur to the certifying doctor.

It must be noted that some of the recorded cases resemble typhoid fever more closely than those described below. The spleen may be enlarged, as in the cases of Duflocq, Moutard Martin, Futcher, and Dieulafoy. The abdomen was distended in the cases of Dieulafoy and Hirschberg and Raïchline. The stools may be loose, as in the cases of Moutard Martin, Duflocq, Hirschberg, and Raïchline.

Further, it is important to realise that fever in syphilis may exist apart from any other specific manifestations, such as iritis, adenopathy, periostitis, arthritis, or skin lesions of any kind. To this variety Fournier has given the name "essential syphilitic fever," to distinguish it from the symptomatic fever which is associated with obvious syphilitic lesions. In the former case the disease may be mistaken for tubercle, as in the cases of Swediaur, Duffin, Stengel, and Janeway; for malaria (Bassereau, S. Phillips, Prentiss, Bassett-Smith, Futcher); or for influenza (Campbell Williams). Of course, typhoid fever and syphilis may co-exist. A fatal case was reported in 1885 by Davies. Etienne has published five cases in which typhoid developed in the course of active syphilis. All ran a severe course. A case illustrating the co-existence of hereditary syphilis with enteric fever I have myself recorded elsewhere.

Other febrile intercurrent diseases, such as tubercle or gonorrhœa, must be excluded before the pyrexia can be attributed to syphilis.

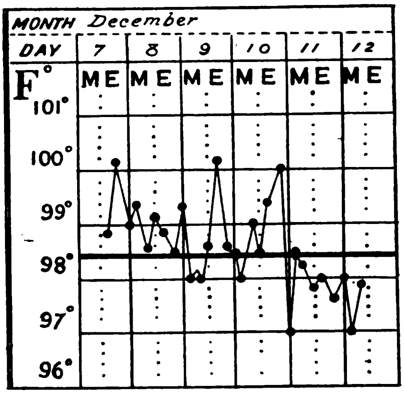
Typhoid can be excluded by a persistently negative Widal's reaction. The effect of mercury and potassium iodide will also be of great service in diagnosis.

Case i.—A man, æt. 35, a butcher by trade, was admitted at 4.20 p.m. on December 7th, 1905, certified to have enteric fever. His wife gave the following history: Three weeks ago he had had a sore throat, which the doctor regarded as diphtheria. Severe headache, which soon became intolerable, developed, and he became delirious. He was, therefore, considered to be suffering from brain disease. It is noteworthy that he had some business worries at the time. His wife had recently had a child, which died at birth, and she had herself suffered from severe headache soon after delivery. Finally, the existence of pyrexia, without anything to account for it, caused him to be certified as suffering from enteric fever. On admission, a discrete eruption of copper-coloured macules, papules, and scales was seen on the trunk and limbs. A healing chancre was found on the ventral surface of the penis at the corono-preputial junction. There was well-marked inguinal adenopathy. The epitrochlear and occipital glands were also distinctly enlarged. The spleen could not be felt, but the liver extended two fingers' breadth below the costal margin. The tongue was covered with thick white fur, and the mouth was full of stringy mucus. The speech was very indistinct, and the mind was clouded, answers to the simplest questions being obtained with difficulty or not at all. Bilateral ptosis, most marked on the left side, was present, the knee and ankle jerks were very active. The plantar reflex was flexor. The abdominal reflex was active. The patient was at once given a mixture containing Liq. Hydrarg. Perchlor. ʒi, and Pot. Iod. gr. x. 4 hourly. Shortly after admission to the ward he became very violent, requiring the constant presence of a porter to control him. The first part of the night he was very violent and noisy, but after two doses of paraldehyde he slept fairly well. The next morning he was very restless and tried to get out of bed. He was constantly picking at the bedclothes, and passed his urine under him. At 5.30 p.m. he became so violent that an injection of morphia was given and a second porter was called in. Widal's test and the diazo and methylene blue reactions were all negative.

December 9th.—The restlessness continued till 3.30 a.m., when another injection of morphia was given, after which he slept till about 8 a.m. During the day the incontinence of urine persisted, and a normal stool was passed in the bed. The ptosis was less marked. The pupils reacted to light. It was impossible to test accommodation.

December 10th.—An injection of morphia being ineffectual, three doses of potassium bromide and chloral were given in the night, after each of which he slept for a short time. While awake, he was still very violent.

December 11th.—The syphilitic eruption was fading and the ptosis was less. There were occasional lucid intervals.

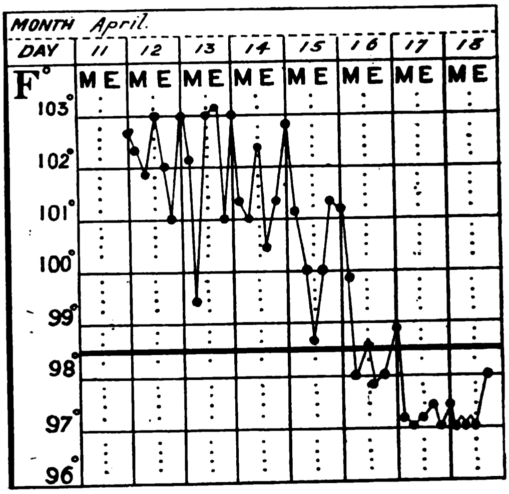


On December 12th he was transferred to Wandsworth Infirmary, where, as Dr. Neal, the medical superintendent, has kindly informed me, he died on January 2nd, 1906, his death being certified as due to cerebral syphilis.

The present case presents several interesting features. (1) The tendency that syphilis has to imitate other diseases. The mimicry is exemplified by the fact that this patient was regarded successively to be suffering from three distinct diseases before he was admitted to hospital. (2) The early implication of the brain by syphilis. Business worries acted, doubtless, as a determining cause. (3) The galloping character of the disease, and the failure of specific treatment find a striking parallel in cases of toxæmic diphtheria, which, though treated from an early stage with large doses of antitoxin, run a rapidly fatal course. (4) The annexed chart shows that the fever was of a low grade and of an intermittent type, in striking contrast to the temperature curve presented by the second patient.

(5) Of special interest in this case is the enlargement of the liver. Carrière says that the liver is always voluminous in syphilitic typhosis. This is not correct, for in some of the recorded cases it is definitely stated that the liver was not enlarged. It is noteworthy, however, that the fever in late syphilis has been attributed by some authorities, such as Crofton and Birt, to the damage done by syphilis to the liver, which is thus prevented from acting as a filter and consequently allows the passage of fever-producing toxines into the general circulation. The irregular fever may also be explained, as Gerhardt and H. D. Rolleston suggest, by secondary infection of the gummata in the liver by pyogenic organisms which have gained access either by the bile passages or the blood. In the cases of Bristowe, Cayley, and Atkinson, an hepatic abscess was suspected, and aspiration was performed. No pus was found. Yet another explanation of the pyrexia of syphilis has recently been advanced by Westphalen. According to him, the pyrexia is due neither to the absorption of necrotic material nor to the special viscus affected, but to the natural reaction against the spirochæta pallida or its toxines. This theory is supported by the fact that the spirochæte has been found in the late as well as in the early lesions, so that, as Westphalen says, the division of syphilis into different stages is rather artificial than biological.

CASE 2.—A girl, æt. 19, was admitted to hospital at 11 p.m. on April 11th, 1906, certified to be suffering from typhoid fever. She had had a headache since the 5th. On the 7th some spots had been seen on the legs. No further history was given. On admission, the patient presented the dazed condition characteristic of enteric fever. The resemblance was heightened by the sordes on the teeth, and the thickly-coated and tremulous tongue. The temperature was 102.6°. Examination of the abdomen, however, did not yield any confirmatory evidence of enteric fever. There was no distension. The spleen was not enlarged. The abdominal reflex was active both above and below the umbilicus. A few faint papules were seen on the abdomen, but they were not of the size or shape of rose spots. There was a dusky red papular eruption on the lower part of the back, the buttocks, and the lower limbs. The upper limbs were less affected. By



daylight on the 12th a generalised roseola could be plainly seen. Mucous tubercles were present in the mouth. The fauces were slightly infected. There was much inflammation of the labia minora and a purulent vaginal discharge. The inguinal glands were hard and discrete. Two grains of mercury and chalk three times in the day were ordered and a vaginal douche of 1-500 chinosol was given morning and evening. The mucous tubercles rapidly disappeared, and by the 17th the roseola had faded, leaving pigmentation. The slight degree of mental obnubilation present on admission gradually passed away. The first three nights the patient was restless, but subsequently she slept well.

The urine, which was free from albumin, presented negative diazo and methylene blue reactions. Widal's test, performed on the 14th, was also negative.

Beyond some tingling of the fingers and a slight attack of phlebitis of the lower part of the right internal saphenous vein, nothing further of note occurred, and the patient was discharged on May 1st.

I am indebted to Dr. J. E. Beggs, Medical Superintendent of the Grove Fever Hospital, for permission to publish these cases.

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Spotted Fever in Stepney.

THE fourth case of spotted fever in Stepney in three weeks was reported on March 14th. The first three have proved fatal. Two cases are reported from Dingle, County Kerry, of which one proved fatal; and a fatal case has occurred at Little Dorby, five miles from Carlisle.

The Belfast medical officer of health reports four cases and one death, bringing the total death-roll to ninety-eight. This brings the total number of fatalities from this disease in that town to 102.

CLINICAL OBSERVATIONS AND EXPERIENCES;

PROGNOSIS AND TREATMENT OF LOBAR PNEUMONIA. (a)

BY JAMES O. AFFLECK, M.D.EDIN., F.R.C.P.,
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AT the outset the author observed that if a body of physicians were asked what disease most taxed their resources and excited their interest, the majority would reply, "acute pneumonia." For this reason, because of the great practical importance to private practitioners as well as hospital physicians of the disease in question, he ventured to bring forward a paper based wholly on his personal impressions, gained during more than thirty years' experience of the disease. Two preliminary points were first to be considered:—(1) Is pneumonia on the increase? and (2) has pneumonia assumed a more serious character of recent years? It was very difficult to get an accurate reply to the first of these questions, but both the Registrar-General's statistics and American statistics point to the fact that the disease was more frequent now than formerly. In regard to the second point he was strongly of opinion that since influenza had become a visitant of this country many more bad cases of pneumonia were met with than formerly. Taking the mortality from various diseases in Glasgow, Edinburgh and the whole of Scotland, it was seen that in the influenza years 1891, 1895, 1897 and 1900 the deaths from pneumonia were greatly above the average. In the U.S. figures the mortality from pneumonia in 1880 was 83.3 per 1,000 deaths, in 1890 90 per 1,000, and in 1900 100.3 per 1,000. In the earlier years of his practice pneumonia was a satisfactory disease to treat, because so many patients did well; now these favourable cases were less common, and every case of pneumonia gave ground for more or less anxiety.

General Points in Prognosis.—There was no means of foretelling how a case might end. It was a very treacherous disease, and at any moment might deviate from the normal course and assume a threatening aspect. Age was a very important factor. Aged people comparatively seldom recovered from acute pneumonia, and this quite irrespective of the previous health. The habits of the patient, particularly in regard to alcohol, had a very important bearing on the prospect of recovery. Alcoholism outweighed the advantage of youth and vigour, and precipitated a fatal result. By far the greater number of alcoholic pneumonias died. The risk was also considerably enhanced by previous or existing chronic disease; in the insane pneumonia was always a very serious malady. Occasionally pneumonia followed a surgical operation and though grave was not always fatal. The speaker instanced the worst case of appendicitis he had ever seen, who developed pneumonia a few days after operation and yet made a good recovery.

Prognostic Indications derived from the Incidence of the Attack.—In some cases the patient is overwhelmed by the toxæmia from the first and dies, marked treatment having no chance. Cases which exhibit gastric and abdominal symptoms at the outset, and simulate some visceral lesion, are often severe. Sometimes the abdominal pain and vomiting are associated with unilateral rigidity of the abdominal muscles, and when this is right-sided the case may be mistaken for appendicitis. Cases with copious perspiration but high temperature are also to be looked on as serious. The diagnosis may be obscured at the outset by severe pleuritic pain, and also by nervous symptoms; in the alcoholic by delirium tremens, in children by a convulsion. In cases of delirium tremens an examination of the upper lobe should always be made, as pneumonia was apt to begin there in these cases.

(a) Read at a meeting of the Edinburgh Medico-Chirurgical Society held March 6th, 1907.

Prognostic Indications during the Course of the Disease.—A very important prognostic element was furnished by the amount of sleep; persistent insomnia was due to toxæmia, and was difficult to control by drugs; it was a very evil sign. Delirium, whether with or without an alcoholic history, was also a danger signal. The temperature was not a reliable guide, but in a favourable case there was often a tendency for it to fall after the fourth or fifth day, and cases in which it remained high, or inclined to rise, were anxious ones. The main determining factor in the prognosis was the state of the heart. The poison of pneumonia affected the left ventricle as well as the right; and it also profoundly disturbed the vaso-motor centres. The pulse rate was very important. If it went over 120 the case was serious, if over 130 anxious, and if over 140 the prospect of recovery was small. Any sudden change in the frequency of the pulse was also a matter of serious import. In old people the rate of the pulse is less important than the quality. A moderate amount of expectoration was better than none, and on the whole a rusty sputum was more favourable than a bloody one; prune juice spit, of course, was bad, but he had known cases recover in which there was every reason to suppose a limited gangrene of the lung had taken place. Cessation of expectoration with progressive cyanosis was very ominous. Double pneumonia was a very grave affair, and complete consolidation of one lung hardly less so.

Prognostic Indications at the Critical Period.—In a favourable crisis the most striking thing was the aspect of relief which the patient presented: at a glance it could be told that he was doing well. The features of the crisis were a fall in temperature, pulse and respirations, with a sweat; if one or other of these was absent, particularly if the temperature fell without a diminution in the frequency of pulse, it was a bad sign. Among the risks at the crisis the chief was collapse. Sometimes the crisis was delayed beyond the usual period, and these cases always gave ground for anxiety. Complications such as pericarditis or empyema might occur. In regard to treatment, it should be remembered that the physician had little power to arrest this self-limited disease. They hoped for a curative serum, but as yet none had been discovered. Three things to be avoided were over-medication, over-stimulation, and over-feeding. It was a great mistake to frequently pour quantities of milk into the patient's stomach, and so embarrass still further the respiration. He tended now to use much less alcohol in treating pneumonia than in the earlier years of his practice. The opinion was gaining ground that it had little beneficial action on the heart, and he now never prescribed it in more than moderate doses. He rather inclined to the use of strychnine early in the malady with the object of sustaining and fortifying the heart's action. Attempts at depletion in the early stage of the disease were inadvisable. For the most part the physician's duty was limited to guiding the case and dealing with symptoms as they arose. For pain he found an ice-bag to the side very useful; some patients, however, could not tolerate it, and on them light warm poultices might be held. He cautioned his hearers against the use of very hot poultices or stupes. Unless there was much pain from pleurisy nothing more than a wadding pneumonia jacket was needed. For cough he gave ammonium carbonate and chloride, but sometimes these were badly borne. When dyspnœa was a prominent feature he found spirit of chloroform and spirit of ether the best remedy. Dyspnœa might arise either from the side of the lungs, of the heart, or from poisoning of the nerve centres, so that the same remedy was not equally applicable in all cases. For insomnia his favourite drug was paraldehyde; next to that chloral with digitalis, and then, though a long way after, sulphonal trional or veronal. Opium should only be used in the early stage and with great caution; never when there was any tendency to cyanosis. The pyrexia required no treatment except sponging. Antipyretic drugs, even quinine, should be avoided. Strychnine and digitalis were the best heart tonics. Digitalis should not be repeated at too short intervals. He had tried oxygen frequently, but had been on the whole disappointed with it. One should always bear in mind that there is danger in meddling too much in pneumonia.

CLINICAL RECORDS.

SOME INTERESTING CLINICAL CASES.

By D. T. BARRY, M.D., D.P.H.

THE following three cases taken from my note-book of cases are somewhat interesting:—

A PECULIAR BULLET WOUND.

CASE 1.—J. R., æt. 22, a shoemaker, was in his shop one afternoon when a friend called. The object of the friend's visit was to order a leather case to be made for a revolver which he carried. Producing the latter, which was loaded in all six chambers, the friend playfully presented it at the shoemaker. The unexpected happened, and "ping" went the trigger.

Being the nearest medical man, I was immediately summoned, and was on the scene within ten minutes of the occurrence. Two policemen were supporting the wounded youth on a chair, one holding a handkerchief to his jaw. On examining this latter, I found a small wound at the angle on the right side, with a tiny splinter of bone just visible. I was at a loss to find where the bullet had got to, till, after a long search, I found it in the subcutaneous tissue over the left acromio-clavicular joint. From here it was easily extracted aseptically.

The splinter of bone at the angle of the jaw was removed, and the patient put to bed. No anæsthetic was given.

A careful search revealed no evidence of a subcutaneous track for the bullet either on the front or back of the neck. There was absolute inability to swallow for three days, and dysphagia for three or four days longer. Hence the bullet must have either pierced the superior constrictor of the pharynx near its origin from the mylohyoid ridge, or passed across by the retropharyngeal space, perhaps glancing off the body of the third or fourth cervical vertebra. The latter course is the more likely, as there was no trace of blood in the mouth or pharynx, and no sign of a wound of the mucous membrane.

The patient was fed per rectum for one week, and made an excellent recovery. It is unnecessary to give in detail the wealth of important anatomical structures which evaded the malign influence of this bullet. Suffice it to mention that it must have been on friendly terms with four cartoids and two jugulars, not to mention vagi and sympathetics.

A RARE COMBINATION OF OLD AND RECENT BRAIN LESIONS.

CASE 2.—W. B., a cabman, had a dispute with one of his confrères which resulted in a fight. B. got a straight blow on the jaw which upset his equilibrium and brought his occiput into violent contact with the kerbstone. He was dazed for some minutes, but did not lose consciousness, and was taken home in his cab.

Some six hours after the injury I was called to see him. He sat on a couch in the kitchen and told me that he felt quite well except for a headache. His temperature was 100 deg. F. There was a small clean-cut wound over the left occipital protruberance. This extended to the bone, which was denuded of pericranium. Probing this wound carefully, I could detect no sign of fracture. He was put to bed and given a purge, and the wound was dressed.

Next morning I was informed that he had died in the night in a convulsion

A post-mortem examination revealed a tough blood clot one inch in diameter immediately beneath the wound, and situated between the dura mater and the bone.

The extraordinary feature of the case was that practically the whole of the right frontal lobe of the cerebrum was disintegrated, and was represented by about two drams of semi-fluid grumous material, as well as by a soft dark blood clot. The dura mater had collapsed in front of the fronto-parietal suture, the parietal and occipital lobes behind the fissure of Rolando being intact. This was evidently softening from embolism or syphilitic arteritis.

At the inquest I stated that death was due to the posterior clot which was caused by the fall. Counsel for the assailant suggested that death was caused by the old-standing disease. But this I denied, while admitting that it may have predisposed to it.

This man had been a heavy drinker, and all his viscera showed signs of this. His intelligence was not below the average for his class, and he was a regular worker. The exact extent of lesion in the ascending frontal convolution could not be ascertained, but it had certainly fallen in, and was softer.

AN ABDOMINAL PUZZLE.

CASE 3.—Mrs. X., a widow of some years' standing, summoned me in great haste, as she was suffering intense pain. I found her seated in an armchair and holding her hands to her right side in the hepatic region. There was no other symptom or sign except this acute pain of sudden onset. The abdomen was somewhat rigid, and there was no region of distinct tenderness, but the pain was referred to the gall-bladder region.

I was at a loss for a diagnosis. A ¼ gr. morphia was given hypodermically, and the patient put to bed.

Later in the evening, on calling, I found the patient somewhat relieved. The temperature was now 101 deg. F. The pain was referred to the right iliac region, where a certain indefinite fulness was felt. There was a history of normal menstruation, and a P.V. examination revealed nothing unusual. I now suspected the case to be appendicitis.

Next day the patient was free from pain, and there was no rise of temperature, but the vague fulness was still to be felt in the iliac region. She continued thus for five or six days with occasional slight rise of temperature, but feeling quite well.

At the end of this period I was sent for very urgently, and found the patient now almost collapsed and in great distress, with a marked bulging of the lower part of the abdomen and a good deal of pain.

A consultant surgeon whom I called in thought it must have been a rupture of an appendix abscess. An operation was at once undertaken, when, on opening the peritoneal cavity, the blood-clots which were presented revealed the true nature of the case. It was an unusual type of ectopic gestation.

After removal of the fœtus, the hæmorrhage being very alarming, the sac was packed with gauze and the wound left open. The patient recovered.

Evidently a partial rupture of the sac first took place, and, combined with the other circumstances of the case, led to confusion. While at first ectopic gestation occurred to me, it was soon set aside by the normal history of menstruation, the absence of evidence per vaginam, the rapid amelioration of symptoms, and last, though perhaps not least, was the patient's widowhood and high social position.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Man brought in Comatose.

By G. LENTHAL CHEATLE, C.B., F.R.C.S.

AMONG the out-patients was a man, æt. 62, who was brought in comatose. He had a recently inflicted wound on the back of his head. The previous history of the case was as follows :—A fortnight before he had had a slight attack of giddiness which rapidly passed off. The report of his doctor was that his heart, lungs and urine had been normal. The history of the present condition was : The patient was seen writing at his desk and performing his usual daily duties, but an hour afterwards he was discovered lying on the floor with a wound at the back of his head. His state when brought to hospital was — he was unconscious and could not be roused, his breathing was stertorous, his pulse was full, 90 per minute ; the surface of the body was warm, his temperature 100° ; his pupils were equal and reacted to light ; there was no facial paralysis ; his arms were rather rigidly held flexed across his chest, his legs were rigidly extended ; his great toe was flexed towards the plantar surface during the plantar reflexes. The wound on his head, although it had bled a good deal, was superficial and did not extend as far as the bone. There was no smell of alcohol, or signs of any volatile poison. His urine contained sugar. He was evidently suffering from compression. The condition of his arteries was very good for a man of his age. There was no sign of fracture of the base, no subcutaneous effusion of blood at the back of the neck, no hæmorrhage from the nose or ears. A lumbar puncture was made for the examination of the condition of the cerebro-spinal fluid ; half a test-tube of the fluid was taken away. When allowed to settle half of it appeared to be blood containing normal red blood corpuscles ; the upper layer of the fluid was coloured by hæmoglobin. Mr. CHEATLE said the evidence deduced from the condition of the cerebro-spinal fluid had a great influence on the diagnosis of the case ; it reduced it to three contingencies : either it was a fracture of the base, meningeal hæmorrhage, or cerebral hæmorrhage. There were no supporting signs of fracture of the base. There was no history of an interval of consciousness after injury to his head, indicating a meningeal hæmorrhage, and therefore on the whole the case seemed to be one of cerebral hæmorrhage. The sugar in the urine was probably the result of the present trouble. With regard to treatment, there being a complete absence of any focal localising signs, surgical interference was contra-indicated. The withdrawal of the cerebro-spinal fluid had had no effect on the symptoms of compression. The hæmorrhage was evidently very extensive and occupied both sides ; there was no unilateral sign or symptom indicating an affection of one side only. The patient was admitted to the hospital and died after four days. The post-mortem revealed extensive hæmorrhage into the ventricles of the brain ; there was no fracture of the base. The main point about the case, Mr. Cheatle said, was the inestimable value of examination of the cerebro-spina fluid obtained by the simple harmless procedure of a lumbar puncture. In every case of coma it is wise, he thought, to make a routine practice of examining the cerebro-spinal fluid obtained by means of a lumbar puncture.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Cholecystostomy.—Mr. Willmott Evans operated on a man, æt. 63, who had been admitted for jaundice, which had lasted several months. At no time had the patient complained of any pain in the abdomen; the jaundice had come on slowly, he had the usual symptoms accompanying icterus: colourless stools, flatulence and irritation of the skin. The urine was loaded with bile pigment Although he had not been weighed within recent years he felt sure that he had wasted. On examination, the only additional sign elicited was the presence on the right half of the abdomen, two inches below the rib margin, of an oval swelling in which doubtful fluctuation could be obtained. The swelling seemed to measure an inch and a half in length and about an inch transversely. It was rounded. Inasmuch as this swelling was in the situation of the gall bladder, and indeed appeared definitely to be the result of dilatation of that viscus, it was decided to explore. The patient having been anæsthetised, an incision was made about two inches in length in the right semi-lunar line, the upper extremity being about one inch below the margin of the ribs. The abdominal wall having been divided, layer by layer, the peritoneum was reached, and when this had been cut through the distended gall bladder presented in the wound. It was drawn forwards, packed round with gauze, and incised; some slightly thickened bile escaped, and, the finger having been introduced within the gall bladder, it was found that a large amount of stones were present; many of these were taken away with a scoop and others still were evacuated when the cavity was washed out with fluid from an irrigator. In all more than one hundred and fifty were removed. The cystic duct was free, but just below the origin of the common duct a firm resistant mass was felt, which was adherent to the neighbouring structures and surrounding the duct. As this mass seemed definitely to be malignant in nature Mr. Evans decided that it would be unwise to attempt its removal. The edges of the gall were therefore stitched to the margins of the wound, a drain was inserted and a dressing applied. Mr. Evans said that in this case the distension of the gall bladder and the profound jaundice pointed to an obstruction of the ductus communis choledocus; the two most common causes of this condition were the impaction of a stone and the constriction of the duct by malignant disease. To diagnose between these two conditions before operation was extremely difficult. The only points on which a diagnosis could be based were the following: if the age of the patient exceeded 50 years, and if the wasting were extreme, it was not improbable that the cause of the obstruction was a new growth, and the likelihood of this would be increased if at no time there had been any history of biliary colic. On the other hand, it must not be forgotten that gall stones were very frequently found in malignant disease, that in many cases they preceded the development of a malignant growth and in all probability they were directly implicated in the production of the carcinomatous mass. It was not many years, he said, since Courvoisier had formulated a law generally called by his name, that when the common duct is blocked and jaundice is produced the gall bladder is generally distended if the cause of the obstruction is a new growth, while if the blocking of the common duct is due to a stone the gall bladder will probably be contracted. Of course this law, Mr. Evans remarked, was only a general law and exceptions were not rare, but it was of practical value in forming a diagnosis. In the case just operated upon he pointed out that gall stones accompanied the malignant growth; they were all small and probably of recent origin, and it was not likely that they had anything to do with the production of the malignant disease; it was far more likely, he thought, that they were themselves produced by the stagnation of the bile in the gall bladder.

The subsequent course of the case was as follows: a large quantity of bile was discharged through the opening, and within a few days the degree of jaundice perceptibly diminished and the amount of bile in the urine also decreased. No improvement in the general condition occurred, though the patient professed himself as more comfortable after the operation. He continued, however, to waste, and death occurred some five weeks later. At the necropsy a mass of carcinoma was found to involve the common bile duct.

Errata.—In last week's "Operating Theatres, 7th and 8th lines, 1st column, for "Enlarged Tonsils, a limp in walking" read: "With a tendency to sway to the left when walking"; next line for "which" read "the pain"; in second line from the bottom 1st column for "mystagmus" read "nystagmus"; 2nd column, for "diplœtic" read "diploëtic"; 7th line from the top 2nd column for "whole" read "hole"; 12th line, for "opening" read "openings"; 29th line, for "labyrinthal" read "labyrinthine"; in 32nd line between "signs" and "due" insert "was"; in 34th line for "also the" read "with an."

TRANSACTIONS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held Wednesday, March 6th, 1907.

The President, Dr. Byrom Bramwell, in the Chair.

Dr. J. O. Affleck read a paper on

CLINICAL OBSERVATIONS AND EXPERIENCES; PROGNOSIS AND TREATMENT OF LOBAR PNEUMONIA.

An abstract of this paper will be found on page 309.

Dr. Affleck's paper was followed by a long discussion.

Dr. Byrom Bramwell referred particularly to the abdominal cases, which were often operated on by mistake for appendicitis. He did not think a pulse-rate over 120 so bad a sign as Dr. Affleck did; in his opinion irregularity of the pulse was a much more serious thing. Cases with jaundice, he thought, were not favourable. He agreed that little alcohol was required. Strychnine and oxygen were the two most useful remedies.

Professor Greenfield urged that no remedy was of such use as strophanthus. Twenty years' experience had convinced him that if a reliable preparation, such as the 1888 B.P. Tincture, was given as soon as the pulse flagged, in doses beginning with 5 minims every four hours, heart failure was in many cases efficiently combated. Strychnine was in no sense a heart tonic, and he believed it was dangerous. Digitalis had the disadvantage that it might accumulate and cause poisoning. If strophanthus was used there was no risk of this kind. It should be given with an equal quantity of tincture of capsicum to prevent its disagreeing, and should not be combined with other drugs. He spoke strongly because he thought that strophanthus was a drug which had not received the attention it merited. It was essential, of course, to use an efficient preparation; the ordinary B.P. Tincture was often quite weak.

Dr. James believed that it was useful to give a purge at the outset. In bad cases he had the idea that musk was a useful though expensive remedy.

Dr. Carnegie Dickson also praised strophanthus in pneumonia. He suggested that it might tend to prevent ante-mortem clot.

Dr. Gullaud discussed the prognostic indications which a blood count afforded. A falling leucocytosis was a bad sign, indicating diminishing power of resistance; rise in the leucocytes, on the other hand, was favourable. Cases with marked persistence of eosonophiles usually did well. The glycogen reaction had much the same significance, from a diagnostic point of view, as the polymorphous leucocytosis.

Dr. Wm. Russell thought that strychnine acted beneficially from being a vasomotor tonic.

Dr. Goodall said that he had recently been examining samples of strophanthus purchased in the open market, and found that some of them were absolutely inert and worthless.

Drs. Ian Struthers Stewart and Peel Ritchie read a note on the use of the

OPSONIC INDEX IN THE DIAGNOSIS OF TUBERCULOSIS.

They found that the results of a single examination of the index was unsatisfactory, and gave a considerable margin of error. They had therefore adopted the inoculation method, the routine being to test the opsonic index on several days, give an injection of Tuberculus R, and watch the result on the tuberculo-opsonic index. In healthy persons there was an early rise to a considerable degree above normal; in cases of localised tubercle there was first a fall, then a rise, but not to so high a level as in normal persons. Their observations had been made on several hundred patients, mostly suffering from surgical tubercle, with corresponding controls. The communication was illustrated with charts, &c., showing the results of injection.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Surgery.

Meeting held Friday, February 22nd, 1907.

The President, Mr. H. R. Swanzy, in the Chair.

FRONTAL SINUSITIS.

Mr. Robert H. Woods exhibited three cases of frontal sinusitis subsequent to operation. He described the clinical history of each case, and gave an account of the operative procedure which he usually carried out for the affection. An incision was carried from within outwards along the line of the eyebrow, and the frontal sinus laid open by means of a small trephine, the aperture being subsequently enlarged by means of gouge forceps. The diseased mucous membrane lining the sinus and its recesses was thoroughly removed with a curette. The entire anterior wall of the sinus was not removed, as was generally recommended in the text-books, in order that the scalp might recede and adhere to the posterior sinus wall, because, in his opinion, this step was unnecessary. Obliteration of the cavity could be brought about after removal of the mucous membrane by the growth of granulation tissue from its bony walls which developed subsequent to the operation. Obliteration of the sinus took place first at the infundibulum as the granulations fused first at this narrow outlet. Drainage, consequently, could not be carried out by this passage as efficiently as by means of a tube introduced by the wound.

Mr. P. Dempsy alluded to the difficulty in the complete eradication of sinus infection. There was nothing easier than to alleviate the discharge, and nothing more difficult than to get it to cease altogether.

Sir Thomas Myles referred to the methods of effecting complete obliteration of cavities in bone, and instanced the difficulty met with in securing the obliteration of a cavity in the head of the tibia—for instance, by granulation tissue.

EXHIBITS.

Sir Thomas Myles exhibited a man, æt. 60, in whom a large abdominal tumour could be detected. The patient had been admitted to hospital for injury to his hip, and had not been previously aware of the existence of the tumour. The swelling, which was suggestive of splenic enlargement, was quite painless and dull on percussion. Numerous hypotheses had been advanced as to the nature of the tumour, but none seemed satisfactory.

Sir Thomas Myles also exhibited a young man, æt. 21, who presented warty growths on both legs. The growths were somewhat painful, and seemed to him to be examples of a rare type of malignant disease, originally described by Hawkins as warty tumours of cicatrices.

Mr. Edward H. Taylor regarded the case as one of warty tuberculosis of the skin, and thought the best form of treatment would be excision, followed by Thiersch grafting.

Mr. Charles Maunsell and Mr. Alexander Blayney regarded the growths also of a tuberculous nature.

Mr. C. A. K. Ball exhibited a gangrenous gall-bladder. The patient from whom it was removed had been sent to hospital as a case of perforated typical gastric ulcer. On admission the patient presented symptoms of general peritonitis, originating probably in the appendix. An incision in the right iliac fossa revealed free blood-stained fluid; the appendix was slightly inflamed, and the cæcum was both inflamed and thickened. Another incision was made below the right costal arch, and a tumour resembling a kidney came into view. It proved to be a distended and gangrenous gall-bladder adherent to the colon. A small concretion was found blocking the cystic duct. The gall-bladder was removed, and the upper abdominal region flushed out. The patient recovered, and her stomach symptoms were relieved. The contents of the gall-bladder were submitted to bacteriological examination, but were found sterile.

Mr. Alexander Blayney exhibited a specimen of Meckel's diverticulum which he had resected. The previous history of the patient pointed to severe attacks of pain, which rendered life miserable. Mr. Blayney thought that these attacks were due probably to slight intussusceptions, occurring from time to time of the diverticulum into the intestine.

Mr. Charles Maunsell alluded to similar cases in his own practice.

Sir Thomas Myles exhibited various specimens of surgical interest, including (*a*) a renal tumour developing from a "supra-renal rest"; (*b*) malignant growth of the testis; (*c*) a pathological vermiform appendix; and (*d*) an extracapsular fracture of the neck of the femur.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Meeting held Thursday, March 14th, 1907.

The President, Priestly Smith, F.R.C.S., in the Chair.

Dr. Rockliffe read notes of a case of

THROMBOSIS OF THE CAVERNOUS SINUS

associated with septic meningitis, which originated from a septic sore on the lip. The patient was a fish dock labourer, whose general health, but for bronchitic attacks, had been satisfactory. He was first seen on November 18th last, and had protosis of the right eye. Five days previously a small spot appeared on the upper lip. He picked it, and eventually pricked it with a pin. The lip and face became swollen, and he then applied a linseed meal poultice. Four days later he was admitted into the Infirmary. He became delirious, and a diagnosis of thrombosis of the cavernous sinus was made. Afterwards lumber puncture was done. He died on November 20th, being two days after admission, and seven days after the spot appeared on the upper lip.

At the autopsy the meninges about the right cavernous sinus were covered with lymph. The right cavernous, the transverse, and part of the left cavernous sinus were thrombosed. The orbital tissues on the right side were inflamed and swollen, but there was no pus.

Dr. **Rockliffe** also read notes on four cases of

SYMPATHETIC IRRITATION,

occurring after 18, 22, 28 and 50 years. In two of these cases a foreign body was found, and the third case probably contained a foreign body, a piece of stone. The injury in the fourth case was a punctured wound. Considerable ossification was present in three of the cases.

Mr. A. R. **Brailey** read a paper on

CYSTS OF THE PARS CILIARIS RETINÆ.

He stated that these structures had frequently been mistaken for sarcomata of the ciliary body clinically, but little was known of their pathology, though their study might throw some light on the secretion of the aqueous. They were found in such a variety of conditions that he was only able to classify them according to their apparent mode of origin. Two changes which played an important part in the origin of some varieties limited to the cells of the unpigmented epithelium were multiplication of the cells, and vacuolation of the cell bodies. This proliferation was most frequently found in senile eyes, and was commonly associated with hypertrophy of the ciliary processes. The cells of the pigmented layer appeared to play a more passive role, and even in cysts arising by simple detachment of the epithelium, it was the unpigmented layer alone which was affected, the adhesion between the pigmented epithelium and the underlying ciliary body being a peculiarly intimate one. The different modes of origin appeared to be: (1) Detachment of the non-pigmented epithelium. (2) Proliforation of the non-pigmented epithelium cells with the formation of a cavity arising either by simple separation of the cells, or by their vacuolation and destruction. (3) Proliforation and union of the cells of adjacent processes, leading to a portion of the posterior chamber being shut off from the remainder.

The number of the specimens was too small for him to come to any conclusion as to the relative frequency of these varieties. The contents of the cysts was usually lost during the preparation of the specimen but when present it consisted of a deeply-staining homogeneous coagulable fluid.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, March 14th, 1907.

The President, Mr. **Frank T. Paul**, F.R.C.S., in the Chair.

NEPHRECTOMY FOR RENAL SARCOMA IN CHILDREN.

Mr. K. W. **Monsarrat** read a paper on two cases with remarks on the pathology and the recent results of surgical treatment. The first case was that of a boy, æt. 3 years, the signs of disease being hæmaturia and abdominal tumour. The growth removed weighed 2 lbs. 6 ozs. The child recovered from the operation but died from recurrence in six months. The growth was a sarcoma containing tubules and striated muscle fibres. The second case was that of a boy, æt. 5 years, with abdominal tumour and hæmaturia. The child recovered from the operation and remained well at the end of six months. The growth weighed 2 lbs. 2 ozs. and was a pure round-celled sarcoma. Mr. Monsarrat found that published records indicated the occurrence of hæmaturia in about a third of the cases. He presented a statistical study of 104 cases published between the years 1897 and 1905 inclusive. These records showed that the present mortality from operation was 26 per cent., and that to the number of complete recoveries a total of seven had been added during the years examined. He considered that operation was justifiable in cases which showed no evidence of metastasis.

The President, Dr. Percy Marsh, Mr. R. W. Murray and Dr. Stookes discussed the paper.

PLEXIFORM NEUROMA.

Mr. G. G. **Hamilton** showed a patient from whom he had removed a large plexiform neuroma. There were about 62 cases on record. This one grew from the iliohypogastric nerve and was incorporated with the neighbouring muscle. It measured 10 by 41½ inches and showed numerous strands of nerve thickened to the size of a toothpick and many of them coiled up into little capsules. There were very few axis cylinders present, the whole nerve being simply a mass of thickened gelatinous endoneurium.

Mr. Hamilton's communication was illustrated by several lantern slides. The pathology of the condition was discussed by Dr. E. E. **Glynn**.

VARIATIONS IN THE NORMAL TEMPERATURE.

Dr. W. **Carter** read a short note on the above subject. After recalling the facts that Ogle and Liebermeister had recorded fluctuations varying from 1.8 to 2.3 Fahr. in 24 hours, and that Dr. Finlayson had observed that aged people in the Glasgow Workhouse Infirmary who died without any definite disease generally sank at the time when, in normal health, the body temperature was lowest, stated that on two occasions at distant intervals he had been able, by the co-operation of the Matron and night nurses of the Royal Southern Hospital, to see if an inversion of the ordinary periods of night and day duty affected the normal rise and fall. Each nurse, towards the end of her period of three months night duty, took her temperature three-hourly, when not asleep in the day; but as the charts, which were shown, proved, the normal depression which took place under ordinary conditions of life at about 3 a.m. remained fairly constant even after three months of turning night into day and *vice versa*. It seemed, therefore, to be deeply impressed on the organism, and independent of external circumstances, so far at least as the trial of three months tended to establish the fact.

Sir **James Barr** doubted if the records of nurses' temperatures taken by themselves could be implicitly relied upon.

A New Astigmometer.—Dr. K. **Grossmann** explained the mechanism of his Astigmometer and demonstrated a working model; a description of the appliance will appear in due course, illustrated by diagrams.

THE SURGERY OF WARFARE AND CATASTROPHE.

Dr. **Arthur Evans**, in an interesting lecture, illustrated by numerous lantern slides from photographs and radiographs, taken during the Boer War, and after the earthquake in Jamaica, drew attention to the great contrast between the conditions under which surgery was practised in modern wars, and those which obtained in sudden catastrophes such as an earthquake. In the one every contingency was foreseen and provided for and the organisation was perfect beforehand; while in the other, all aid had to be organised under the most appalling conditions and literally without a moment's notice.

The **President** proposed a vote of thanks to Dr. Evans for his lecture and of congratulation upon his escape from the earthquake and the great services he had been able to render to the injured. The vote was carried by very hearty cheers.

The third Latin American Medical Congress was opened at Monte Video on March 17th. About 100 delegates were present, representing all the Latin American countries. Sittings will continue throughout the week.

ULSTER MEDICAL SOCIETY.

Meeting on Thursday Evening, March 14.

The President, Dr. D. P. Gaussen, in the Chair.

Professor Milroy read a paper on the "Movements of the Stomach," based on experimental research with dogs. He said that there was a regular peristaltic wave towards the pylorus, which was excited by pressure, such as the presence of food. If only fluid was present there was no reverse peristalsis; but if there were solid there was a reverse peristalsis also. The fundus showed a tonic contraction, a much slower wave with smaller waves superadded. Salivary digestion he had found to continue for two hours in the fundal portion of the stomach. The peristaltic action depended on nerve ganglia between the muscle coats. If the external muscle coat is separated, the ganglia are removed, and the internal muscular coat does not show the peristaltic action. If a ring of the muscular coats is removed right round the stomach, leaving the mucous membrane intact, the peristaltic wave is not stopped, but jumps the gap. In vomiting, leaving abdominal action out of the question, two factors were always present—reversed peristalsis and relaxation of the cardiac orifice.

Professor Milroy also gave a demonstration of the "Vascular Supply of the Central Nervous System."

In the Anatomical Department, Dr. C. G. Lowry showed sagittal sections of the trunk, and a case of single kidney. Dr. P. T. Crymble showed specimens illustrating the air sinuses connected with the nose, and Mr. H. Cunningham showed specimens of the middle ear.

In the Pathological Department Professor Symmers and Mr. Cunningham showed some Eye specimens. Drs. Houston and Rankin showed examples of opsonic indices with various microbes, and Dr. Wilson read a short paper on "The Value of the Widal Test, as Ascertained by its Use on 230 Occasions," and also notes on a new method of isolating the bacillus typhosus from water.

Professor Sinclair showed a specimen from a case of umbilical hernia exhibiting numerous constrictions and gangrenous patches. Dr. Dempsey showed several gynæcological specimens, and Dr. Darling showed the brain, cord, &c., from a case of cerebro-spinal meningitis.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 17th, 1907.

Treatment by Ions.

It would seem that the future is more and more, even in medicine, reserved for electricity, or at least a more complete knowledge of its laws must develop a new horizon for the healing art. It is thus that we are on the eve of a complete revolution and are given seductive promises regarding ionic medication.

Everyone knows the principle of galvano-plasty; that is to say, the properties possessed by an electric current passing through a saline solution decompositing the dissolved salt. Take, for instance, a bath separated into two compartments by a porous partition and filled with a solution of sulphate of copper. If an electric current is passed through the solution the sulphuric acid is let free by the positive pole while the metal is freed by the negative pole. The positive pole is called anode, and the negative cathode.

A displacement in an inverse sense of the molecules of the sulphuric acid and copper takes place thus in the bath, the copper metal travelling, so to speak, from the cathode to the anode; that is to say goes up the current and the acid going from the anode to the cathode, or descends the current.

The name of ions (travellers) is given to these elements separated by electrolysis.

What happens in a saline bath can also happen in the human body the organism of which is impregnated with saline solutions. The blood itself contains a large quantity of chloride of sodium, and consequently the body, or living tissues, may be considered as electrolytes (the name given to the sulphate of copper solution), and that the conductibility of the human body is nothing else than electrolytic conductibility.

If an electric current were passed through the body, and that between the metal plates, platinum, for instance, a solution of iodide of potassium were interposed, the metal ion or potassium would be set free by the anode and would penetrate into the body to pass to the cathode, while the iodine would take the return journey.

Consequently it is possible, by means of this method, to introduce a drug to any particular part of the body, where it is required to act, and there only and with a regularity and surety without precedent in therapeutics.

It is thus there can be produced at will local action on the skin or general therapeutic action in the organism, according to the electrolytic solution employed, the intensity and the duration of its application.

Professor Leduc, the initiator of ionic medication, says that "in some future time the present treatment by which, in order to act on a very limited part of the body, we introduce into the whole organism noxious substances, particularly injurious to the most delicate tissues, the nerve centres, for instance, will appear grossly absurd. One of the aims of medicine should be to replace as much as possible general by local treatment."

The treatment by ions is a purely local treatment. The medical agents it introduces into the organs reach the morbid tissues directly, very few of them entering the general circulation, as has been proved by experiments with salicylate of soda.

However that may be, it has been already proved that one of the most constant and efficacious actions of this electrolytic treatment is its resolving influence on fibrous formations by means of electrolysis of chloride of sodium. Complete ankylosis of the articulations got well rapidly under its influence and without forced extension or pain.

It would be impossible to give here all the cases in which the ionic treatment has been successful in the hands of Dr. Leduc.

It would seem, in any case, to be particularly successful in pleural affections, painful pleuritis, dry pleurisy, and above all, pleural symphysis. Remarkable results were also obtained in the treatment of neuralgia, tic doloureux of the face by salicylic ions.

Professor Leduc affirms having cured a case of neuralgia of four years' standing, and for which every other treatment had been tried in vain.

One of the drawbacks to this new method lies in the special instruments required and the necessity of long and laborious experiments to understand the local effects (caustic, antiseptic, coagulating of the conductibility, vitality, &c.) of the different ions. Their local action varies not only with each kind of ion but also with the dose of the same drug employed.

Intravenous Injections of Collargol.

Intravenous injections of collargol have been employed with success in numerous cases of septicœmia, and they deserve to be more generally employed. The *modus operandi* is simple. A bandage is placed above the elbow and sufficiently tight to distend the veins; an ordinary hypodermic syringe, previously sterilised, is charged with the collargol solution (2 per cent.). The needle is passed obliquely into the vein in the sense of the blood current, and as soon as the blood flows from it the syringe is adjusted and the liquid injected. After which the needle is withdrawn

The only accident that might happen in this little operation is that of missing the vein and injecting the solution into the surrounding tissues. To avoid this it is sufficient to wait until a drop of blood flows from the needle, to be certain that no error is made.

According to Riobald these intravenous injections of collargol are very successful in certain cases of acute arthritis rebellious to all internal treatment. Of fifteen cases thus treated by him, a complete cure was obtained in eleven, and the remaining four were greatly improved. The general condition appears also to be considerably modified by these injections; the temperature falls in a few hours.

This method cannot supersede, however, the treatment by salicylate of soda of acute rheumatism; but in those sub-acute cases, and especially in gonorrhœal rheumatism, it possesses almost a specific action.

This treatment might be associated with the Bier method: an elastic band tightly wound above the joint until complete cyanosis of the parts is observed; that is to say, from one to two hours, and repeated twice a day.

As has been mentioned, the strength of the solution is 2 per cent., and from 4 to 8 syringes might be injected the first time, and increased to 6 or 10, and repeated every day until relief is produced.

If at the end of two or three days there is no improvement it is better to suspend the treatment. However, failure is rare.

Tuberculous Meningitis in Children.

The treatment consists in mercurial frictions and iodide of potassium, given in large doses internally.

Iodide of potassium, grs. 20.
Syrup of orange, dr. 3.
Water, oz. 3.

A teaspoonful every hour.

Ice to the head; a flying blister followed by rubbing in with iodoform ointment (1-10).

Syrup of iodide of iron.
Syrup of lactophosphate of lime.
Syrup of cinchona.
Antiscorbutic syrup.
} āā oz. 2.

Three tablespoonsful a day.

In case of agitation, convulsions, warm baths and

Bromide of potassium, gr. 10.
Hydrate of chloral, gr. 6.
Syrup of peppermint, dr. 3.
Water, oz. 1.

A teaspoonful every hour.

Calomel in fractional doses (6 gr. in 10 powders) every hour. Constipation should be treated by suppositories, castor oil scammony or enemas with glycerine.

The patient should be shielded from the light and fed on milk and beef tea.

The lumbar puncture is especially useful as an aid to diagnosis.

GERMANY.

Berlin, March 17th, 1907.

Accidents and Cardiac Diseases.

Through the Insurance laws the determination of the relationship between accidents and subsequent disease of the heart has become an important one to the professional expert. The subject has been recently treated in the Argt. Sachverst Zeitung by Prof. Strauss, of this city. The paper is based on cases observed clinically by himself. The diseases mentioned in the paper are four in number. (1) Traumatic endocarditis; (2) serious muscular insufficiency; (3) sensible symptoms of irritation; and (4) arteriosclerosis. As regarded the first form the writer observed a case in which a brewery workman held on to the rim of a vat with all his force in order to prevent being pitched head foremost. After some weeks shortness of breath came on, which got worse, and although he was months in bed in hospital the case ended fatally. The autopsy showed warty deposits on the mitral valve, hypertrophy of the left ventricle with dilatation of the right. The following points were in favour of a causal connection between the cardiac disease and the accident. The nature of the accident rendered the occurrence of the mitral lesion quite possible, the continuity of the symptoms from the time of the occurrence of the accident might be held to be proved.

2. Excessive muscular insufficiency without coarse lesion of either valves or muscles or pericardium. These might also occur. A turner was struck whilst at work at his lathe by a tool that flew off and hit him over the heart. He first became giddy, then lost his breath. On being admitted into hospital the symptoms of cardiac muscular insufficiency and dilatation of both sides of the heart were observed. The symptoms at first improved, but they got worse again and the man died. A post mortem showed dilatation without any valvular changes, but there was narrowing of the aorta. This latter condition, in the writer's opinion. rendered the dilatation worse. The injury, however, might be looked upon "as the exciting cause of the pain and disturbance of health of the patient."

Simple straining with a narrowed aorta might lead to symptoms of muscular insufficiency. To prove this it would be necessary to prove the patient's perfect health up to the moment at which the strain took place, that this was excessive, and that no other explanation of the disease was possible.

In all cases of muscular insufficiency, pericardiac symptoms and aneurysm should be looked for. As regarded the first, a systolic murmur should be looked for at the apex, and a diastolic tumultuous movement of the chest wall. For the aneurism X-rays would have to be made use of.

3. Cardiac pain, pressure over the heart, and complaints of accelerated movement of the heart, without any abnormal pathological condition. The causal connection between the accident and the symptoms was first brought into consideration by the statement of the patient himself, if reliable. All the methods of examination that were employed in determining undue irritability were to be made use of. Orthostatic tachycardia, if present, should be noted, the conditions of the pulse when the patient had risen quickly off a chair. Herz's test (acceleration of pulse whilst stretching the flexed arms), the Hering-Kratschmer trigeminal reflex (the effect on the heart of ammonia vapour on the nasal passages), the Mankopf, Rumpft and Erb's tests. Only the positive failure of the tests was of any value, but they should all be applied and their value appraised.

4. Arteriosclerosis. This could only come into question in so far as a latent arteriosclerosis might be made manifest through an accident. The possibility must also be conceded that the origination of an arteriosclerosis might be accelerated by a long standing general neurosis.

Cardiac Activity and Blood Pressure Influence from Points Tender on Pressure.

Prof. Rumpf, of Bonn, has an article on this subject in the *Munich Med. Wochensel*, 4, 1907, from which the following note is gathered. In many cases of general neurosis in which neuralgia or tender points are present, changes in the cardiac activity and in the circulation may be effected by irritation of such points. These changes are: (1) simple acceleration of the heart movements; (2) transient preliminary slowing of the beat with subsequent accelerations; (3) weakening of the beat; (4) sometimes irregularity of the pulse, or intermittency in the beat; (5) distinct cyanosis of the face; (6) lowering of blood pressure; (7) raising of blood pressure.

All these changes in cardiac activity and in that of the vessels have this in common, that on ceasing the pressure on the tender points the changes ceased soon afterwards. The pulse rate was the first to return to the normal, whilst the change in the blood pressure were recovered from more slowly. In relation to general pathology the change in the blood pressure, by pressure on the tender point, was of special interest, as both the lowering and the raising of the pressure threw light on many pathological symptoms.

The Aetiology of Eclampsia.

A contribution to this interesting and obscure subject has recently been made by Dr. Brauns, *Deutsche Med. Zeitung*, 17.07. The first case observed was that of a woman who, previous to pregnancy, had been perfectly healthy. There was nothing whatever to indicate that she had had any nephritis before this. Both in the sputum and in the urine tubercle bacilli were present. In nine other cases of eclampsia also there were "splinters," *i.e.*, pannula globular elements that had been split off from the parent body of a tubercle bacillus. The writer considers the discovery of these splinters as proof of tuberculosis of the kidney. With the increase in the quantity of urine after delivery the number of "splinters" diminished, but even for months afterwards individual and extra cellular fragments could be shown to be present.

AUSTRIA.

Vienna, March 17th, 1907.

Theory of the Exanthem in Variola.

At the "Gesellschaft" Pirquet endeavoured in a long paper to show that the eruption in small pox was due to the agglutination taking place in the capillaries that produced the pustules. In previous vaccination the variola poison is modified by some bacteriolytic action produced by the vaccine, but when the vaccine itself was introduced fever and areola follow on the eighth or tenth day with undeviating regularity, thus proving the presence of a toxic agent, after which an antitoxic condition is produced. By inoculating smallpox a similar state is induced with the peculiar exanthemata. From this it follows that there is a connection between the antitoxin and the exanthem, as it is not until the antitoxic or immune condition is produced the rash appears on the cutaneous surface.

Is this antitoxin which produces the exanthem the agglutinin floating in the circulation and coagulating the blood in the capillaries producing congestion, inflammation, and finally pustules? This theory appears to explain Weigert's histological discoveries, who found the efflorescent patches on the skin contained in the arterioles tubular zoogl œa masses which was probably the result of the agglutinin. Measles again have apparently the same agglutinating bacteria in operation with incubation, prodromal fever and a leucocyte curve similar to that met with in small pox, which also supports the theory of the antitoxic exanthem.

Kraus thought this new theory violated the logic of our knowledge of immunity in variola by vaccine. He considered the exanthemar rash to be the result of a general toxic condition and not depending on the formation of a new endotoxin as Pirquet suggests. It is simply a generalisation of the virus, as that occurring in typhoid, syphilis, etc. Another point against the new theory is that no agglutinin or precipitin have been discovered in variola, although observed in typhoid, which leaves the theory without support. Again the doubtful immunity of vaccination renders speculation on the lytic properties of any newly-developed antitoxin or properly or more correctly endotoxin, a dangerous adventure.

Escherich thought this new idea of Pirquet's should not be passed by lightly, as it opened up the consideration of a very difficult subject. It has frequently been observed that the strong have a more intense rash than the weak in attacks of measles, while undeveloped or dark-coloured exanthems is a signum mali ominis.

Pirquet's hypothetical, endotoxin may not be the cause of the rash, but it is a good explanation of the resisting constituent of the organism.

Knopfelmacher reminded his hearers that the exanthems of the immune and non-immune behaved very differently after injections, and quite agreed with Pirquet's theory of the agglutinin producing the rash.

Neuritis Optica.

Reiter and Lauber showed a case of neuritis of the optic nerve following an attack of typhoid fever, which they pointed out as very rare, as only twenty such are to be found in medical literature. They considered the case as one of descending neuritis from the meningitis that preceded the advent. In other cases the poison may be the cause, and pure toxic neuritis result. Salomon said that in the different infectious diseases such as scarlatina, typhoid, etc., which he had examined he always found a certain amount of congestion in the papilla.

Lauber said this case was not a congested papilla, but a genuine neuro-retinitis. Wenternitz and Schrötter expressed their surprise that this complication was so rare, as they had been many years among these infectious diseases and had not seen one before.

Noorden was inclined to believe that the toxin was the active factor in these cases, as he had frequently, like Salomon, observed congestion of the papilla as a complication which he associated with the disease.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Report of the Carnegie Trust.—The following are the main points in the report of the executive committee concerning the administration of the Trust during 1906:—Under the scheme of allocation of £40,000 annually for five years among the four universities, £37,288 has been handed over during the year. Grants have also been made to the following extra-mural schools:—School of Medicine of the Royal College, Edinburgh Medical College for Women, Anderson's College Medical School, Glasgow Technical College, Heriot Watt College, West of Scotland Agricultural College, East of Scotland Agricultural College. To these institutions £9,000 has been allotted. Under the Research Scheme appointments were made to 17 Fellowships and 37 Scholarships, and grants were given to 40 applicants. A list of the published researches of beneficiaries under the scheme has been prepared. In the Royal College of Physicians' laboratory 29 workers have carried out investigations during the year; a tenth volume of laboratory reports will soon be issued. In the last report the executive committee drew attention to the financial difficulties which then faced them in relation to the payment of class fees, from the multiplication of classes and the raising of the fees in certain arts classes. The Trust was, in fact, nearly at the end of its resources, and had therefore to reconsider the regulations; they resolved, as a provisional measure, to adopt two modifications which appeared to be called for also upon educational grounds. The one modification limited payment of fees for further classes to beneficiaries who had passed their graduation examination up to that date, and the other restricted the payment of fees for advance classes to those who had proved their ability to profit by such by passing the ordinary graduation examination on the relative subject. This year, despite the rise in arts fees, the expenditure has diminished by £6,563; it is not possible to say how far this relief to the Trust has been at the expense of the Universities, and how far at the expense of beneficiaries. The number of beneficiaries has been 2,911, as opposed to 3,184 in the previous winter session. The time for a second quinquennial allocation of funds under Head A of the Trust Scheme is now approaching, as the present five-yearly period terminates in 1907. The following general considerations will influence the new allocation of grants:—(1) The wishes and requirements of each educational centre will be considered as a whole, so as to avoid, as far as possible, duplication and lack of co-ordination; (2) an attempt will be made to come to some arrangement as to an inclusive fee to be paid by the beneficiaries for their whole education. (3) Some of the present educational difficulties and anomalies will be removed by Ordinance.

CLOSING OF GIRGENTI HOME FOR INEBRIATES.—The Glasgow Corporation have arranged to close this Home, which has now been in operation for six or seven years, and to transfer the inmates to Perth. The Home was started experimentally, and through its agency a number of women have been reclaimed, but it is not felt that the results justify its continuance at a cost of nearly £1,300 a year. The Home Secretary has intimated that in future the grant is to be diminished and this, no doubt, has influenced the city authorities in coming to their decision.

THE BIRTHPLACE OF A GREAT QUACK.—It is of some interest to learn that Edinburgh has the honour(?) of having produced one of the great charlatans of the nineteenth century. "Prophet" Dowie, whose death was recently announced, was the son of John Dowie, a breeches maker, and Ann MacFarlane, who sixty years ago resided in Leith Street. The following entry in the Register of Births, 1855, attests the facts: "Edinburgh, December 31st, 1855—John Dowie, breeches maker, and Ann MacFarlane, his spouse, had a lawful son born at Leith Street, St. Andrew's parish, on the 23rd day of March, 1847, named John Alexander."

BELFAST.

ULSTER HOSPITAL FOR WOMEN AND CHILDREN.—The annual meeting of this hospital was held last week, the Lord Mayor (the Right Hon. the Earl of Shaftesbury, K.C.V.O.), presiding. The medical report, read by Dr. Fielden, showed an increased number of patients in all three departments, Children's, Women's and Maternity. The number of children treated in the wards was 247,174 operations were performed, and there were 10 deaths. The women treated in the wards numbered 81, there were 63 operations and two deaths. The extern maternity cases numbered 260, and the total number of patients to whom the hospital afforded relief was 3,787. The medical staff reported with regret the resignation of Dr. Cecil Shaw, who had been Ophthalmic Surgeon to the hospital for 15 years, and secretary of the staff for 13. He had been obliged to resign owing to the pressure of other duties, but had been elected to the honorary consulting staff. Dr. A. B. Mitchell spoke on the work of the hospital, and explained the great need for further and improved accommodation. A movement has been started to rebuild the hospital, and a start has been made with a promise of £1,000 by Mr. G. W. Wolff, M.P., towards the total of £10,000 which it is estimated will be needed.

THE UNIVERSITY QUESTION.—A meeting of the Council of the Royal University Graduates Association was held last week, at which certain resolutions were passed condemning Mr. Bryce's scheme. They also "condemned in the strongest manner the extraordinary conduct of the thirteen members of the Senate who withdrew their opposition to a scheme which four months ago they declared to be disastrous to the interests of education and gravely injurious to the welfare of the country." In view of the frequent paragraphs in the daily press referring to the Presbyterian Church and University education it may be as well to say that the views and resolutions of the General Assembly's Committee on the subject need not be taken too seriously, as they do not represent any very large body of Presbyterian opinion. The Ulster Presbyterian is a singularly independent individual, and forms his opinions on University as well as other matters without any ecclesiastical guidance, and even among the clergy of that church there are wide diversities of opinion on this question.

CEREBRO-SPINAL MENINGITIS.—About twenty new cases of cerebro-spinal meningitis have occurred during the past week, and seven deaths. In one case, where a child of four months old had died without medical attendance, an inquest was held. It appeared that five weeks ago another child in the same family had died of cerebro-spinal meningitis, and from the *post-mortem* appearances it was evident that this child died from the same disease. The father was a labourer earning eighteen shillings a week, and the family of six occupied one room, at a rent of 1s. 4d. a week. The whole place was horribly filthy, and the court where the house was situated had been closed as insanitary, but opened again. It is a good case for the present Health Commission to investigate, specially as to why the house was allowed to be occupied after being condemned. The members of the Health Commission have been making various visits and inspections in the city, and will sit again on Tuesday, 19th.

LETTERS TO THE EDITOR.

MEDICAL LAW REFORM.

To the Editor of THE MEDICAL NEWS AND CIRCULAR.

SIR,—In reply to your correspondents who ask what practical steps can be taken to promote the appointment of a Royal Commission, I would suggest that the first thing to be done is to start a medical Law Reform Association or Committee, and to provide them with the necessary funds to begin with. The job would be a big one, but it is well within the power of the profession to carry it through if only they will unite and act with determination. They could show that it is their duty to take up the task on behalf of suffering humanity, and could establish their case for legislation on overwhelming evidence. Quackery, practiced by unqualified pretenders, and the traffic in quack nostrums, form a gigantic system of cruel fraud, which in the present state of the law cannot be interfered with. Exposure would kill it; but the exposure must be complete and indisputable. My personal position is one of almost complete detachment. Personally, I am not remotely affected by the evils I complain of. My knowledge of them and my acquaintance with problems of medical legislation have gradually grown during the past thirty years. During this time I have learnt to pity the victims of cynical villainy, and to detest the criminal gangs who amass wealth by this the most nefarious of methods. I also sympathise with the profession, whose status remains inferior largely in consequence of their lack of due privilege and protection. When I first broached my project of a Royal Commission I offered to back my opinion as to its efficacy to the amount of £50; and I am ready to renew this offer on the same terms. If ninety-nine others can be found to put down a like sum, or if the balance of £5,000 can be guaranteed, I will make myself responsible for the amount named; and I will leave this offer open for a year from this date. It seems useless to discuss further procedures until we see what response my proposal elicits.—Yours truly,

HENRY SEWILL.

March 13th, 1907.

VOLUNTARY *v.* STATE HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

DEAR SIR,

PROPOSITION A.

That the hospitals should be associated in their management with the Borough Councils.

Let it be granted that the health of the community is the concern of the State (the State here means the civitas, the city, town or borough).

Also that voluntary hospitals are maintained for that end, namely, health. Therefore the Borough Councils should recognise and encourage voluntary hospitals, in so far as they tend to the well-being of the community, and should prevent them from doing harm economically.

It follows: (1) That the hospital will be free of rates, for no rate is levied on the Town Hall, or the Free Library, or the Workhouse Infirmary. (2) That the State, *i.e.*, the Borough Council, will assist in and control their management. For (*a*) the health of each individual concerns the community as a whole; and (*b*) the committees of hospitals must act in harmony with the other work of the Council. The Council will therefore appoint a proportion—one-fourth or one-third—of the board of management of every hospital within the borough, and the accounts of the hospitals will be audited by the Borough Accountant.

It will follow that when the voluntary subscriptions diminish or cease, the hospital will be, in part or wholly, closed. For if it were then to be rate-aided, it would cease to be a voluntary hospital and would become a Workhouse Infirmary, to which the principles and rules of the Poor Laws would apply.

I am, Sir, yours truly,
March, 1907. John Euclid.

THE *PALL MALL GAZETTE* ON INSANITY.

To the Editor of The Medical Press and Circular.

Sir,—Can nothing be done to bring home to the minds of newspaper editors the gravity of their responsibility to the public in many medical matters. I enclose a cutting from the *Pall Mall* of this evening, March 9th, and I would ask whether it is right for a paper of the highest class like this to point out a misleading string of paragraphs in such a sensational fashion. I know nothing at all about Dr. Hollander or his works, and assume he occupies the position of scientific distinction the *Pall Mall* assigns to him; he must surely be disgusted to find himself forced into public notoriety in this way, and will, no doubt, hasten to take steps to disavow any knowledge of the transaction.

I am, Sir, yours truly,
An Obscure Practitioner.
March 9th, 1907.

ANTIVIVISECTIONISTS AND FALSEHOOD.

To the Editor of The Medical Press and Circular.

Sir,—May I venture to protest against an expression of opinion found in your issue of March 13th, to the effect that Antivivisectionists "positively revel in wild and wicked exaggerations, and do not scruple even to tell the grossest falsehoods," etc.

Antivivisectionists are fallible, and may make mistakes, but I believe even the medical papers have sometimes gone astray in matters of fact, and even apologised for unintentional inaccuracies. Surely it would be more charitable and certainly more just to believe that when an antivivisectionist falls into an error he does so inadvertently. Although we all feel a certain temptation to apply such adjectives as "cruel" to men who undoubtedly do cruel deeds, most responsible antivivisectionists carefully abstain from doing so, and reserve their adjectives for the deed rather than the doer.

You appear to feel no such scruples when attacking us, and I think a little consideration will induce you to withdraw at least one very objectionable remark in the article to which I allude, and which is certainly more extreme and more insulting than anything that has been written on our side against vivisectors. I refer to the following sentence:—"The honest man has no place in any of the Antivivisectionist organisations of our time." Those who are acquainted with medical men, who, holding Antivivisection views, do not scruple to say so publicly, and thus expose themselves to attacks from their own profession, which cannot be pleasant, and to calumnies in the medical press such as that which I have quoted, cannot but feel that these men at least deserve the epithet "honest," which is the smallest recognition that can be accorded to them by those who hold opposite views.

I am, Sir, yours truly,
B. E. Kidd,
Secretary British Union for the Abolition of Vivisection, 32, Charing Cross, S.W.

OBITUARY.

SAMUEL BARKER, M.D., M.R.C.S.Eng., L.R.C.P. Edin.

We regret to announce the death on March 11th, of Dr. Samuel Barker, of Brighton. The venerable physician was one of the founders of the Children's Hospital, and to the end of his days he remained actively associated with it as Consulting Physician. Dr. Barker had ceased his private practice nearly twenty-five years, and he lived to see his 86th year. For some time he had been failing from old age. He enjoyed brilliant distinction in his profession, and held the degrees of M.D., St. Andrew's (1858), L.R.C.P. Edinburgh (1861), and M.R.C.S. England, and L.M. (1857). He devoted himself chiefly to the study of children, and his services to the Hospital in Dyke Road were appreciated at the highest value. Among his best-known publications were: "Prevention and Cure of Skin Diseases by Heat and Fumigation" "The Turkish Bath in the Treatment of Disease," "Diet of Infancy and Childhood" "Domestic Management of Infants and Children in Health and Disease," "Remarks on the Only True Foods for Children," and "Scarlatina: Its Successful Treatment." It was about fifty years ago when he came to Brighton, and he always commanded a high position as a professional man in the town. The Children's Hospital was not the only public Institution which claimed his interest. For years he was physician to the Brighton and Hove Dispensary, and subsequently was made Consulting Physician. He was also Hon. Physician to St. Mary's Hospital, Queen's Square, Brighton. Dr. Barker was a Fellow of the Royal Meteorological Society.

WILLIAM A. F. BATEMAN, M.R.C.S., L.S.A.

By the death of Dr. W. A. F. Bateman, Richmond (Surrey) has lost its oldest medical practitioner, and one who has for forty years taken a leading part in philanthropic and literary movements in the town. Dr. Bateman, whose death followed an operation, had reached the age of 72, and was one of the first members of the Richmond Hospital, of which he was the senior member of the honorary medical staff. It was largely owing to his energy that the extension of the hospital and the erection of a children's ward were undertaken. He was also Surgeon to the Royal Female Naval School at Isleworth and to the Orphan Home, Ham Common. He had been a keen volunteer, but he retired some years ago with the rank of Surgeon-Lieutenant-Colonel with Volunteer Decoration.

ROBERT ELLIOT LITTLE, M.B., C.M.Edin.

We regret to record the death in Duns Hospital on March 11th, of Dr. Robert Elliot Little, who was spending part of his furlough from Nigeria with friends in Berwickshire. Dr. Little was a native of Wamphray, and was related to Professor Charteris. He was a graduate of Edinburgh University, and was for a number of years in practice in Gordon, Berwickshire, but left some five years ago for service in Nigeria, and was spending a holiday with his friends in Gordon, where he contracted pneumonia. At first there were good hopes of his recovery, but he had a relapse on the following Sunday, and died. He was unmarried.

ARTHUR ERNEST SANSOM, M.D.Lond., F.R.C.P.

We much regret to record the death of Dr. Arthur Ernest Sansom, M.D., who died at Bournemouth, at the age of sixty eight. He was educated at King's College, London, and in 1859 took the M.B. degree, London, and was admitted a member of the Royal College of Surgeons, England, and a licentiate of the Society of Apothecaries. In 1866 he proceeded to the M.D. degree, and in 1878 was elected a Fellow of the Royal College of Physicians, London. Dr. Sansom was consulting physician to the London Hospital and to the North-Eastern Hospital for Children and physician to the Royal Albert Orphan Asylum, and had formerly been examiner in medicine for the Royal College of Physicians, London, and the Royal College of Surgeons, England, and also for the Universities of London and Durham, and physician to the Royal Hospital for Diseases of the Chest, City Road. He was a Fellow of King's College, an ex-President of the Medical Society of London, and a member of various learned societies in this country and abroad. He contributed largely to medical literature, his chief interest being centred in diseases of the heart, in which he was universally regarded as one of the greatest living authorities.

SPECIAL ARTICLE

THE SECOND CONGRESS OF THE INTERNATIONAL SURGICAL SOCIETY.

Under the patronage of His Majesty Leopold II., King of the Belgians, will be held in Brussels in September, 1908, under the Presidency of H. Excellency Professor Czerny, of Heidelberg.

At the first Congress, held in Brussels in September, 1905, it was decided to organise an exhibition illustrative of Cancer and its treatment for the second Congress to be held at the same place in 1908.

With a view of securing a systematised method of procedure in the construction of reports relating to specimens, some suggestions have been prepared by Dr. Jules Dollinger, professor of Clinical Surgery in the Royal University of Budapesth and president of the International Cancer Museum. Specimens for exhibition will be received by Professor Depage, General Secretary of the Society, 75, Avenue Louise, Brussels, from the 1st to the 8th September, 1908. This exhibition is not necessarily confined to members of the Society. The Congress will be so arranged as to allow exhibitors to make such demonstrations as may appear desirable by the Society during the meeting. The International Surgical Society consists of over 600 members and includes 23 national committees co-operating in various parts of the world. By the statutes of the Society the number of members is limited. The official languages of the Congress are English, French, and German. The subscription is a triennial one only of forty francs (£1 13s. 4d.) payable on election, and includes a copy of the transactions of the Congress. The members of the Society elect in Congress the National committees and other office bearers.

Application for membership should in the first instance be forwarded to the Honorary Secretary of the National Committee (Iles Britanniques) for transmission to the International Committee which meets in Brussels. The subjects selected for discussion at the Congress in 1908 and the names of the nominated reporters will be announced later on. Copies of the statutes of the Society and other information may be obtained from the Honorary Secretary, Mr. Reginald Harrison, 6, Lower Berkeley Street, Portman Square, W.

REVIEWS OF BOOKS.

FREYER ON ENLARGED PROSTATE. (*a*)

That a third edition of this work by Mr. Freyer should be required in such a short time shows in itself how useful this book has been to surgeons. The operation of suprapubic prostatectomy is very fully described, the text being assisted by numerous illustrations which make the steps of the operation very easy to follow, nor has the after treatment been neglected, for here in particular the author has spared no pains to make his methods absolutely clear to his reader, and with the large experience of over 300 prostatectomies, there is no surgeon living whose remarks can carry as much weight as those of Mr. Freyer must do on this subject. It is a pity that a little more space and attention is not given to the very interesting question of the pathology of the enlarged prostate. Mr. Freyer says: "All we know of the disease is that the enlargement of the gland is mainly, if not wholly, of an adenomatous character. Having fulfilled its purpose the gland has a tendency to run to seed, as it were, but why it does so has yet to be explained." Surely Ciechanowski's exhaustive work and his findings on the subject of hypertrophy of the prostate deserve more notice than this, not to mention the writings of a host of other pathologists. Again, in the chapter dealing with the after treatment of prostatectomies, Mr. Freyer advocates washing out the bladder solely by means of the suprapubic wound for the first week. It is, however, quite impossible to really clean out the neck of the bladder by this means, unless lotion is passed through the urethra, either direct or by means of a catheter, into the bladder and allowed to flow out through the suprapubic wound; failure to thoroughly cleanse this portion of the bladder is very likely to be followed by epidydimitis, a complication that is not mentioned; indeed the only trouble the surgeon is warned to be on the look out for after prostatectomy is the danger of secondary hæmorrhage.

That part of the book which deals with the author's claim to be the originator of the operation of total removal of the prostate by the suprapubic route might well be omitted; the proofs adduced are not convincing, and the point is one of little importance, for the whole profession cannot hesitate for a moment to give Mr. Freyer the greatest credit for demonstrating in the most wonderful way the utility of this operation. The book should be in the hands of every surgeon who does bladder work; there are many useful hints for the physician also, who will often have to treat cases of enlarged prostate gland.

HARRISON ON URETHROTOMY. (*a*)

This small work really consists of a series of lectures delivered at the London Medical Graduates College; in them the author describes the operations of internal and external urethrotomy, and a combination of these two operations, which he has often found useful, the description of these operations is not very full, the object of the book being rather to show in what type of disease or injury to the urethra urethrotomy will prove the best form of treatment. Speaking of internal urethrotomy, Mr. Harrison says this method of treatment may be indicated in cases of stricture of the urethra, and their complications, when dilation by bougies proves insufficient, and with this statement no surgeon will find any fault; but the writer then relates that out of 255 cases of stricture 182 required internal urethrotomy, the remaining 73 being treated by other measures. This surely is not the experience of most genito-urinary surgeons, treatment in many if not in most cases of stricture being very satisfactorily carried by dilating with metal bougies. Again, in performing internal urethrotomy, the author prefers one deep incision through the roof of the stricture, instead of, as is commonly done, making multiple incisions, which need, of course, not be nearly so deep; the reason for this being that the multiple incisions tend to increase the amount of cicatrix. No attempt is made to prove this somewhat doubtful statement. Hæmorrhage coming on after such an operation is lightly dealt with, it being merely stated that bleeding is rare. When more than one fatal hæmorrhage has been recorded following this form of operation, it surely deserves more attention than this.

There is, however, much of practical use in this book for the operating surgeon, many useful hints being given in the after treatment of cases. The chapter on kidney capsulotomy in particular is full of interest, brevity being its only fault.

(*a*) "Clinical Lectures on Enlargement of the Prostate." By P. J. Freyer, M.A., M.D., Surgeon to King Edward's Hospital and to St. Peter's Hospital for Stone. Balliere, Tindall and Cox. Third Edition. 1906.

(*a*) "The Urethrotomies and Kidney Capsulotomy." By Reginald Harrison. John Bale and Sons. 1906. Price 2s. 6d.

DUTCH ON FOOD AND DIGESTION. (*a*)

In the preface the author comments on the way in which the smaller text-books on dietetics are too often written for the express purpose of promulgating some special doctrines in regard to food, and he attempts to give an unbiassed account of the principles which govern food and digestion in health and disease. The good intentions of the author are, however, marred by the loose verbiage which characterises the book. It is obvious that he has striven to produce a volume that could be appreciated by persons with no previous knowledge of medicine, chemistry and hygiene, and his efforts have resulted in the adoption of a style more suitable for a child's reading-book than for a scientific treatise.

The various articles of diet and their use and abuse are considered, and a section is devoted to dietaries in disease. The work ends with a glossary designed "to facilitate the correct interpretation of the technical terms used," which, like the remainder of the book, shows a lamentable carelessness on the part of the author in his choice of words.

THE BACTERIOLOGY AND ETIOLOGY OF ORIENTAL PLAGUE. (*b*)

It has been shown by Dr. Klein and others that a patient may exhibit symptoms simulating those of bubonic or Oriental plague without suffering from this disease, the absence of plague being shown by bacteriological examination. This renders the bacteriological evidence a very important factor in establishing the nature of the malady, and since the disease is one that calls for extreme precautionary measures to prevent a sporadic case causing an epidemic, the value of the evidence obtained from a bacteriological examination of the patient is of immense importance. From a public health standpoint the diagnosis of the disease in rats is as important as the examination of suspected human cases, owing to the terrible part these rodents play in spreading the disease. As in the case of man, Dr. Klein has shown that rats which clinically possessed manifestations of the disease, in some cases gave a negative result on bacteriological examination, and these results were confirmed by no further cases occurring. The author has shown that different species of rats vary greatly in regard to their susceptibility to the disease. The white rat is the most susceptible, the brown ship rat or brown dock rat coming next, then the black rat and a Norwegian species, and finally the least susceptible of all—our own common sewer rat.

Professor Klein cites cases of healthy rats living in the same cage or in close proximity to infected animals that did not contract the disease, which appears to show that the disease is not spread by means of fleas from one rodent to another.

The various manifestations of the disease in man and rodents, the methods and conditions of infection, the agglutination and disinfection of *bacillus pestis*, and protective inoculation, are fully considered. A considerable space is devoted to the characters of the specific organism and to microbes simulating *B. pestis*, and a chapter is devoted to the analysis of plague materials. Altogether the work is a most admirable digest of the subject of bubonic plague as recent research has revealed it. The illustrations are numerous and excellent and add greatly to the value of the book. The volume is what we should expect from a savant like Dr. Klein, who by his extensive researches and wide knowledge of the subject he deals with is well fitted to deal with and sift the clinical and experimental work performed in connection with Oriental plague.

MANUAL OF SURGERY (*a*)

It is a little over two years since we reviewed the first edition of Thomson and Miles' Surgery, and strongly recommended it to the practitioners and students. The early appearance of the second edition proves that the work has received the favour which it deserves.

The second edition has been brought thoroughly up to date and contains over fifty more illustrations and the same number of additional pages. The illustrations are even better reproduced than in the previous edition, and are particularly useful and instructive in connection with the text in the chapters dealing with fractures, dislocations, and deformities. A series of micro-photographs of the more important bacteria concerned in surgical diseases, also some very fair examples of X-ray photographs, have been added. The text has been revised, and made somewhat fuller in several particulars, and some of the more important matter has been changed from small into large print. The index contains more references.

On the whole this edition of Volume I. is a pleasing improvement on the previous one, and is well calculated to increase the usefulness of this work, and further ensure its popularity.

BREND ON MEDICAL JURISPRUDENCE. (*b*)

On taking up a small handbook of the type of this work of Mr. Brend's, we naturally ask ourselves if there is any reason why it should have appeared, and if it is anything more than a condensation of larger books on the same subject. To these questions we are satisfied that we may say "Yes." It is an original and interesting little book, not so much condensed as to be dry, and not so diffuse as to be ill-proportioned. Indeed, as a work it is well-managed, sufficient consideration being given to each subject, and modern instances and new discoveries being judiciously embodied. We may go so far as to say we know no work of its size so well adapted for students

LITERARY NOTES.

We have received as usual Willing's invaluable "Press Guide." It has now reached its thirty-fourth annual number, and for those engaged in press work it is one of the most handy and useful reference works. It contains a short, comprehensive index of all the newspapers, magazines, periodicals, guides, together with directories, journals, proceedings, and reports of societies issued in the British Isles. Besides, there is a classified list of trades, professions, sciences, religious denominations, telegraphic and reporting agencies, and a variety of other information indispensable to those who work with the pen.

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THE SPIROCHÆTA PALLIDA IN DISEASES OF THE EYE.

The March number of the *Ophthalmoscope* contains a brief but important communication referring to the spirochæta pallida by the editor, Mr. Sydney Stephenson. This protozoon, it appears, has not yet been demonstrated in syphilitic lesions of the eye, except in such as have been produced artificially in the laboratory. Mr. Stephenson now announces the fact that he has found the organism in the corneal lesion of two cases of keratomalacia in syphilitic babies, seen at the North-Eastern Hospital for Children, London. Material from the ulcerations was stained by Giemsa's method after it had been smeared on the surface of cover-glasses, and a limited number of spirochætæ were found in each instance.

(*a*) "Food and Digestion in Health and Disease, during Infant, Child, and Adult Life." With an Introduction on the Nature of Matter and the Phenomena of Life, and an account of the Source, Properties and Influence of Water. By M. A. Dutch, M.D., D.P.H., Pp. 224 and viii., with two illustrations. 1906. London: Henry Kimpton. 2s. 6d. net.

(*b*) "The Bacteriology and Etiology of Oriental Plague." By E. Klein, M.D., F.R.S., Lecturer on Advanced Bacteriology at the Medical School of St. Bartholomew's Hospital, London. Pp. 301 and xii., with 89 photograms. 8vo. London: Macmillan and Co., Ltd. 12s. net.

(*a*) "Manual of Surgery." By Alexis Thomson, F.R.C.S.Ed., Assistant Surgeon, Edinburgh Royal Infirmary; Surgeon to the Deaconess Hospital, Edinburgh; and Alexander Miles, F.R.C.S.Ed., Assistant Surgeon, Edinburgh Royal Infirmary; Surgeon to Leith Hospital. Vol. I., General Surgery, with 313 illustrations. Pp. 808 and xxi. Edinburgh and London: Young J. Pentland. 1906.

(*b*) "Medical Jurisprudence and Toxicology." By William H. Brend, M.A.Cantab., M.B., B.Sc.Lond., of the Inner Temple, Barrister-at-Law. London: Charles Griffin and Co., Ltd. 1906.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT PATHOLOGICAL LITERATURE.

A New Nitro-prusside Reaction in the Urine.—According to Arnold (*Zeitschrift fur Phys. Chemie*, Bd. 49, Hft. 4 and 5), the following reaction appears in the urine about ten minutes after the injection of soup, and persists for some hours: Take 10-20 c.cm. of urine and add to it a few drops of a 4 per cent. sodium nitro-prusside solution, and 5-10 c.cm. of a 5 per cent. solution of caustic potash, there then appears in the urine a pure strong violet colour which quickly turns purple and later reddish brown. The violet solution gives a spectrum between the lines D and E, and is turned first blue and later yellow by the addition of acetic acid. The body which gives the reaction is destroyed by heating with mineral acids, but is not affected by heating the untreated urine. It is non-volatile, but can be extracted by acetic ether and by chloroform. It does not appear to be of endogenous origin, and the reaction that it gives differs from that of other known urinary contents.

M.

The Blood in Pernicious Anæmia. — Emerson analyses the series of blood counts made from 89 cases of pernicious anæmia in the Johns Hopkins Hospital during the last few years (*Johns Hopkins Hosp. Bulletin*, February, 1907). His analysis deals both with the red cell and white cell changes. As regards the latter, he is able to draw the following conclusions: (1) An absolute lymphocytosis, meaning by that term the presence of over 2,000 lymphocytes per cm., is occasionally met with, and appears to be of evil significance. (2) A relative lymphocytosis is very common, being found in 61 out of 69 cases. (3) Total disappearance of eosinophile cells is a bad sign, but on the other hand an increase in their number does not always mean that the prognosis is good. (4) Myelocytes occur more constantly and in greater numbers in pernicious anæmia than in any other disease, except leukæmia. (5) As a rule the total count of white cells runs parallel with that of the red. As regards red cells and the hæmoglobin content, it was found that the hæmo globin index was almost always above unity. The symptoms complained of by the different patients on admission varied with the blood count; thus those who had under 1,000,000 per cm. complained of dyspnœa and weakness; those with counts from one to two millions had gastro-intestinal symptoms; while nervous symptoms predominated amongst those who sought admission with counts over two millions. In very few cases was it possible to get the number above four millions, even by prolonged treatment, and it was noticed that the count tended to vary in a wave-like manner, a period of gradual rise being succeeded by one of gradual fall. Sometimes the rise in number coincided with a general increase in the symptoms complained of, though as a rule the reverse was the case. Probably in the former type the rise in number is due to concentration of the plasma and is not a genuine increase. The counts at death varied considerably according as death was due to some terminal infection, or to simple weakness and anæmia. M.

Primary Tuberculosis of the Kidney. — Curtis and Carlier (*Arch. de Med. Experim.*, 1905, p. 439) call attention to the occurrence of primary renal tuberculosis, as distinct from the variety that occurs by spread up the ureter. They describe a kidney which they believe to be of the primary type removed by operation from a man, æt. 27. The organ was very much enlarged and was composed of numerous cysts, resembling those found in congenital cystic tumours. The bacillary virus had given rise to interstitial, epithelial, and cystic changes. Clinically, the long duration of the affection was remarkable. After operation, which was performed some years ago, the patient has continued to enjoy excellent health, a fact which is in favour of the condition being primary. The authors believe that it arose by way of the blood stream, and that the first change took place in the cortex. M.

The Relationship of Gonococci to Meningococci.—Recent investigations have shown that precipitin reactions may be employed as a means of grouping different varieties of bacteria into genera. For example, the same immune serum may prove effective against different bacteria, and may also give a precipitate with the bacterial products of different members of the same genus of bacterium. Similarly agglutination is capable of being used to distinguish genera. Tupnik has attempted to investigate the relation of gonococci to meningococci by the above indicated methods (*Berlin Klin. Woch.*, 1906, No. 53). In several cases of cerebro-spinal meningitis he isolated a coccus resembling that of Weichselbaum, and indistinguishable in growth on the ordinary media from gonococci. He then proved that gonococci and meningococci produce similar agglutinins precipitins, toxines, and anti-toxines, and in consequence holds that they belong to the same genus, although they differ in kind by producing different pathological effects in the animal body. The same genus includes amongst its members the diplococcus conjunctivitidis, and most probably Pfeiffer's diplococcus catarrhalis as proved by the same tests. M.

Ovarian Influence upon the Uterus.—Marshall and Jolly report some experiments which they have made in connection with the above (*Edin. Med. Journal*, March, 1907). The ovaries were removed by anterior incision from 33 rats, and the animals were killed at periods varying from two and a half to eight months after the operation. On examining the uterus it was found that that organ differed from the normal as follows: It was usually small and atrophic, the mucosa was thin and poor in cells, the mucosal glands small, and the connective tissue was increased in amount. In those cases where traces of the ovary had been left behind no atrophic appearances were found. The authors then attempted transplantation of ovarian tissue and succeeded in eight cases in transplanting the ovary from its normal site to another situation in the same animal. Two cases of heteroplastic transplantation also proved successful. The appearance of the uterus was later found to bear a relation to the microscopic appearances of the graft. If the graft had failed there were signs of uterine degeneration, but if it had taken the uterus was normal. The authors conclude that the uterus is dependent for its proper nutrition on some internal secretion of the ovary.

M.

The Conduction of Sensory Impressions in the Spinal Cord.—Simpson and Herring make (*British Medical Journal*, December 21st, 1906) an important contribution to our knowledge of the paths taken by sensory impressions in their transmission to the brain. They note the great variety of opinions held both as to the tracts of the cord in which the impressions travel, and as to the question whether crossing takes place in the cord or at a higher level. The authors' experiments were performed on cats, the cord being exposed and a lesion produced by the galvano-cautery. The animals were then kept for three or four weeks, their sensibility being fully tested. The lesion was exactly located by a post-mortem examination. The following conclusions were arrived at: (1) The integrity of the grey matter is not essential to the conduction of impressions of pain; in several cases where the animals responded at once to painful stimuli, the grey matter was found to be entirely destroyed. (2) Total destruction of both posterior columns does not affect sensibility to pain. (3) Impressions of pain travel both crossed and uncrossed, principally the former. Lesions involving the whole transverse section of the cord, with the exception of the antero-lateral column on one side and a thin zone of grey matter adjacent to it, did not abolish the sense of pain on either side, but the response was more ready on the side of the lesion than on the sound side. (4) It is probable that impressions of cold travel by the lateral columns, and that the conduction is both crossed and uncrossed. (5) The only lesion which abolished the passage of all forms of sensation was a complete transverse section. R.

The Spirochæte in Congenital Syphilis.—Schultz (*Journal of Medical Research*, December, 1906) reports very fully the microscopic findings in two cases of congenital syphilis. They bear out the statements of Levaditi, Herxbenner, Gierke, and others. The characteristic organism was found in practically all the organs of the body—liver, spleen, kidneys, adrenals, thymus, pancreas, heart. It was found, also, but very scantily, in the placenta and umbilical cord. The organism appears to be usually intracellular, and, therefore, may not be demonstrable in smears, even where very plentiful. In the organs it is situated chiefly in the proliferating connective tissue. It is also found in considerable numbers in the walls of the arteries. In one of the cases a gumma was present in the lung. No spirochætes were found in the necrotic mass, a few were found in the fibrous capsule, and many in the infiltrated tissue around. This observation supports the statement of Metchnikoff and Roux that gummata are infective, but that large quantities of material are necessary for successful inoculation. The paper is illustrated by some fair micro-photographs. R.

Functional Albuminuria in Athletes.—Collier publishes (*British Medical Journal*, January 5th, 1907) a note on functional albuminuria in athletes, which shows both that the condition is more common than is generally believed, and that the albumin is often considerable in amount. He has examined the urine of men who have rowed or run in severe races. Of specimens of urine obtained from 156 apparently healthy young men training for the "Torpids," 81 showed by the cold nitric acid test a very definite amount of albumin, albumin being present in smaller quantity in 24 other cases. These specimens came from men after moderate exercise. When specimens were obtained after racing, the number of those containing very definite amounts of albumin was strikingly increased. The urines of the Oxford crew after the last Oxford and Cambridge race were examined, and all of them found to contain albumin, 50 per cent. in large quantities. The urine of men or boys who had run races was in every case but one of some 50 examined found to contain albumin. Collier believes the condition of little bearing upon health, and thinks functional albuminuria should not be given such weight in examinations for life assurance. R.

Lesions Due to Trichina Spiralis.—Frothingham (*Journal of Medical Research*, December, 1906) publishes a careful account of the examination of the body of a patient who died while suffering from trichina. He concludes: (1) The finding of trichina embryos in the mesenteric lymph nodes and in liver sinusoids, shows that they enter by the lymph stream and are distributed by the circulating blood. This is confirmed by the discovery of the presence of trichina embryos in the hæmorrhagic areas in the lungs of man, a fact already observed in the case of animals. (2) The embryos may escape from the vessels in the liver, pancreas, brain, and heart (and possibly other organs), causing local destruction of the tissue. (3) The capsule of the encysted trichina is formed of connective tissue which surrounds the whole of the invaded fibre. R.

The Tonsil as a Defence.—Brown (*Medical Record*, March 2, 1907) argues in favour of the view that the tonsil is a wall of defence towards, rather than a portal of entry for, infective organisms. As is well known, the tonsils have a rich blood supply, and they are covered superficially with a close mesh-work of lymphatics. Brown states that there is a constant exudation of leucocytes through the tonsillar crypts on to the mucous membrane, this exudation being markedly increased in the presence of virulent infective agents, Adopting the correct view of inflammation as a defensive measure, Brown argues that the frequent occurrence of tonsillitis is in fact an illustration of the greater defensive power of the tonsil than of other parts of the mouth. In this suggestion he assumes that germs may enter other buccal surfaces without stimulating the reaction known as inflammation. There is much in favour of the view that the tonsils in the mouth, like the Peyer's patches in the intestine, are less, rather than more, pervious to bacteria than the neighbouring surfaces. Anything we know of lymphoid tissue goes to prove that in every situation it has defensive functions, and it is unlikely that the tonsils and Peyer's patches should be exceptional. R.

Internal Diverticula of the Intestine.—Skirving (*British Medical Journal*, February 2, 1907) reports a rare and curious condition of the small intestine encountered while operating for hernia. Scattered over a distance of nine inches there were six hollow finger-like processes projecting obliquely into the lumen of the gut. All ended blindly, and were apparently localised invaginations of the whole thickness of the wall of the gut. The shortest was one inch in length, the longest two inches. All attempts at reducing one of them failed. Skirving is unable to suggest any explanation of the condition. R.

Inquest on a Medical Man.

Mr. Luxmoore Drew concluded his inquest at Hammersmith, on Saturday, on "Jack S. Egerton Layton," aged 43 years, a ship's doctor, who died from prussic acid poisoning at Sinclair Road, West Kensington. The deceased came from Australia in December last as surgeon on the SS. "Wakool," and stayed at a boarding-house at Sinclair Road. He afterwards signed a contract to return to Australia on February 5th as surgeon of the "Narrung," belonging to the same company. On February 14th, the deceased was found dead in bed, with an empty bottle by his side, and Dr. Crawford Thomson attributed death to a large dose of prussic acid. The police reported that inquiries had been made at the General Medical Council's registration offices, the Colonial Offices, the Crown Agents for the Colonies, at Ealing, Kingstown (Ireland), Guy's Hospital, and the London Hospital and other places, but nothing could be found to lead to the deceased's identification. Some of his books were marked "W. A. Best," but that was the name of a doctor who died in Sydney, N.S.W., in 1905. Many persons had tried to identify the deceased, including a countess living at Eaton Place. After other evidence the coroner said the deceased's whole life seemed to be a mystery which it appeared impossible to clear up. The jury returned a verdict of "Suicide whilst of unsound mind."

MEDICAL NEWS IN BRIEF.

The Irish Medical Schools and Graduates Association.

THE thirtieth annual meeting of the above association was held on Saturday last, March 16th, at the Hotel Cecil, when Dr. E. Irwin Scott, having completed his year of office, resigned the Presidential Chair to Sir John William Moore, of Dublin. The Vice-Presidents elected for the ensuing year were: Sir James Dick, K.C.B., Sir William Whitla, Drs. H. Macnaughton Jones, E. Irwin Scott. Dr. J. H. Swanton continues Chairman of Council and Dr. Kenneth Frazer Vice-Chairman. Dr. M. J. Bulger was re-elected Hon. Treasurer and Dr. T. Hobbs Crampton, Mr. E. Canny Ryall, and Dr. W. Douglas continue as Hon. Secretaries.

The following were elected to fill the vacancies in the Council: Drs. W. H. Bourke, Campbell Boyd, Morgan Dockrell, J. G. Fitzgerald, J. Finch Haines, J. A. Macdonald, J. Moorhead, and R. Jocelyn Swan. The other members of Council being Drs. W. Barter, G. W. Dawson, T. Beech Johnson, J. J. Macan, Alex. McDonnell, L. Strong McManus, Moyle O'Connor, W. Booth Pearsall, Redmond Roche, James Stewart, Dr. J. A. Preston,, and Surgeon-Lieutenant-Colonel R. Ross Brown, J.P. were appointed Hon. Auditors.

The Council reported the continued professional and social success of the Association, which had enabled many old friendships to be renewed and maintained, also the satisfactory financial position of the Association. The Council had pleasure in stating that the Arnott Memorial Medal had been awarded to Sir Almroth Wright, F.R.S., for his valuable contributions to medical science. Also that they had received with great regret the resignation of Dr. James Stewart, who had been for nearly twenty-two years Hon. Provincial Secretary, and in that position had by his zeal and energy done much to promote the welfare of the Association.

Mr. W. Booth Pearsall, Member of the Council, presented to the Association a presidential badge in enamel work, designed and made by himself. The badge is in the form of a small shield, having a border with the motto of the Association. This encloses a design in green enamel with shamrocks surrounded by blue to represent the sea. In the centre, on a white ground, is displayed the red cross of St. Patrick. The badge was much appreciated not only for its own value, but as being the work of one of the members.

The St. Patrick's Festival Dinner was held after the meeting, the principal guests being the Rt. Hon. Sir Albert Henry Hime, K.C.M.G., Sir Almroth E. Wright, F.R.S., and Admiral of the Fleet Sir E. Seymour.

Tropical Medicine and Hygiene.

THE new Society of Tropical Medicine and Hygiene met at the Royal College of Physicians on March 15th for the purpose of drawing up rules. Sir Patrick Manson presided, and a sub-committee to make the necessary arrangements was formed of the Chairman, Colonel Melville, Dr. Sandwith, Dr. Carnegie Brown, Professor Ronald Ross (Liverpool School of Tropical Medicine), Dr. G. C. Low, and Mr. Cantlie. To these gentlemen the following were added in order to constitute a general committee: Professor Nuttall (Cambridge), Dr. William Hartigan, Dr. Leopold G. Hill, Dr. Charles F. Harford, Lieutenant-Colonel Andrew Duncan, Lieutenant-Colonel Oswald Baker, Lieutenant-Colonel G. M. Giles, Dr. A. T. Stanton, and Dr. Sambun. At yesterday's meeting the chair was taken by Dr. Sandwith, and among those present were Dr. John Anderson, Professor W. R. Smith, Dr. T. P. Beddoes, and Professor Haffkine, the discoverer of a prophylactic for Indian plague. The Chairman explained that the promoters of the society hoped to see it become universal, embracing every man and woman interested in tropical medicine and hygiene. Another gentleman remarked that nine-tenths of the members would probably live abroad, and it may be added that the purpose of the association is the mutual instruction and support of the members.

The University Question in Ireland.

Two important series of resolutions dealing withthe University question have been adopted by various bodies within the past week. The first of these was adopted by the Higher Education Committee of the Presbyterian Church. The series is too lengthy for us to publish *in extenso*, but their general purport is to approve in the main of Mr. Bryce's scheme with certain provisos. The present Chief Secretary for Ireland is an ingenious and resourceful man, and if he can combine these provisos with the provisos which will be and no doubt are being insisted upon by the Roman Catholic Hierarchy, he will have performed a task that few other men would attempt even to tackle. His effort is bound to be of the greatest interest to all those interested in the social and political life of Ireland. The second series of resolutions also comes from Belfast, and has been adopted by the Council of the Royal University Graduates Association. These resolutions condemn Mr. Bryce's scheme lock, stock, and barrel, and wind up by directing attention to "the extraordinary conduct of the thirteen members of the Senate who withdrew their opposition to a scheme which four months ago they had declared to be disastrous to the interests of education and gravely injurious to the welfare of the country." In addition to these resolutions an important "statement" has been issued by the Dublin University Defence Committee.

Numerous meetings have also been held both by supporters and opponents of the present scheme. On Thursday a public meeting was held at the Mansion House, Dublin, under the Presidency of Professor Magennis, F.R.U.I., in support of the scheme, and it was addressed by, amongst others, Mr. McArdle, F.R.C.S.; Dr. Pye, Queen's College, Galway; and Dr. Connor Maguire. On the other hand, a meeting of the resident members of the University has been held at Oxford at which resolutions protesting against interference with Trinity College were adopted. Meetings of a similar nature were also held at Bristol and Manchester. On Friday, March 22, a meeting of the graduates of the University will be held in Trinity College.

Royal College of Surgeons.

Meeting of the Council.—An ordinary meeting of the Council of the Royal College of Surgeons was held at the College last Thursday, Mr. Henry Morris, President, being in the chair. The following members of the College, having passed the required examinations and conformed to the bye-laws, were admitted Fellows of the College: Mr. Lionel Edward Close Norbury, M.B., B.S., L.R.C.P.Lond., of St. Thomas's Hospital; and Mr. Gerald Charles Frederick Robinson, L.R.C.P. Lond., of Guy's Hospital. Mr. Henry Orton Howitt, of McGill University, Canada, and London Hospital, was admitted a member of the college, and a diploma of the licence in dental surgery was issued to Mr. Thornton John Barnett, of Charing Cross and Royal Dental Hospitals.

Appointments and Awards.—Mr. J. Ernest Lane, Surgeon to St. Mary's Hospital, was admitted a member of the Court of Examiners. Mr. J. Rickman Godlee, Vice-President, was appointed Bradshaw Lecturer for the ensuing collegiate year. Mr. A.

Pearce Gould was re-appointed one of the two representatives of the college upon the senate of the University of London for the next four years. Mr. J. Ward Cousins was re-elected the representative of the College on the Central Midwives' Board for the ensuing year. The President reported that the Sir Gilbert Blane's medals had been awarded to Staff-Surgeon James William Wilcocks Stanton, of H.M.S. "Suffolk," and Surgeon Bernard Ley, of H.M.S. "Algerine."

Women's Diplomas.—The Secretary submitted a list of 2,594 signatures in support of the petition to the council in favour of the admission of women to the examinations of the college, sent from the London School of Medicine for Women. The list contains no signatures of medical women, or of lay persons, other than those officially connected with the School of Medicine and the Royal Free Hospital.

A National Anthropometric Survey.—A letter was read from Dr. Arthur Keith reporting his attendance as the representative of the college, with the deputation to the Prime Minister to urge the importance of a national anthropometric survey, and giving a short account of the grounds upon which the importance of the survey was urged and of the reply of the Prime Minister.

Festival Dinner of the Hospital for the Paralysed and Epileptic.

A FESTIVAL dinner in aid of the funds of the National Hospital for the Paralysed and Epileptic and of the Nervous Diseases Research Fund of that institution was held on March 11th, at the Hotel Metropole. Sir Edgar Speyer, the treasurer of the institution, presided, and in proposing "Success to the Hospital" said the hospital did not pretend to deal with chronic cases, but it dealt with many cases which a few years ago were considered to be incurable. He appealed to them on behalf both of the cure and of the investigation of the terrible diseases with which the hospital dealt, the consequences of which were worse than any other class of diseases. Owing to the failure in receipts of legacies, which in 1906 fell very much below the average, the income had not balanced the expenditure, and the institution had had to borrow from the bankers. It was urgently necessary to repay the £4,000 borrowed and to maintain the institution at its present level. At the present time 100 patients were awaiting admittance. Mr. Macmillan, in responding said that the committee of the hospital had combined the *maximum* of efficiency with the most rigid economy. Sir Victor Horsley, in proposing "Success to the Nervous Diseases Research Fund," said the hospital had not only founded a clinical laboratory, but it had also organised a fund for research into nervous diseases, which would have an influence in all countries. Donations and subscriptions were announced amounting to over £2,500, and it was stated that unless the donors had otherwise stipulated, five-sixths of the amount subscribed would be applied to the hospital fund, and one-sixth to the research fund.

Invalid Prisoners.

The following explanatory memorandum is prefixed to the Released Persons (Poor Law Relief) Bill [100], brought in by Mr. Herbert Samuel and backed by the Home Secretary:—

The object of this Bill is to meet a difficulty which arises when a person who is due for discharge from a prison is destitute and in such an infirm state of health as to require immediate Poor Law relief.

In such a case it is the duty of the governor of the prison to see that the invalid shall receive proper care on his discharge. Where the place of settlement can be ascertained, an order for his admission to the workhouse of the union can be applied for, but if, as often happens, the place of settlement cannot be ascertained or is disputed, the only course open is to take the invalid to the workhouse of the union in which the prison is situated and apply for his admission as a case of urgent necessity. In the case of a large prison from which many destitute and infirm prisoners may have to be discharged this course imposes a liability on the ratepayers of the union in which the prison is situated.

To remedy the evil this Bill (following the precedent of the Criminal Lunatic Act, 1884) proposes to throw the *prima facie* liability for the relief of an invalid prisoner, whose place of settlement is unknown, on the union in which he ordinarily resided at the time he committed the offence for which he was sent to prison, or, if that cannot be ascertained, on the union where the offence was committed. The guardians of the union where he is sent in the first instance will be able afterwards, if they see fit, to take steps for his removal to his place of settlement.

Clauses 2 and 3 of the Bill extend the principle to persons discharged from reformatory and industrial schools and inebriate reformatories, as the same difficulty has been experienced in these institutions.

Death under Chloroform.

AN inquest was held at the Preston Infirmary, on March 13th, concerning the death of Emma Gittins, wife of a boilermaker. Deceased's husband said that for six weeks his wife had been suffering from pains in the bowels. On Saturday she was removed to the Infirmary on medical advice.

The medical eveidence showed that an operation was necessary to save life. The anæsthetic had been skilfully administered, when the patient suddenly collapsed. Everything possible was done to resuscitate her, but without avail. Had the operation not been performed, the patient would probably have died in forty-eight hours, as the inflammation was rapidly extending. All known methods of restoration were applied for threequarters of an hour.

The Coroner said the jury would agree that every consideration had been given to the case. Doctors Sellers, Dunn, and Collison, and the staff of the Infirmary had consulted, and decided that it was advisable the operation should take place. They believed they might be able to save the patient's life. Everything possible seemed to have been done to restore her. The Foreman: I think they have done everything possible. A juror expressed the belief that most extraordinary care had been exercised. A verdict that "Death was due to misadventure." was returned.

More Litigation in Dental Partnership Case.

THE final action of Hill *v.* Clifford was heard before Mr. Justice Warrington in the Chancery Division in which the plaintiff claimed a declaration that a notice he had given for the dissolution of a dental partnership was valid and binding upon the defendants, Isidore and Ruben Edmund Clifford. It appeared that the defendants were members and managers of the American Dental Institute, which carried on a dental business at Liverpool and London, and, on the ground that the Institute had been guilty of "infamous" or disgraceful, conduct in a professional respect, the names of the defendants and others were struck off the dental register by the General Medical Council. This, the plaintiff contended, entitled him, under the partnership articles, to dissolve his partnership with the defendants. In two similar cases to which Isidore Clifford was a party his lordship had held that the finding of the Medical Council was not binding on the court, and upon the facts before him professional misconduct had not been proved. Mr. Norton, K.C., who, with Mr. Ward Coleridge, represented the plaintiff, contended that this case differed from the previous inasmuch as he should produce evidence that before the Medical Council, counsel for the defendants admitted professional misconduct. Mr. H. Terrell, K.C., with whom were Mr. Houston and Mr. Drake, was not called upon. His Lordship held that the case was governed by the action of Clifford *v.* Timms and Clifford *v.* Phillips, and therefore there must be judgment for the defendants, with costs.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

M.O.H.—You can get all information *re* the Gordon Memorial College at Khartoum from the Principal, Mr. James Currie. The laboratories are at present in the College, but an appeal has been made for a separate building.

OBSTETRICIAN.—The question of fees for medical men called in by midwives still remains before the Central Midwives' Board. No fewer than six midwives were censured at the last meeting for not having called in a doctor, but the usual indifference was shown to the fact that no fee would have been forthcoming for his attendance.

M.R.C.S.—The Paper you are doubtless thinking of is in the "Journal of Abnormal Psychology," which came out last April, and is called "The Pathogenesis of Some Impulsions," by Dr. Pierre Janet.

YOUR PORTRAIT FOR NOTHING.

THE enterprise of the Leibig Extract of Meat Company is decidedly progressive. They now announce that in order to make their preparation, "Oxo," still more widely recognised by the medical profession they will give away, free of charge, enlargements of purchaser's own photographs. These are mounted to measure 23 by 19 inches, and are said to be beautiful reproductions. To obtain one of them, the purchaser has to save the coupons fixed over the capsules of "Oxo" bottles until 21s. worth has been collected, when they should be sent, together with the photograph to be enlarged, to "Oxo Portrait Department, 4 Lloyd's Avenue, London, E.C." In exchange for additional coupons, to the value of 21s., applicants' pictures can be framed in oak, with gold slip.

PATER.—We have not the official figures before us for the past year, but we understand there has been a considerable falling off in the number qualified compared with previous years.

M.D. (Nottingham).—We cannot take the responsibility of publishing the terrible charges you make without authoritative references to the operations you describe. If these experiments were done without anæsthetics, they should be substantiated by chapter and verse and brought before the notice of the Royal Commission now sitting. If done under anæsthetics, of course, no pain would be felt.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 20th.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Lecture:—Prof. C. F. Beadles: The Cerebral Arteries (illustrated by specimens, drawings, and lantern slides).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Cunning: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. J. Poland: The Use and Abuse of Skiagraphy in Fractures and Dislocations.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, MARCH 21st.

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—9 p.m.: Clinical Meeting. Patients in attendance at 8 p.m.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. H. J. Curtis: Liver Abscesses, their Etiology, Symptoms, and Treatment.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m.: Demonstration:—Dr. G. B. Price: Clinical Examination of the Urine.

FRIDAY, MARCH 22nd.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: Clinical Evening for the Exhibition of Cases followed by Discussion. Patients in attendance from 8 to 9 p.m.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Lecture:—Prof. C. F. Beadles: The Cerebral Arteries (illustrated by specimens, drawings, and lantern slides).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. H. Tilley: Clinique. (Throat.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

MONDAY, MARCH 25th.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN (20 Hanover Square, W.).—Casual Communication:—Dr. J. W. Pare on "A New Local Anæsthetic." Short Paper: Mr. J. G. Turner on "Hereditary Hypoplasia of Enamel." Dr. Charles Stewart will exhibit and describe some Dental Specimens from the Hunterian Museum.

TUESDAY, MARCH 26th.

THERAPEUTICAL SOCIETY (Apothecaries' Hall, Blackfriars, E.C.).—4.30 p.m.: Papers:—Dr. W. E. Dixon on "How Drugs Produce their Effects" and Dr. Nestor Tirard: "Opium in the Treatment of Pneumonia."

Vacancies.

Leeds Public Dispensary.—Two Junior Resident Medical Officers. Salary £100 per annum, with board and lodging. Applications to the Secretary of the Faculty, Public Dispensary, Leeds.

Whitehaven and West Cumberland Infirmary.—Resident House Surgeon. Salary £120 a year, with board and lodging. Applications to W. H. Sands, Secretary, Whitehaven.

The General Infirmary at Leeds.—Resident Casualty Officer. Salary £125 per annum, with board, lodging, and washing. Applications to the Secretary to the Faculty, General Infirmary, Leeds.

Manchester, Township of.—Assistant Medical Officer. Salary £110 per annum, with furnished apartments, fire, light, washing, and attendance. Applications to James Macdonald, Clerk to the Guardians, Poor-Law Offices, New Bridge Street, Manchester.

Royal South Hants and Southampton Hospital.—House Surgeon. Salary £100 per annum, with rooms, board, and washing. Applications to T. A. Fisher Hall, Secretary.

Asylums' Service of the Metropolitan Asylums Board.—Male Third Assistant Medical Officer. Salary £150 per annum, with rations, board, lodging, attendance, and washing. Application of the Board, Embankment, London, E.C.

Durham University, College of Medicine, Newcastle-upon-Tyne.—Head Laboratory Attendant in the Bacteriological Department. Applications to the Secretary. (See advt.).

Appointments.

BENNETT, H. G., M.R.C.S., L.R.C.P.Lond., House Physician to Out-patients at St Thomas's Hospital.

BRISTOW, W R., M.R.C.S., L.R.C.P.Lond., to the Throat Department at St. Thomas's Hospital.

BURGESS, A. S., M.R.C.S., L.R.C.P.Lond., Junior Ophthalmic House Surgeon at St. Thomas's Hospital.

BUTLER, G. G., M.R.C.S., L.R.C.P.Lond., House Physician to Out-patients at St. Thomas's Hospital.

CARLETON, H. H., M.B., B.Ch. Oxon., to the Children's Surgical Department at St. Thomas's Hospital.

CASSIDY, M. A., M.B., B.C. Cantab., Resident House Physician at St. Thomas's Hospital.

DREW, J. H., M.B., B.S.Lond., Senior Casualty Officer to St. Thomas's Hospital.

DUNKLEY, E. V., M.B., B.S.Lond., Resident House Physician at St. Thomas's Hospital.

FIRTH, A. C. D., M.R.C.S., L.R.C.P.Lond., Junior Obstetric House Physician at St. Thomas's Hospital.

GAMLEN, R L., M.R.C.S., L.R.C.P., Resident House Surgeon at St. Thomas's Hospital.

GARDEN, W. SIM, M.B., B.Ch. Aberd., Second Assistant Medical Officer at Menston Asylum, near Leeds.

GRIMWADE, S. W., M.R.C.S., L.R.C.P.Lond., to the Children's Surgical Department at St. Thomas's Hospital.

HAY, K. R., M.B.Camb., M.R.C.S., L.R.C.P.Lond., Honorary Physician to the Westminster General Dispensary.

HOWITT, A. B., M.B., B.C. Cantab., Junior Casualty Officer to St. Thomas's Hospital.

HUGGINS, G. M., M.R.C.S., L.R.C.P.Lond., House Surgeon to Out-patients at St. Thomas's Hospital.

HURLEY, JAMES, L.R.C.P., L.R.C.S.Edin., L.F.P.S Glasg., Medical Officer for the Magor District by the Newport (Mon.) Board of Guardians.

HUSTLER, G. H., M.B., Ch.B.Leeds, Medical Officer to Hospital Ship (Royal National Mission to Deep Sea Fishermen.)

ILES, A. J. H., M.R.C.S., L.R.C.P.Lond., to the Electrical and X-Ray Department at St. Thomas's Hospital.

LINDSAY, D. LAUDER. L.R.C.P. and S.Edin., L.F.P.S.Glasg., L.M. Surgeon to the Police at Aldershot, Hants.

MACDONALD, S. G., M.B., B.C. Cantab., Resident House Surgeon at St. Thomas's Hospital.

NEILD, F. M., M.R.C.S., L.R.C.P.Lond., House Surgeon to Out-patients at St. Thomas's Hospital.

NIGHTINGALE, H. J., M.R.C.S., L.R.C.P.Lond., House Surgeon to Out-patients at St. Thomas's Hospital.

PAGE, C. M., M.B., B.S.Lond., Resident House Surgeon at St. Thomas's Hospital.

PHILPOTT, H. A., M.R.C.S., L.R.C.P.Lond., Resident House Physician at St. Thomas's Hospital.

POLLOCK, W. B. INGLIS, M.D.Glasg., Consulting Ophthalmic Surgeon to the Ayr County Hospital.

READ, H. W., M.R.C.S., L.R.C.P.Lond., to the Dental Department at St. Thomas's Hospital.

RODGERS, J. W., L.R.C.P. and S.Irel., Certifying Surgeon under the Factory and Workshop Act for the Dorking District of the county of Surrey.

SANKEY, W. O., M.B., B.S.Lond., Resident House Physician at St. Thomas's Hospital.

SCOTT, H. M., L.R.C.P. and S.Irel., Certifying Surgeon under the Factory and Workshop Act for the Enniscrone District of the county of Sligo.

Marriage.

MITCHELL—THOMAS.—On March 9th, at the Parish Church, Weybridge, Annie Gladys, eldest daughter of J. Edwin Thomas, Esq., Adelaide, South Australia, to Charles Martin Mitchell, M.R.C.S. Eng., L.R.C.P.Lond., of Oakfield, Lydney, Glos.

Deaths.

FINCH.—On March 16th, at 2, Western Terrace, St. Marychurch Torquay, Thomas Finch, M.B.

GREENWAY.—On March 12th, at Llandrindod Wells, Alfred Griffith, Greenway, M.D., M.Ch., second son of the late William Partridge Greenway, of Moseley Court, Bushbury.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, MARCH 27, 1907. No. 13

NOTES AND COMMENTS.

The Thaw Trial Still.

THE interminable Thaw case drags on from day to day and week to week, and even the American quidnuncs have lost interest in it. So, too, have the British. All possible moral garbage and pathological sludge having been duly displayed to the eye of the world, the actual result of the trial seems little further to concern them. As a matter of fact, the medico-legal, and, we believe, the sociological, importance of the case increases daily. This trial, owing to the wealth of the Thaw family, is a concrete *reductio ad absurdum* of the legal theories of criminal responsibility, and if its lessons are taken to heart there is no saying what result it may not have on the attitude of civilised countries towards crime. Thaw has shown himself, and been shown by the expert witnesses, to be a rather under-average man of dissipated tastes. Being well-supplied with money and, like Dolon, the victim of an adoring female household, these deficiencies were in no way corrected and counteracted in his upbringing, and he had a free rein to indulge in the pursuits he desired. There are, of course, hundreds such in London, New York, and every large city, and they do not attract much attention; indeed, except in a few cases, they eventually become decent citizens and sit in the House of Lords or on the county bench. By force of circumstances, however, Thaw found himself involved with White, and nursed his grudge till a good opportunity of killing him presented itself. When it occurred, with considerable deliberation, Thaw produced a revolver and shot him. In all, a painfully commonplace crime, such as happens in its scores in every country in every age.

Its Real Significance.

Now, judged by the ordinary criteria, there is no doubt whatever that Thaw knew he was doing what was wrong in the eyes of society, and also, no doubt, that he was possessed of sufficient control to have prevented himself from committing the murder had the circumstances proved inauspicious. He was under no delusions—in the technical sense—about White; for whether White was the sensual monster he was supposed to be or not, the evidence on which Thaw rested his belief was sufficient and reasonable. On the theory of poetic justice, the crime was justifiable, and on poetical grounds, appeal is certain to be made to the sentiment of America if all other pleas fail. As the American law courts deal in prose—and that very plentifully—the plea for Thaw escaping the penalty of his action is that of insanity. After many days of expert evidence, the Court has practically decided that it is incapable of judging on this point. Medical men have given evidence on both sides, the gist of which, stated in plain language, is that crime being abnormal is itself evidence of mental abnormality, and that the question is really one for society. Does it wish judicially to execute abnormal people? The Thaw legal expenses will not be wasted if they can get an answer to that point, which is really what civilisation has long been working up to without realising it. Thaw is abnormal, but probably no murderer was less abnormal than he.

Mrs. Osler's Death.

THE death of the venerable mother of Professor Osler will call forth general sympathy from the medical profession in this country. Quite recently we had the pleasure of commenting on the rejoicings that accompanied that lady's hundred-and-first birthday, when children, grandchildren, and great-grandchildren were assembled from all over the world to congratulate their common parent on her extraordinary vitality. And now she has passed away. Mrs. Osler was remarkable for more than being the mother of her distinguished son; she was a woman of great industry and accomplishments, and to the end of her long life took a keen personal interest in all matters of pith and moment. May her longevity prove as hereditary as her good qualities!

"Doctor's" Crime.

IF registration is to confer on medical men a mark whereby they may be known, and if no man can use a title implying that he is registered when he is not, it ought to be possible to prevent the terms physician, surgeon, doctor, and medical practitioner, being applied to charlatans and unqualified practitioners. For instance, last week in the *Daily Telegraph* there was reported from the Central Criminal Court the case of a Caleb Charles Whitefoord, who was indicted on a charge of performing illegal operations on women, and eventually found guilty and sentenced. Now this man was struck off the *Medical Register* years ago for this same offence, and yet we find the report headed "Doctor Sentenced," and the prisoner himself described as "medical practitioner." Naturally, all the people who read the *Daily Telegraph* have come to the conclusion that "another doctor has been found out," and very likely "they are all the same, only they are not all caught." The profession has to bear a heavy enough burden without being saddled with injustices of this description, and we think it is time that leading dailies should have learned to distinguish between qualified registered medical men engaged in legitimate practice, and unregistered practitioners who dabble in fraud, crime, and conspiracy. The distinction demands as little perspicacity as is required to distinguish between a jeweller who keeps a shop and a thief who robs it.

A Union of Hearts. The fissiparous character of anti-vivisectionist societies is a phenomenon of sufficient significance to deserve some study; it is extraordinary how toilers in the same vineyard cannot manage better to agree among themselves, but the fact is sufficiently witnessed to by the number of societies that now appeal for support. A more than ordinarily diverting instance of this dissension was made public last week in an action tried at the Lancashire Chancery Court. It appears that Miss Frances Power Cobbe left a legacy of £5,000 to the British Union for the Suppression of Vivisection, the organisation with which she was connected for many years, and which naturally looked to her for support. However, when the estate was wound up and money was ready for handing over, lo! no one could tell who was competent to receive it. It appears that the union, after the master-spirit of Miss Cobbe was withdrawn and before the money was ready, had divided into two sections, and no agreement could be patched up as to who was to get the spoil. According to the report in the *Manchester Guardian*, there was a great array of counsel, all sorts of interests being represented. There was evidently a fine fighting spirit abroad, as the Vice-Chancellor was anxious to make a settlement lest all the money should be spent in litigation. But, as he told the minority to watch the majority, and to take proceedings in Court if they thought the money was not properly spent, there may yet be trouble in the wind.

LEADING ARTICLE.

THE TUBERCULOSIS ROYAL COMMISSION.

THE appendix to the second Interim Report of the Royal Commission appointed to enquire into the relation between human and bovine tuberculosis records the elaborate series of experiments conducted by Dr. Arthur Eastwood, the head of the Commissioners' laboratory at Stansted. Like the postscript of a lady's letter, it contains by no means the least important matter of the communication of which it forms part. The conclusions of the appendix are clear, conclusive, and founded on apparently unassailable observations, although in the light of previous experiences individual experiments must always be received with a certain amount of caution. The two main points emphasised by Dr. Earlwood are: (1) The marked difference in the severity of the morbid processes produced by different viruses; (2) the underlying histological unity which characterises all these processes, from the mildest to the most severe, as typical of tuberculosis. With regard to the first-named condition of activity, it is hardly possible to insist too strongly upon its importance as a pathological factor. The introduction of a virulent virus into the system is followed by tissue reaction which, however vigorous and sustained, is sooner or later overcome by the invading bacilli, and large numbers of bacilli gain access into the general circulation. On the other hand, with a less virulent virus, the invaded tissues are able to offer a resistance that is not only vigorous but effectual. To quote the words of the Report:—"At the site of inoculation (of a mild virus) the tissue reaction is, within a few weeks, completely successful, and a dense, leathery, fibrous zone is formed which completely debars the entrance of the great mass of the inoculated material into the body. The bulk of the inoculated culture, in fact, is as much external to the body as it would be if it were enclosed in a test tube." The second point alluded to, namely, the histological unity of all degrees of tuberculosis, is obviously a matter of vital concern to the ultimate object of the Commission. Dr. Eastwood states with confidence that there is no valid reason for doubting that human and bovine tuberculosis belong to the same family, a fact that was never seriously disputed before the year 1901. The inter-communicability of infection is similarly and consequently accepted. Dr. Eastwood remarks that his work has been especially concerned with the endeavour to ascertain how far it is possible to recognise tubercle bacilli isolated from the human body as being of bovine or other animal origin. The proof that bovine bacilli are a danger to man he regards as established by his researches on evidence that is conclusive and final. As to the identification of human and of bovine bacilli by bacteriological tests and microscopic examination of morbid processes produced experimentally, he points out that the bovine virus when inoculated, produced severe disease with definite histological characters, but it appears that there are many human viruses which are not completely identical with them. The difference, in point of fact, appears to be one of degree. Altogether, Dr. Eastwood's five years of devoted work have resulted in conclusions of incalculable importance to the human race. For obvious reasons it has been out of the question to do more than indicate in the merest outline the scope of his investigations, but all who are interested in the subject will naturally study the original document with minute and careful attention.

Apothecaries' Hall, London.

THE following candidates having passed the necessary examinations, received the L.S.A. Diploma of the Society, during March, entitling them to practise Medicine, Surgery, and Midwifery:—F. A. Bainbridge, A. E. Blythman, A. F. Palmer and W. F. Skinner.

CURRENT TOPICS.

The Development of British Health Resorts.

The neglect of our own spas and seaside places by fashionable folk who are given to visiting foreign resorts, has long formed a subject of regretful comment among medical journalists. Some day the tide of popular favour may happily set in the direction of our own beautiful coast and inland health resorts. If it be patriotic to befriend colonists who fall in under the broad banner of our vast empire, it is surely not a whit less desirable and infinitely more practical to spend our holiday money upon our own spa and seaside countrymen. A first step towards a better understanding is clearly to secure the support of the medical profession, which naturally has a good deal of influence in matters of the kind. From this point of view the work of the Balneological Society deserves the hearty support and co-operation of local seaside and spa authorities. A recent visit of that body to Hastings aptly illustrates the mutual advantages of such an event. A large number of medical men visited that fine old Sussex town and were entertained by the Mayor and by the local medical practitioners. In the course of excursions, receptions, dinners, and other hospitality, a vast amount of the right sort of information was pleasantly conveyed to the visitors. The Balneological Society is full of energy and enterprise, and has already visited many of our most notable spas and seaside towns. Their work is worthy of hearty support by every well-wisher of our national prosperity.

Milkmen and Street Noises.

Of all the curses of modern town life, that of noise is perhaps, from the medical point of view, the most baneful, at any rate so far as the nerves of mankind are concerned. Noise is more than a nightmare to the literary man whose thread of thought is apt to be rudely snapped by every passing jar. Hence the diabolical hotchpotch of discords that makes up the sum-total of street sounds has been again and again delineated in terms both forcible and picturesque. It may be doubted, however, if any single pen has ever done justice to the milkman's contribution to the infernal din. His carts rattle, his cans jangle and crash, and his work goes on from early morn till dewy eve to the accompaniment of a villainous street cry worthy of his flagrant disregard of all the common decencies of life. Why should not the milk-cart have rubber-tyred wheels? Why should not the cans be deposited quietly on the pavement? And why should the milkman have a discordant cry, when the butcher and the baker are silent? Why, in short, should he not conform as far as possible to the rules drawn up by the Society for the Suppression of Street Noises. The indictment against the milkman is already heavy enough without the knowledge recently given to us by science that this noisy tradesman is to a great extent responsible for the tuberculosis in our midst. When we bring the contents of the milk-cans under control it is to be hoped that steps will be taken at the same time to secure distribution of the supply in a reasonably quiet fashion. With some simple but efficient bye-laws in that direction and the general substitution of wood paving for reverberating stone, we may look forward to a quieter and saner future.

The Crime of Abortion.

Last week an ex-medical man was sentenced at the Central Criminal Court to ten years' penal servitude for the crime of procuring abortion. The man in question, Caleb Whitefoord, was an old offender, for some time ago he underwent a sentence of five years' imprisonment for a similar illegal act, and his name was subsequently struck off the *Medical Register*. Happily this particular offence is rare among medical men, although there is no reason to doubt that it is of extremely frequent occurrence in other classes of society. One curious fact is the immunity with which abortion may be practised for many years by persons who are in some instances of notorious reputation in that direction. The police are naturally loth to act unless they are able to secure evidence likely to lead to a conviction, a state of affairs that is often extremely difficult to compass in dealing with this kind of criminal. At the same time it is somewhat of a mystery how certain well-known offenders, sometimes within, but more often without, the pale of the medical profession, are allowed to escape scot free for many years together. There can be little reasonable doubt that the modern revolt against child-bearing expresses itself to no small extent in the prevalence of this medico-legal crime.

"Doctors, Limited."

It is much to be hoped that the two Bills introduced into the House of Lords this session by Lord Hylton will have a good chance of reaching the Statute Book. These Bills are designed to prevent persons in the one case from trading as doctors and in the other as dentists, under cover of the Companies Act. It is a serious scandal that unqualified persons have only to band themselves together, form a bogus company, and register it, for them to be able to carry on business under the title of doctors, dentists, surgeons, or whatever title they wish, without the General Medical Council or any other power being able to touch them. The Board of Trade should have power to refuse to register an obviously fraudulent company, and any company trading under medical titles obviously is fraudulent. Lord Hylton's Bills simply ask Parliament to declare that whatever would be an offence under the Medical Acts when committed by an individual person shall also be an offence when committed by a number of persons formed and incorporated into a company—surely a very modest request. The British law, as a rule, regards an offence to be aggravated when brought about by conspiracy instead of by individual sin, but with that delightful paradoxical way in which the law as regards medicine is laid down, it is not wrong to do by agreement what is wrong if done alone. If Parliament has any sense of humour, to say nothing of that of justice, these two useful little Bills will glide through without opposition. But the quack companies are sure to have secured some Parliamentary sympathisers to oppose them.

Suffragettes and Hysteria.

IT is noticeable how little the word hysteria has been used in connection with the suffragettes. Two reasons might account for this. Either the relationship between screaming and struggling women and hysteria is too obvious to be worth mentioning, or the already terrorised male fears to deflect the current of their wrath from the broad chest of the policeman to his own unlucky head. But where man fears to tread, an angel has slipped in in the person of Miss A. E. Bertram, a lady who has put forward the physiological argument that owing to the hysterical nature of women it is undesirable that they should sway the national destinies. Naturally a flood of hysterical letters have descended upon her, either denying that women are hysterical, or asserting that men are hysterical. Miss Bertram, however, is a philologist as well as a physiologist, and she points out that whereas it is no crime for a woman to be hysterical, man is etymologically absolved from any association with the complaint. The special calls on the nervous system of woman, she says, are such as to excite in a special degree those peculiar functional disorders of the nervous system, characterised by increased irritability to physical and psychical stimuli. There is a remarkable amount of good sense and good physiology in these words, and we think it a healthy sign of the Home Secretary's nervous stability that he has not opposed hysteria by hysteria, but has been content to undo metaphorical stays and pour metaphorical cold water on those hysterical women whose psychical irritability culminates in unseemly gymnastics in the precincts of Westminster.

Coventry Dispute.

WE sincerely trust that the splendid fight being waged at Coventry between the medical staff of the Dispensary and the Committee will end in a complete and signal triumph for the doctors. The point at issue is a vital one, namely, whether the profession is to be the tool of interested laymen or whether it is to determine fair conditions of practice for itself in conjunction with its patients. In no town probably does systematised contract practice prevail to the extent that it does at Coventry, there being no less than 18,000 members of the Provident Dispensary. The medical men are claiming a wage limit, the abolition of a privileged staff, and proper medical representatives on the management. If contract practice is to be carried on under anything like fair conditions these points are of the most urgent and the most necessary, and the medical men are having a long and tough fight for them. They may rely on the hearty approval of their confreres all over the Empire. The latest phase of the struggle is that five members of the staff, Drs. Pickup, Hird, Fenton, Heal and Arch—all honour to them—have resigned their appointments. It is not clear why the two remaining ones, Dr. McVeagh and Dr. London, have not done so too. In this great struggle for justice we hope we can confidently depend on the honour of the profession not to supply any "blacklegs." Any medical man seeking to undermine the work of the local members of his profession by offering his services to the Dispensary under the present conditions would deserve the severest reprobation from all right-thinking people. United we stand; divided we fall. May Coventry herald a new era of fair dealings between the profession and the public!

Ammanford Collieries Fight.

ANOTHER fight is in progress with the Ammanford Anthracite Collieries Branch of the South Wales Miners' Federation. Here the points are much the same, the wage limit being as much to the fore as ever. It is a curious and, we may add, disturbing factor in the industrial situation that the Trade Unions who have fought for justice for their own members, and in the main obtained it, treat with dislike and opposition any similar demands on the part of the medical men. Competition has its good points, but unrestricted competition can only lead to sweating and oppression. Combination or trades unionism in one form or another is the obvious and proper remedy, and we cannot conceive how those who have found out its blessings can wish to deny them to their best friends in times of ill-health and sickness? Their sense of fair play should be sufficient alone to restrain them from withstanding medical unity and reasonable conditions of service. In the district under notice one medical man is reported to have said that he has to attend a farmer, possessed to his knowledge of £12,000, for half-a-crown a year, each visit entailing a journey of over four miles. Can the trades unions produce a fact to compare with that for meanness?

Women and Public Health.

THE movement inaugurated by Her Excellency the Countess of Aberdeen to interest the women of Ireland in matters of public health is one that deserves the best support. In these questions medical men can only direct the way; no advance can be made without the formation of a sound public opinion. In Dublin probably more than anywhere in the Kingdom is there room for the exertions of an association endeavouring to rouse public opinion, for nowhere else would the present scandalous condition of public health be tolerated with equanimity. It is possible, however, that the enthusiasm roused by the starting of Lady Aberdeen's Health Association is a sign of better things, for it is not often that the College of Physicians is able to give hospitality to such a large and interested meeting as the inaugural meeting held last week. His Excellency, the Lord Lieutenant, in the regretted absence of Lady Aberdeen through illness, explained the objects of the association. We are glad to see in the forefront the subjects of consumption and infantile mortality, for it is precisely in reference to such questions that the work of women can be most effective. We are glad to note, too, that the new association wishes to make it clear that it intends to run as a colleague and not as a rival to existing associations whose objects are in any way similar.

Medical Men under the New Compensation Acts.

THERE are many interesting problems under the new Workmen's Compensation Act, and it seems not improbable that some of them at least will have to be settled in the Law Courts. The question of whether a practitioner is to be liable for accidents to his locum tenens arising in the course of the employment of the latter is one of them. If the payment is at the rate of £250 a year, in all probability the question of liability will not arise, as anyone receiving that amount of wages cannot claim. If, say, the rate is at £150, then an assessment of value of board and lodging will probably bring the sum up to the minimum £250. A locum at £100 might reasonably claim under the Act. The majority of qualified assistants, house surgeons, junior medical officers, and so on, would be clearly entitled to compensation provided their total honorarium in money or in kind did not exceed £250 per annum. In some of the leading London hospitals it is the custom to give an honorarium of 50 to 100 guineas to members of the visiting medical and surgical staff. It is interesting to speculate as to the responsibility that would be incurred by the hospital authorities under these circumstances should any of the staff thus receiving money be injured in the performance of duties connected with the work of the institution. Doubtless many shrewd difficulties will arise in the administration of this drastic but evolutionary Act, which, readers may be reminded, comes into force on July 1st next.

The Marriage of Consumptives.

AMID the rush and excitement of modern scientific progress, there is a constant tendency to forget old friends in our worship of new and strange gods. In the case of tuberculosis we find the problem attacked from every possible coign of vantage afforded by the bacteriologist and the sanitarian. Latterly we have been advocating the rigorous control of dairies and of flesh used for human consumption in order to exclude the ubiquitous bacilli of tuberculosis. But, of all obvious predisposing causes of the malady, the marriage of tuberculous persons is perhaps the one most neglected. In the days before bacteriology was born, our less scientific ancestors attached an exaggerated value to the heredity of the disease. Nowadays all that is changed, and medical men readily pass many candidates for life insurance who have a family history of phthisis. Sometimes a man with an early history of undoubted pulmonary tuberculosis is able to secure a life policy. Professor Karl Pearson has recently pointed out that the elder offspring of tuberculous stocks appear subject to tuberculosis at a far higher rate than the younger members. This observation would be of practical use in any attempt to limit the marriage of persons having a marked tuberculous history. Probably in the light of modern knowledge, no serious proposal would ever be made to prohibit marriage to any but those showing evidence of active tubercle. Before the world has educated itself up to so exalted a pitch of philosophy, however, it seems highly probable that tuberculosis will have been stamped out of existence. The broader question of the prevention of marriages among the insane, the syphilitic, and the otherwise unfit, remains to be considered. Some day in a remote future the serious problem of race degeneracy may be partially met by a more scientific control of the processes of generation. So far social reformers have barely touched the fringe of the subject.

PERSONAL.

HER MAJESTY THE QUEEN has kindly intimated that she will attend on June 13th to perform the opening ceremony of the Fete for Crippled Children at the Mansion House to be known as "The Queen's Fete."

H. R. H. THE PRINCE OF WALES will preside at a dinner to be held at the Hotel Cecil on May 14th in aid of the National Sanatorium for Workers suffering from Tuberculosis.

DR. E. B. HURST HUGHES has been appointed Resident Medical Officer of the Swansea Workhouse Infirmary.

SURGEON LIEUT.-COLONEL G. J. COATES, R.A.M.C., has been selected for charge of the Military Hospital, Cork, taking over the duties forthwith.

MR. WILLIAM HENRY POWER, C.B., F.R.S., medical officer of the Local Government Board, has been appointed to be chairman of the Royal Commission on Tuberculosis, in the room of the late Sir Michael Foster.

D. F. M. SANDWITH has been appointed Gresham Professor of Medicine in place of the late Dr. E. Symes-Thompson.

THE news of a fanatical outrage has just come from Morocco, in which a French medical man, M. Mauchamp, was the victim. He erected a pole and hoisted a white flag in front of his house, a large crowd gathered and ultimately stoned the unfortunate. Dr. Manchamp was formerly for five years official French physician at Jerusalem.

THE authorities of St. Mary's Hospital Medical School (University of London) having had under consideration the proposal to concentrate the preliminary and intermediate medical studies at an institute of medical sciences at South Kensington, have decided not to participate in this scheme, but to continue to maintain as hitherto complete courses of instruction in these subjects in the medical school.

A Clinical Lecture
ON
POINTS OF INTEREST CONNECTED WITH TROPICAL SANITATION. (a)

By RONALD ROSS, C.B., D.Sc.Dub., LL.D., F.R.C.S.Eng., F.R.S.,

Professor of Tropical Medicine in the Liverpool University.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

The subject of tropical medicine is a very large one, and it is difficult to select the particular points which will interest you most. Nor do I know what amount of detail I ought to give. It is always difficult to know how deeply one ought to go. And obviously you are not all experts, or you would not be here. I think it will be better to assume that you have a moderate knowledge of the subject, and the best way will be to speak to the lantern slides, a large number of which I shall show you dealing as much with the points of scientific interest as the time will allow. I shall confine my remarks chiefly to three points: First, the disease known as sleeping sickness; secondly, yellow fever, thirdly, malaria in various parts of the world, and its prevention. Of course, I shall devote attention to that aspect which interests you most—prevention.

Sleeping sickness occurs in animals and in man in Africa, and it is due to a parasite called the trypanosome. It lives in the blood, and is carried from one animal to another by the tse-tse fly. Closely allied parasites, though not quite the same, are also found in beasts and in birds. Closely similar ones are also present in fish and in insects. The disease is a very important one, and is becoming more so, not only because of the mischief it does to cattle and domestic animals, but because it is killing large numbers of men in Africa at the present moment. It is very much "in the air," so to speak, like influenza, and therefore you may be interested in hearing one or two points about it. I show you photographs of an animal and of an African native suffering from the disease; the pictures are those of Colonel Bruce, who is now in London. For the purpose of studying the disease, the Royal Society has sent out several Commissions, and the Liverpool School of Tropical Medicine has sent out many. Professor Koch is also studying it now. The parasite causing the disease in man is now generally accepted to be the Trypanosoma gambiense, and was discovered by Ford and Dutton, of the Liverpool School. Dutton, I regret to say, lost his life, a martyr to his researches. A patient with this disease is sleeping constantly, and can hardly be roused. This, however, is the terminal symptom of the disease; at first, the patient hardly feels anything at all. The parasite is found in only small numbers, comparatively, in the human blood; but in animals it is very plentiful. Later on, the parasites cause enlargement of the glands, at the back of the neck especially, so that this presents a ready means of detection in a comparatively early stage, before the sleepiness becomes pronounced. Later on, the parasites find their way into the cerebral fluids, and cause this symptom. The pathology of it, however, is not quite so simple as that. Finally, the patient falls into a condition of almost absolute coma; he becomes more or less emaciated; then suddenly the temperature, which had been above the normal, falls, and the patient sinks and dies. We are studying the tse-tse fly very minutely in Liverpool, where we have a special entomologist, Mr. Newstead. It would occupy several lectures to give you the whole anatomy of the fly; but we know as much about these flies as we know about ourselves, if not more. Still, their bionomics are not known as well as they ought to be. They only produce one young, which is a larva, and shortly becomes a pupa, and takes five weeks to develop into a mature fly. I show you a photograph of trypanosomes, taken by the "thick film" method. What is spoken of as the nucleus is, I think, more than the nucleus. A few weeks ago, Professor Moore, of our University at Liverpool, and myself, published a note in the *British Medical Journal*, in which we drew attention to this point concerning the nucleus. I show you drawings of trypanosomes made by Professor Moore, the cytologist on the Cancer Research Committee in Liverpool. The "wet" method of preparing and staining is probably the best and more correct, and we should use for parasites the same stains, &c., which cytologists find best. An authority on the subject spoke to me of the "dry" method as "barbarous," and I am inclined to agree with him. I show you also a photograph presenting a dividing nucleus, but whether it is by spindle or by amytotic division I cannot say.

With regard to the cure of the disease, it is often remarked that prevention is better than cure; but we are beginning to find out, in several instances, that the only way of preventing a disease is to cure it. One way in which to reduce the prevalence of the disease trypanosomiasis in man is to cure the patient by killing the parasite in him by appropriate drugs. He then ceases to spread the disease, and thus cure becomes a part of prevention. In malaria, the same thing is done. According to Koch, one way to prevent the spread of malaria is to kill the parasites in man by quinine. In trypanosomiasis we cannot get rid of the carrier of the germ; the fly cannot be got rid of so easily as can the mosquito, apparently. The important thing to sanitarians is, How are we to prevent this disease? Remember it is prevalent among the poorest natives, and over large areas of almost wild country. You can hardly get the natives to protect themselves from the bites of the insects, and they cannot spend their lives in mosquito nets, they must frequent the edge of the water to draw water and do their fishing, and go about in canoes. The result of the consideration of how to prevent the disease has been almost to cause despair, and the other day a certain Committee, almost decided to give it up. There was only one way in which to prevent it, and that is to cure it. We are at a loss to know how to kill the parasite in man. If you kill the parasite you may kill the host also. Professor Koch has been using atoxyl, which was first suggested by Drs. Thomas and Breinl. It has a great effect on the parasites in the experiments conducted on animals. Dr. ——, of Liverpool, has been at work on the subject in Liverpool, and I hope he has now got a better drug than atoxyl. It is difficult to tell what is the effect in human beings, because they may live as long as eight, nine, or even ten years with these parasites in their blood—that is, in the peripheral blood and yet such patients may ultimately die of sleeping sickness. But atoxyl should be used because it produces great temporary alleviation. There is a method which has been recommended by Dr. Todd, that is, quarantining the trade routes.

(a) Delivered at the Royal Sanitary Institute, London, on Friday, March 1st, 1907. The Chair was occupied by the President of the Institute, his Grace the Duke of Northumberland.

The disease is now spreading quickly in Africa chiefly owing to our civilization, which enables large areas to be traversed by caravans, where formerly it moved very slowly. It is easy to diagnose the early stage of the disease by the enlarged glands in the neck, which I referred to, and Dr. Todd's scheme is that no caravan shall be allowed to take a native who has these enlarged glands from village to village. In a few months we shall be sending an expedition out to attempt this method, and we hope it will lead to something promising. There is already a frightful loss from the disease, as it kills nearly every patient, and some districts are almost depopulated by it. Nevertheless it does not cause so much sickness as do dysentery and malaria throughout the world.

Now as to yellow fever. This disease is known to be carried by the tiger mosquito, so called because its legs are banded like a tiger, and because it bites like a tiger. Though this is found nearly everywhere in the tropics it is curious that yellow fever is carried by it only in certain parts of America (Central), the West Coast of Africa, and Spain. The history of the discovery of this mosquito as the carrier of yellow fever is a startling and dramatic one. The disease exists chiefly on the Island of Cuba and in the district of Panama, whence it spreads to other parts, and the mortality from it is, roughly, one in four. Naturally the prosperity of the Island has been much impaired by the disease, and up till 1883 nobody could conceive how the disease was carried. In that year a British subject, Dr. Finlay, of Havana, suggested that the disease was carried by the mosquito, and he also carried out a number of experiments directly on human beings. Spaniards coming to Havana went to a medical man to be inoculated against the disease; as if they were going to be sick they would prefer to be so in Havana where they could be properly treated and looked after. And Dr. Finlay availed himself of that fact to indicate that the mosquito carried it. The discovery is of the utmost importance to the New World, and I hope that some day the British people will do something to thank or reward Dr. Finlay, who has not had a "Thank you" for his work up to the present. In the year following the conquest of Havana by America, the Americans set to work to study the disease, and sent out a Commission. One of the members of it—Dr. Lazear—watched a mosquito biting his hand, and said: "I wonder if this mosquito is infected. If so, I shall have the disease." Sure enough, he acquired the disease in a few days, and died. They made some admirable experiments on human beings, and Spaniards volunteered for the purpose. They built a house, and brought Spaniards in and tried to infect them with the clothes worn by yellow fever patients, but not one of them caught the disease. Another seven they caused to be bitten by this mosquito, and six of them were attacked. Twelve days is the extrinsic incubation period. A repetition of the experiments produced the same results. At New Orleans one and a half years ago, there was an outbreak of yellow fever, and the Americans set to work at it with great energy and broke the back of the epidemic. The Americans are very active in an emergency and when danger threatens. Surgeon-General Wyman sent a whole army of naval and army officers and men to cope with the disease, and with admirable results. I wish the Americans were as good sanitarians always, but those who have visited such cities as Baltimore, or even Chicago, will know that they are not nearly equal to ourselves in these matters. The Municipality must keep an efficient army of workers, and pay enough for the work; and they must attack the evil from every point of view. The mosquito which carries the disease lives largely in the roof, and I show you a photograph of men spraying a house which is infected. It is necessary to destroy every mosquito possible. This may be done by fumigating the whole house, first filling up with paper all cracks and crevices. A very good mixture for this purpose is equal parts of carbolic acid and camphor put on a heater, from which the fumes rise. A doctor in the district visited by the epidemic did not believe in the mosquito theory, and refused to obey the instructions, so he was promptly carried off to jail. Wire gauze is very largely used in Central America; it, of course, also protects the inmates from ordinary mosquitoes, as well as from flies and wasps. I only wish wire gauze was more used in British dominions. However, it is being used more now than formerly. I always recommend that wire gauze should be used in the tropics. It is costly in Panama; what costs us 2d. here costs there about 1s. The mortality from the disease at Panama while the French were working there was frightful; I was told by the British Consul that 50,000 persons died of it there while the French were working at Panama. When the Americans took up the work, they saw that the first thing to do was to get rid of the disease. They appointed Colonel Gorgas to tackle it, he having already done such good work in Havana, though he has had very little reward for it. There has been a gradually diminishing mortality since the Americans conquered the country in 1898. The disease was first attacked by ordinary methods of sanitation—isolating contacts, &c.—and they thought they had produced an appreciable result. But after that the yellow fever came back the same as ever. So General Wood, who had command of that Colony, gave the order that the mosquito must be attacked. General Wood was originally a medical man, and he knew the value of scientific methods. He said that no expense was to be spared. The table I show you presents the results. The period is not carried further because there were no cases. But last year, I am sorry to say, fifty or sixty cases occurred, probably because, having conquered the disease, they got a little sleepy over their work. The same methods are being adopted in Panama against malaria and against yellow fever, and the returns for November and December show that the numbers of cases have been greatly reduced. Americans feel confident that they can keep down the disease, and it is well under control, in spite of newspaper scares. One of our principal allies is a little fish not quite threequarters of an inch long, which, when put into puddles eats up the larva. They actually have a "mosquito engineer" there—Mr. le Prince.

Dr. Laveran discovered the parasite of malaria; he is working at the Pasteur Institute, and he has also done much work in connection with trypanosomiasis. Probably the mortality from malaria in India approaches five millions, but you must remember that the population of the country is 300 millions. There must be a very large death-rate from malaria seeing the large number of children who are infected. It is not a disease which kills directly; it does so by enfeebling the patients. One can get a good idea by studying the admissions to hospital of soldiers and convicts. Many people who fall sick with malaria do not come to hospitals. On the whole I estimate that the number of attacks of malaria during a year equal about half the population. Cholera attacks a smaller number of people, but the death-rate is much higher. Probably the death-rate from malaria is higher than it seems because many of the deaths really due to it are returned under intercurrent affections. Amongst the European troops in India 710 men on the average are constantly in hospital for the disease—or equal to a whole regiment. Besides that hundreds of troops are taken ill when going on active service, largely through relapses. This is a large item of expense in connection with military expeditions. Sometimes cases of ankylostomiasis and kala azar are included under malaria. If a patient has chronic malaria through not having been properly treated and is then dosed with quinine, an attack of black-water fever is precipitated, as was shown by Koch and others. I show you a number of slides illustrating the subject. The anophales mosquito sucks up the parasite, which passes through the stomach wall into the body cavity, and then the spores find their way into the salivary glands. They get into the lumen of the salivary duct, and are projected into the skin of the patient when he is bitten. They live in the mosquito nine days, whereas in the case of yellow fever the period is twelve days. We have not discovered the yellow fever parasite. The ancient Romans understood the value of drainage in reducing malaria, for we find Mark Antony, when a candidate at an election, promised to drain the Pontine marshes if he got into power. When he got into office, he forgot all about it, and the marshes remained undrained. The anopheles breed principally in stagnant water, natural collections. The great outstanding principle in tropical sanitation is, have no puddles or stagnant water in your town area. Sierra Leone is known as the "White Man's Grave," and I show you a series of photographs by which you will see the enormous number of puddles in the streets; the rainfall there is very heavy. There are several ways of dealing with the disease — draining away or filling in the puddles, killing the parasite in the patient, having proper gauze mosquito nets. The advantage about draining the puddles is that it does not involve taking a nauseous drug, nor covering one's house so that it looks like a meat safe. A gentleman gave £2,000 towards this work in Sierra Leone, and we sent an expedition out there. I went with Dr. Logan Taylor. I do not think the authorities backed us up enough. A good deal of work has been done at the mathematics of the mosquito, and Professor Karl Pearson has been dealing with the subject. People have asked whether the insects will not come in from the outside and spoil the effect of the drainage, and perhaps be blown in by the wind? It is a statement which is made by those who have not carefully considered the matter. Every mosquito which may come into a given area is lost from the outside. Moreover, a wind which will blow mosquitoes into a particular area will also blow them out again. Professor Karl Pearson has shown, in what he calls the problem of the "random walk," that, except for some special attraction, the chances of a mosquito continuing always in one direction is almost infinitely small; the chances are that a mosquito starting from a particular spot will end up not far from where it started. A great effort is being made to lessen the amount of malaria in Greece. Greece is the birthplace of civilization, and the carrying out of this great work will constitute a fitting climax to the antimalaria campaign. We sent them £200 towards their work. There is a great deal of drainage being done, and a determined band of men are at work in the country. Although malaria is rife in Italy, there is said to be half as much again in Greece. The question of disease and history is a very important one, and I do not doubt that malaria has sapped the national life in Greece; which has waned since the time of Pericles.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by F. J. Poynton, M.D., F.R.C.P., Lond., Physician to University College Hospital, London, Assistant Physician to the Hospital for Sick Children, Great Ormond Street, on "Observations on Arthritis." The lecture was delivered at University College Hospital, and will be illustrated.*

A petition has been forwarded to the Home Secretary and to the President of the Local Government Board by the Women Sanitary Inspectors' Association opposing Mr. Ramsay Macdonald's Home Work Regulation Bill, on the grounds that the sanitary regulations are unnecessary, being already provided for in the Public Health and Factory Acts; that the proposed licences would prove a hindrance to the sanitary authorities in carrying out their duties with regard to infectious disease; that the placing of autocratic power in the hands of one individual, whether an officer of the State or of a municipality, is strongly to be deprecated; and that the intervention of the magistrate is necessary in revoking licences as a protection both to the licence and to the inspector.

ORIGINAL PAPERS.

A CASE OF
CANCER OF THE OVARY,

INVOLVING THE SIGMOID FLEXURE. REMOVAL OF BOTH OVARIES AND EXCISION OF PART OF THE SIGMOID, WHICH WAS UNITED BY END-TO-END ANASTOMOSIS.

By FRED. BOWREMAN JESSETT, F.R.C.S.,
Senior Surgeon, Cancer Hospital, Fulham.

Mrs. W., widow, æt. 48, was sent to me by Dr. Wickham on August 3rd, 1905, suffering from vaginal discharge.

She had had four children. Menopause occurred about six months previously. Since April she had been suffering from an irregular vaginal discharge, sometimes sanguineous and at other times watery.

She was a healthy looking woman, well nourished and very active. No tenderness or fulness on abdominal examination was found.

Per vaginam, the os is seen to be eroded and thickened; bimanually a small tumour can be felt, apparently connected with the posterior surface of the uterus. The uterus is somewhat enlarged, but quite mobile. There was no discharge coming from the uterine canal. I considered the discharge came from the eroded os uteri and advised some local treatment with douches, at the same time impressing upon her to let her medical man see her from time to time. The small tumour which I took to be a fibroid caused her no inconvenience, so I recommended her to leave it alone, but if it increased in size it would have to be dealt with

She improved rapidly under treatment, and I saw no more of her until the first week of November of 1906, or about fifteen months after she first consulted me. She had then seen Dr. Wickham again, who found a good-sized tumour in her abdomen, and sent her on to see me at once. I found her with a tumour extending nearly to the umbilicus and somewhat fixed. *Per vaginam.* The os was found to be quite healthy, but a tumour was felt connected apparently with the posterior wall of the uterus in the pouch of Douglas. Bimanually this tumour was evidently one with that felt by the abdomen. The whole tumour was somewhat fixed, but seemed to be connected with the uterus. I advised early operation, looking upon the case as a rapidly growing myoma of the uterus.

On November 3rd, with the assistance of Dr. Wickham, I operated through an incision in the middle line below the umbilicus; on the abdomen being opened a large tumour presented itself, to which the omentum and intestines were adherent. These were separated fairly easily, but on passing my hand down behind the tumour to lift it out of the pelvis I found it was firmly connected with the sigmoid flexure, which it had pushed across from the left side. There was no ascites. The adhesions were so strong and the intestines so intimately connected with the tumour that I found it impossible to separate it without tearing its covering. As the tumour had all the appearance of being malignant I was loathe to cut any of it away and so release the bowel, and so I excised a portion of the intestine. Having

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(a) Read before the British Gynæcological Society, March 14, 1907.

done this I was then enabled to lift the tumour out of the pelvis. This proved to be the left ovary. I ligatured the pedicle and removed it. I then examined the other ovary, and, as that was unhealthy, I removed it as well. Subsequently Dr. Paine, whose report I append, pronounced both ovaries to be malignant, *vide infra.*

I then proceeded to unite the sigmoid flexure by end-to end anastomosis, which was a very difficult matter, as I had neither bobbin or intestinal clamps, and the portion removed was very low down, almost at the junction of the rectum.

I however succeeded in uniting the two ends. For safety sake I anchored the part to the abdominal wound, so that in case of accidents it could be found readily. The abdominal wound was then closed in layers, and the patient returned to bed. She bore the operation very well, and all went well for the first forty-eight hours. But we could not get any action of the bowels and the abdomen was becoming very distended. On the third day, as the patient was becoming more and more distended and no action of the bowels had taken place I thought it wise to open the abdominal wound and see if there was any knot or other reason for the bowels not acting. I found the anastomosis quite intact, and so far as I could see there was no other reason than paresis of the bowel to account for the non-action. I took the precaution, however, of fixing a portion of the sigmoid in the proximal side of the anastomosis to the abdominal wound so that in case the bowels did not act an opening might be made for their evacuation. Happily, however, this did not become necessary and first flatus and then liquid fæces passed *per viam naturalem.* All went well for a fortnight, when the temperature commenced to rise and the patient complained of pain in the abdomen. In the course of a few days pus escaped at the lower angle of the wound, followed by fæces. This continued open for some weeks, but gradually became smaller and smaller. In the meantime some of the sutures which connected the ends of the intestines came away, though the wound and the sinus rapidly closed. Bowels acting regularly. This is an interesting case in many points of view. In respect to diagnosis, the small tumour when first seen appeared to be intimately connected with the uterus,. There was no pain or discomfort caused by it, neither did digital examination nor pressure cause pain, which one would have expected from an enlarged and diseased ovary. Yet I cannot but regret I did not advise operation at that time. The case emphasises the necessity of early operation in small tumours connected with the uterus. It also is interesting as showing how frequently if one ovary is the seat of malignant disease the other will also be found to be similarly affected. According to Olshausen the disease is bilateral in 50 per cent. of cases.

The greater number of recorded cases are usually secondary, but there is no doubt that cancer may arise primarily in the ovary.

Steffeck was able in one instance to trace to his satisfaction the origin of the cancer to the epithelial lining of the Graffian follicles, thus proving conclusively the possibility of a primary origin of the disease of the ovary. Doran has also recorded cases.

Pathologist Report by Dr. Paine.

DOUBLE OVARIAN TUMOURS.

Both ovaries were found microscopically to present the characteristics of an alveolar carcinoma of the ovary, but in different stages.

The larger of the two which was solid and rather soft was seen to be cellular and growing actively. The growth had become atypical, the aggregated masses of epithelieum showing in parts tendency to degeneration (mucoid in character). The fibrous stroma which was ill-developed being infiltrated with a large number of inflammatory cells.

The smaller growth was less advanced and more typical; in it the arrangement of the ovarian tissue could be more readily traced; and there was less tendency to degeneration.

PRIMARY CARCINOMA OF THE VAGINA. (a)

By H. MACNAUGHTON-JONES, M.D., M.A.O.

The patient from whom the growth shown was removed was a woman, æt. 65, a widow, who had been thirty-eight years married. There had been four pregnancies. She had a vaginal discharge for two years. The growth had not, however, been discovered until one week before I saw her, when she had come a long distance by train, and was carried into my study. I found a fœtid mass inside the vulva; the bladder was distended, and I drew off some four pints of water. The patient was too exhausted to make a complete examination, as she had been suffering from sciatica, and the pain she felt on movement of the limbs made it most difficult.

On the fourth day, I removed the growth under the scopolamin, morphia and chloroform method of anæsthesia. Part came away as a slough. I found it grew from the lower border of the lateral wall of the vagina, and that it descended deeply into the connective tissue and encroached on the bladder. It was botryoidal in character, and the deeper part was pedunculated—so that I thought it was of sarcomatous type, being similar to a case of sarcoma of the vagina which I brought before the society on a former occasion.

Neither the uterus nor any other part of the vagina was involved, nor were the inguinal glands affected. Severe neuritis in the left thigh was the only other trouble. I ablated the growth, going as deeply as I could into the cellular bed, and then used the cautery freely. She left the home shortly afterwards, as there was no use in detaining her further. (*b*)

"Dr. Cuthbert Lockyer's report was as follows: Malignant growth, made up of branching columns and masses of squamous epithelial cells. The latter are burrowing cell nests, and lie in alveolar spaces, the stroma around consisting of coarse fibrous tissue. There are also present blind tubules lined with columnar epithelium, actively proliferating in a malignant manner. The presence of two types of epithelioma in genital carcinomata is common in elderly females."

Roger Williams, in his paper on vaginal cancer in the *New York Medical Record* (November 30th, 1901) says, that of 9,226 tumours tabulated,

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(*a*) Read before the British Gynæcological Society, March 14th, 1907.

(*b*) I have now learned that the patient died ten weeks after operation from implication of the bladder.

there were 40 of cancer of the vagina, and 2 of sarcoma. He considers that "notwithstanding its rarity, cancer of the vagina is by far the most common form of vaginal neoplasm. According to Friedl, the medical journals up to 1896 contain records of 130 cases. Roger Williams himself has met with five examples. He places the proportion at 4.3 per cent. of all cases of cancer in women, taking his statistics from the chief London hospitals. Gurlt, from the Vienna hospitals, gives it at 1.6 per cent. In Hamburg, of 7,498 cancer deaths tabulated by Reiche, only 29 were from the vagina —that is, 0.38 per cent., and of Reiche's 4,507 cancer cases, 1.1 per cent. were vaginal. Williams, averaging these latter results, comes to the conclusion that some one per cent. of all cancer in women is of vaginal origin. Williams notes some interesting clinical and histological facts in connection with vaginal cancer. Briefly stated these are :—

(*a*) Vaginal irritation does not appear to play a part in its production. Pessaries exert no influence.

(*b*) Nearly all primary vaginal cancers appear to partake of the squamous epithelial or epidermoidal type.

(*c*) Having discussed the histological features of the vaginal membrane, in the comparative absence of pigment and glandular structure, as also its embryological development, he divides the forms of vaginal cancer into two—tubular and lobular.

The tubular begins "in proliferating cells of the inter-papillary region of the rete mucosum, or its aberrant extensions growing into the adjacent stroma." Multiplication and development proceeding, knobby projections and ingrowing columns result ; these may grow slowly, and there may be no dissemination. This gives the chronic type of the disease.

The lobular, and much more usual form, is on the other hand, marked by the formation of nests ; rapidity of growth is common by branchings and anastamoses, and this causes dissemination.

(*d*) Regarding its clinical characters, the posterior wall and upper part of the vagina is the most usual seat ; it may commence either as a papillary excresence, an elastic nodule, or an infiltration, and then follow the usual characteristics of the disease, with all the consequences of dissemination and pelvic involvment of organs.

The initial symptoms vary; pain, discharge and menorrhagia may be present, though before the existence of the disease is discovered it may have made considerable progress. The dissemination may be associated with and followed by metastases in different organs, and suppuration may occur in the inguinal glands (as in Herman's case), which are frequently involved. Death usually occurs from asthenia.

(*e*) The most common period of occurrence is after the menopause. Nulliparæ are as prone as multiparæ.

I have written to a few colleagues on the Continent asking them to give me the results of their experience in regard to primary carcinoma of the vagina. I have had the following replies :—

Professor Fritsch.—During the thirteen years in the Bonn Frauenklinik has not seen one single case of primary carcinoma. In Breslau he had seen four cases.

Professor V. Kronig.—During the two and a half years he has been at Freiburg has not seen a single case of primary carcinoma. Speaking from memory (as the results of his work at Jena and Leipzig were not available) he could only remember having operated on four cases in all, and with the exception of one case the disease quickly recurred.

Professor Jacobs (Brussels) says that in his experience primary carcinoma of the vagina is very rare. He has only met with four cases.

Professor Bumm (Berlin) says that he has only seen carcinoma of the vagina twelve times amongst 433 cases of carcinoma of the female genitalia. In these cases there was only one in which the carcinoma was primary. Cancroid of the portio, and cancroid of the vulva encroaching on the vagina, were not included in this number.

Professor Schottlander (Heidelberg) says that of 150 cases of carcinoma of the uterus he found 44 primary of carcinoma of the vagina. This is above the usual average—2 per cent. is probably excessive.

Professor Franz (Jena) says that of 125 cases of carcinoma of the portio, which he has had in the klinik since October, 1904, there have been two of primary carcinoma of the vagina.

Professor Zweifel (Leipsic, says that in 1906, out of 1,400 cases of carcinoma, there were four of primary carcinoma of the vagina.

Professor A. Martin (Griefswald) regards carcinoma of the vagina as a disease of great rariety. Some of the cases are undoubtedly metastatic and occur after operations for cancer of the portio or for chorio epitheliomea. Operative results are unsatisfactory.

ON THE TREATMENT OF
INVETERATE CASES OF MÉNIERÈ'S COMPLEX OF SYMPTOMS BY HYPNOTIC SUGGESTION,

WITH REMARKS ON THE NECESSITY OF INCLUDING HYPNOTISM AMONG OUR SCIENTIFIC REMEDIAL AGENTS.

By T. WILSON PARRY, M.A., M.D.CANTAB.

ABOUT two years ago I published in THE MEDICAL PRESS AND CIRCULAR (*a*) the case of a man, æt. 44, who had suffered from distressing attacks of Ménierè's Symptoms for eight years, and who had been most successfully alleviated by hypnotic suggestion. The case was the first of its kind that had ever been recorded, and I feel sure it will be of no little interest to such of our profession who may have similar chronic cases coming under their care to hear how this patient has fared during the now nearly two years that have elapsed since it first was published.

The attacks had become so frequent and formidable that the patient had been rendered quite unable to follow his employment. When he presented himself for examination on September 8th, 1904, he was noticeably bald, and he volunteered to me that he attributed this period of ill-health, due to these frequent attacks of Ménierè's Symptoms, to be the cause of his profuse loss of hair, and that it had also aged him much in other ways.

(*a*) THE MEDICAL PRESS AND CIRCULAR, May 3rd, 1905, pp. 445-448; May 10th, 1905, pp. 476-478.

He had also lost over a stone in weight during the previous three months. To use his own words: "The constant attacks I have had during the past eight years have much depressed me, and I am willing to undergo any treatment that may give me even partial relief."

On September 29th, October 7th, and December 1st, 1904, the patient was hypnotised by Dr. A. E. Jones, and the suggestion that there should be no more attacks of vertigo was impressed upon him. He was only hypnotised these three times, and each of these three ocasions only occupied a few minutes. From the dates abovementioned it will be observed that the treatment only covered a period of two months. The results were amazing. From September 29th, 1904 (the date of his first being hypnotised), to April 25th, 1905 (when I went to press), there had been no attack of giddiness, the vomiting had entirely vanished, and even the tinnitus, that had been an exceedingly trying accompaniment of the other more formidable symptoms, had ceased to trouble him as formerly and had become at length quite bearable.

Being anxious to learn whether this favourable condition of things had been maintained, I recently wrote to him, and received the following reply, dated February 6th, 1907:—

"I am in receipt of your letter and very pleased to say that I have been fairly well in health. I have only had slight attacks of giddiness and vomiting at long intervals since I last saw you (if I had done so I should have let you know). I am, however, still suffering from the hissing in the left ear, but that does not affect my health, and so long as the giddiness, &c., keep off, I must not complain, as you and Dr. Jones did me so much good (before seeing yourself and him I was in a very bad state). I may add that the attacks I have had have only lasted on and off for a few hours. I have not had occasion to see any other doctor since I last saw you and Dr. Jones. I suffer a little from nervousness, and after I have done my outdoor work in the morning I have to rest in the afternoon before resuming work; but considering I was under several doctors before seeing you and Dr. Jones, and they did me no good, I have much to be thankful for."

(I must here repeat that the whole honour of this case belongs to Dr. Jones and none to myself. I am merely the scribe.)

Remarks.—I am quite convinced that the value of this method of treatment cannot be overestimated. The general practitioner looks for results. In this case the results were all that could be desired. This case stands out not only on its own merits but as a type of that class of kindred nervous affections of obscure origin which often defies treatment by drugs or such other recognised rational system of treatment that may have done good in similar cases. It is this kind of case that often brings so much discredit upon the medical profession. It is well-known that patients suffering from complaints of this nature often spend their whole lives going from hospital to hospital, practitioner to practitioner, specialist to specialist, as their means will allow, always seeking rest but finding none. Can one wonder that if some practical cure be not effected the patient may often ultimately find himself, though perhaps most unwillingly, in the hands of the quack or Christian scientist? Is it not for us, as a strong, fearless, honourable profession, to lift hypnotism out of the hands of the charlatan and employ it, as a method of treatment, in such cases as are likely to be benefited by it, and have already refused to be ameliorated by all the ordinary recognised methods employed? To this the medical profession should give answer. To my mind, it is as important that there should be classes for practical psychology, where students can learn the art of hypnotism, as there are schools for teaching the essential elements of massage and electricity.

CLINICAL RECORDS.

CASE OF SARCOMA OF THE PAROVARIUM.

By W. D. Spanton, F.R.C.S.Eng. and Edin.,

President of the British Gynæcological Society; Consulting Surgeon North Staffordshire Infirmary, &c.

The patient was a woman, æt. 42, who had been married sixteen years, had two children born alive and one miscarriage twelve years ago. General health very good, never had any illness until five years since, when neuritis of the limbs and head appeared. Catamenia regular about every three weeks up to two years ago, since then had only four or five periods. She was seen by Dr. Dawes on December 15, 1906, thinking herself pregnant, and having noticed enlargement of the abdomen for twelve months. He examined her, and thought she had an ovarian or some other form of cystic growth, which had much the sensation of hydatids from its mobile flaccidity.

I saw the patient with Dr. Dawes on December 15, 1906, and found her looking ill with an enlarged abdomen, containing a fluctuating and apparently cystic tumour. To the right side of the uterus a hard mass could be felt, movable like the base of a multilocular ovarian cyst. The uterus was normal.

On December 20, I opened the abdomen and found a very thin parovarian cyst, which contained about two gallons of clear, straw-coloured fluid, and at its base a solid growth springing from the outer extremity of the left Fallopian tube The growth was removed, the base ligatured, and the ovary left behind. She made an uninterrupted recovery.

The pathological report states the tumour is extensively infiltrated with a spindle-celled sarcomatous growth, which is probably of endothelial origin. It has a capsule of fasciculated fibrous tissue, and the periphery is more or less alveolated by strands of unabsorbed stroma. Towards the centre there are more alveoli and less stroma. No ovarian tissue can be detected.

The interest of the case lies in the sarcomatous tumour forming the base of a simple cystic one, having all the characters of a rapidly growing parovarian cyst. The extreme thinness of the cyst wall is unusual for one of such size. It appears to be quite independent of the ovary.

CASE OF LARGE MYOMA, WITH SARCOMATOUS OUTGROWTH, ABDOMINAL: HYSTERECTOMY.

By W. D. Spanton, F.R.C.S.,

President of the British Gynæcological Society, &c.

A widow, æt. 49, who had one child twenty years before, saw me on January 24, 1907, on account of almost constant metrorrhagia, with a good deal of general abdominal pain and frequent sickness. I found a large, solid tumour, which had been growing for several years, now reaching half way between the umbilicus and ensiform cartilage, and was freely movable. The cervix was small and apparently normal. She was very thin and feeble, but anxious for an operation.

I performed abdominal hysterectomy, leaving the cervix on February 5, without any complications. The interest of the case lies in the fact of the different nature of the uterine tumour and that of the outgrowth, to which the omentum was attached. The report by Mr. J. H. Targett of the uterine tumour was as follows :—"It has the naked eye and microscopical structure of a uterine fibroid, undergoing hyaline and mucoid degeneration. There is nothing suggestive of sarcoma. Here the two conditions are combined, but whether they are related is a very difficult question to decide." That of the outgrowth is "this tumour is a spindle-celled sarcoma. The tissue is dense, with areas of hyaline degeneration in places, and one or two foci of mucoid softening."

We have here an excellent illustration of the association between a simple and sarcomatous growth, and it is a question whether the latter is not simply "matter in the wrong place" and too much of it?

OPERATING THEATRES.

NORTH-WEST LONDON HOSPITAL.

EPITHELIOMA OF THE FLOOR OF THE MOUTH WITH EXTENSIVE SECONDARY DEPOSITS IN BOTH SUB-MAXILLARY TRIANGLES.—MR. MAYO COLLIER operated on a man, æt. 42, who was the subject of a large epitheliomatous growth in the floor of the mouth on the right side with excessive deposit in the neck on both sides. Mr. Collier said that the case came under his care at an extremely late stage, the affection having lasted already some five months, and it had proceeded to a condition which several surgeons had considered hopeless on being consulted. The case had come under Mr. Collier's care four days previously, having been sent to the hospital for an opinion as to the possibility of removing the secondary deposits in the neck. Mr. Collier said that having regard to the otherwise healthy condition of the patient and the mobility of the large masses under the right sternomastoid and at the angle of the left jaw he thought it was justifiable to attempt removal, as the alternative would be a painful and horrible death within at most a few months. The gravity of the procedure about to be adopted was fully explained to the patient, as well as the alternative of a painful and miserable ending if the disease were left alone. The patient being only 42, it seemed a pity to let him drift to destruction without affording him a helping hand. Mr. Collier said that in very few cases were these secondary deposits irremovable; a man who knew his anatomy thoroughly and had trusty assistants could certainly undertake the removal of a large percentage of these growths with a fair prospect of the patient recovering from the immediate effects. With these few explanatory remarks he proceeded to ligature the lingual and to clear out the left submaxillary triangle by the usual curved incision. The patient, who was of very short stature, and who had a thick bull neck, was not a very promising subject for a speedy ligation of the linguals; however, in the course of some thirty minutes the clearance of the whole of the glands and the ligation of the lingual were effected. During the whole of this time extreme difficulty was experienced by the anæsthetist; the patient's breathing had become very difficult and his colour was ominous. At this point of the operation things came to a climax; the patient ceased entirely to breathe and was almost of coal black colour. All attempts on the part of the anæsthetist to draw out the tongue and bring forward the epiglottis, which had apparently collapsed over after opening of the larnyx, were unavailing. Mr. Templeton, who was present and very kindly assisting, most promptly and skilfully opened the trachea and inserted a large tracheotomy tube through which artificial respiration was maintained for a few minutes. The natural breathing and pulse action promptly returned and the operation was proceeded with. Mr. Collier next attacked the right side, and the enormous mass which extended from the side of the larynx almost to the cervical vertebræ was removed. The details of this procedure were carefully and skilfully carried out and in the course of an hour and twenty minutes the whole mass was removed and the lingual safely tied. The patient having now been two hours and a half on the table, the later step of removing the tongue and the floor of the mouth was postponed to a future date, when the man would be in a condition to stand the procedure. Mr. Collier remarked that it would be quite impossible to complete the whole operation in one stage; in these cases, experience has taught that the removal of the tongue and the floors of the mouth may be safely undertaken some fortnight or three weeks later. It was the practice of some surgeons, he said, to remove the tongue and floor of the mouth first and the glands at a later stage, but he pointed out that the patient was much more likely to stand the extensive dissections which are requisite to remove the secondary deposits if he is able to feed and sleep comfortably with an intact tongue and floor of the mouth.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD MARCH 22ND, 1907.

The President, Mr. CLUTTON, in the Chair.

Mr. H. H. CLUTTON showed a case of

CONGENITAL HYPERTROPHY OR GIANT GROWTH OF FEET.

The patient was a girl, æt. 17. The deformity, which was noticed by the mother at birth, slowly increased up to the age of fourteen. During the last three years the growth had been much more rapid, producing particularly a greater inequality in the length of the two lower extremities. The feet were enormous, but fairly equal in size, the distal parts being rather larger than the proximal.

Mr. F. W. FORBES ROSS showed a case of

PANCREATIC CYST, OPERATION AFTER RUPTURE OF.

Rupture of the cyst had occurred a fortnight after an operation for rectal prolapse. The contents were purulent.

Administration of hydrochloric acid produced a ready flow of pancreatic juice from the sinus.

Dr. H. BATTY SHAW, and Mr. R. HIGHAM COOPER showed a case of

HYPERTROPHIC PULMONARY OSTEO-ARTHROPATHY OCCURRING IN THE LOWER EXTREMITIES ONLY, IN ASSOCIATION WITH CONGENITAL CARDIAC DISEASE.

The patient was a woman, æt. 21, The patient was cyanosed, and there was well-marked clubbing of the fingers, toes and nose. A systolic murmur was heard over the precordium. The lungs were free from signs.

There was obvious swelling of both legs, largely due to thickening of the bones.

Radioscopic examination.—There was considerable enlargement of the tibiæ and fibulæ of both legs, more especially the right, when compared with the corresponding bones of the patient's sister, who was quite healthy and of similar height. There was uniform thickening of the lower two thirds of the tibiæ and fibulæ, and irregular bony deposits were present at the attachment of the periosteum to the interosseous membranes. The upper halves of the shafts of the femora appeared to show the same changes, but in a more marked degree, especially in the right leg; the head, neck, and lower halves of the femora appeared to be normal.

Dr. G. A. **Sutherland** showed a

CASE OF OSTEOGENESIS IMPERFECTA (? SYPHILITIC).

A male infant, æt. 8 weeks, a first child. He was born after an easy labour, and "the left wrist was seen to be broken and the arm to hang as if dislocated The thigh and leg bones on the left side were broken." Multiple fractures in the long bones were shown in a skiagram taken seven days later. No fresh fractures had occurred.

On admission, four weeks ago, great pain and tenderness were present in the extremities, which were the seat of periosteal swelling, especially around the epiphyses. A condition of pseudo-paralysis existed, movement being limited to the fingers and toes. Signs of fracture were manifest in all the long bones of the extremities and in many of the ribs. A swelling was present over the right parietal bone with a large irregular gap in the osseous tissue. There was general peeling of the skin over the trunk and extremities. Under observation improvement had occurred. Mercurial treatment has been carried out.

Dr. **Leonard Guthrie** thought that some, but not all of such cases were due to syphilis. The cases might be divided into two groups according to whether the fractures were found only at birth, or occurred at a later period. He read the notes to a case similar to the present one, including an account of a careful *post-mortem* examination. He also mentioned two cases that had first shown signs about the age of two years.

Mr. W. G. **Spencer** suggested that the condition might be due not to disease, but to an arrest of development. If this were so, later improvement might be wrongly attributed to mercurial treatment.

Dr. **Sutherland**, in reply, said that in his opinion the present case was probably syphilitic; the spleen was large, there was ulceration about the arms, and the case had responded to mercury. If so it should not be placed in the idiopathic osteogenesis imperfecta group.

Mr. A. H. **Tubby** showed

A CASE OF FACIO-HYPOGLOSSAL ANASTOMOSIS FOR POST-OPERATIVE PARALYSIS.

Patient was a male, æt. 19. An abscess was opened on April 27th, 1905, and when he recovered from the operation he found the left side of the face paralysed. On admission to Westminster Hospital there was facial palsy, and the patient had lost all taste on the anterior part of the left side of the tongue. On October 16th an anastomosis was carried out. An incision was made with a tenotomy knife deeply into the hypoglossal nerve, and the distal ends of the facial were implanted into it laterally. On October 23rd it was noted that the palebral fissure was lessened in size, and the eye could be temporarily closed. On October 28th the patient began to move the left angle of the mouth. At present movement was almost perfect; there was slight atrophy of the left side of the tongue.

Mr. A. H. **Tubby** showed

TWO CASES ILLUSTRATING THE TREATMENT OF COMPLETE PARALYSIS OF THE GASTROCNEMIUS AND SOLEUS WITH TALIPES CALCANEUS, BY NERVE-GRAFTING.

The patients were both æt. 9, and had old standing poliomyelitis. The nerve branches to the muscles had been isolated and implanted into the external popliteal nerve. The results were excellent.

Mr. W. G. **Spencer** thought that physicians should decide on a limit beyond which spontaneous recovery was impossible in these cases, and then call in a surgeon.

Mr. **Tubby** said that the distinction was not always clearly made between the direct effect of muscular paralysis and the secondary effects of contractures. If this were done surgical measures would often be resorted to earlier.

Dr. F. **Parkes Weber** showed a case of

ACUTE THYROID SWELLING, WITH ACUTE HÆMORRHAGIC ŒDEMA OF THE RIGHT SIDE OF THE PHARYNX AND LARYNX.

The patient was a man, æt. 54. He was under treatment for interstitial nephritis, and had a blood pressure of 230 mm. On the afternoon of March 4th his neck suddenly began to swell. On admission to the German Hospital at 7 p.m. the whole thyroid gland, but especially the right lobe, was much enlarged, tense, and tender. There was likewise considerable general swelling of the neck and over the upper part of the sternum, and there was great œdema of the right side of the pharynx and larynx. The pharynx was scarified and the patient was much relieved by a morphine injection, rest in bed, and the external application of ice to the neck. The swelling gradually subsided. Eventually (March 17th) the man felt almost in his usual condition again, but the thyroid gland was somewhat enlarged, and the skin of the neck (especially the right side), and the upper front part of the chest was discoloured, as if from extensive bruising. The skin of these parts presented various shades of green, greenish-yellow, and purple, and there was still much ecchymosis of the mucous membrane of the pharynx and larynx.

Dr. **Forsyth** said that the anatomical structure of the thyroid gland made it improbable that a hæmorrhage occurring therein would produce symptoms such as those described. At present the gland had preserved its normal shape.

Dr. **Weber**, in reply, said that the gland had certainly been tense and swollen.

Mr. H. **Betham Robinson** showed a case of

ENLARGEMENT OF THE CLAVICLE AND LOWER JAW.

The patient was a boy, æt. 13, with chronic inflammatory swelling of right clavicle and left side of lower jaw, dating from a fall six months before. There was some nodular enlargement of right half of thyroid gland. There had been some reduction in size under potassium iodide.

Mr. **Tubby** remarked that he had once seen a growth, secondary to a thyroid tumour, situate in the clavicle.

Dr. **Harry Campbell** showed a case of

DISAPPEARANCE OF THE SUBCUTANEOUS FAT ABOVE THE REGION OF THE LOWER EXTREMITIES.

Girl, æt. 21. The disappearance especially marked in the face, chest, and abdomen, including the region of the *mons veneris*. There was no disappearance of fat from the mammary glands or the orbits. There was an abundant deposit of subcutaneous fat in the buttocks and lower extremities generally. The patient was said to have been perfectly normal up to the age of seven. From this time until the age of fourteen there occurred a gradual disappearance of fat from the affected regions.

Mr. **Clutton** compared the condition to morphœa.

Mr. **Donald Armour** showed a patient from whom

A LARGE POLYCYSTIC KIDNEY WAS REMOVED TWO AND A HALF YEARS AGO.

The patient was a woman, æt. 29; had been quite unaware of the tumour, and there were no urinary symptoms.

Dr. **Parkes Weber** wondered whether the opposite kidney was also cystic. He referred to a recent case in which a French surgeon had removed what he took to be a cystic kidney, but which proved at autopsy to be a polycystic pararenal growth of Wolffian origin.

Mr. **Armour**, in reply, said that there were no evidences of affection of the other kidney.

Mr. W. G. **Spencer** showed a case of

OBLITERATION OF BILATERAL PSOAS ABSCESS.

The patient, a woman, æt. 25, had recovered, apparently completely, after several operations.

Mr. **Warren Low** referred to the advantages of closing the wound after operation in such cases.

Mr. **Spencer**, in reply, said, that that was at first impossible in this case, as the sac was already septic when he first saw the case.

Mr. A. H. **Tubby** also showed a case of "Congenital Dislocation of the Hip."

Mr. A. E. J. **Barker** showed a case, in a woman, æt. 24, of "Fixation of the Jaw." The left masseter was fibrous.

ROYAL ACADEMY OF MEDICINE IN IRELAND

Section of Medicine.

Meeting held Friday, March 1st, 1907.

The President, J. M. Pedmond, R.C.P.I., in the Chair.

A CASE OF MANIACAL CHOREA.

The President of the Royal Academy (Dr. J. Magee Finny) read a paper on maniacal chorea, and based it on the clinical report of a case which had lasted nine days from the onset of the chorea, and which had been preceded by an attack of rheumatism of a fortnight's duration. The patient, a girl, æt. 17, was admitted to Sir Patrick Duns' Hospital on June 14th, 1906, with chorea minor, and presented a distinct systolic apical murmur. This murmur was audible up to her death, and was considered probably due to organic disease of the mitral valve. The day following her admission the choreic movements became very violent, and one or two nurses were necessary to keep her in bed and prevent self-injury. With the access of the muscular movements maniacal symptoms set in, and so greatly did they overshadow the motorial disturbance that the house surgeon was about to send the patient into the lunatic asylum, believing it to be a case of acute mania. The temperature was not raised for five days, but on the sixth it reached 103.4° for a few hours, and the pulse from 80 shot up to 130 on the day of her death. I never saw a human being so tossed about and agitated in every limb as this girl. The skin of her lips, back, arm, and legs was rubbed off from the violence and suddenness of the movements, as no appliances of wadding, bandages and stockings, &c., could be kept on; and at times it required four to eight persons to restrain her in bed. Calm was obtained—but very temporarily—by chloral inhalation of chloroform, and the hypodermic of hyoscin hydrobrom gr. 1-200 or 1-100. Death was preceded by semi-coma of six to eight hours' duration. Curious to say, all through (except for last day or two) intelligence was retained, and she could occasionally answer a question in a few words. At the autopsy, made by Dr. O'Sullivan, the brain showed very little gross alteration beyond engorgement of the vessels of the cortex, and there was an absence of meningeal inflammation of brain or cord. On microscopic examination some small vessels of the cortex in the Rolandic area were thrombosed; in others collections of cells with oval nuclei lay heaped up in the perivascular lymphatic spaces. The spinal cord presented nothing abnormal. The cerebro-spinal fluid was examined bacteriologically for Wassermann's coccus (*Diplococcus rheumaticus*), but with negative results. The cultures remained sterile. No other organ presented any abnormality, except the heart, which was small and in an atrophied condition. The mitral and other valves were not inflamed. He called particular attention to the agreement between *clinical observation* that rheumatism and chorea are due to the same poison, and the *recent bacteriological* work of Poynton and Holmes, which demonstrates that the diplococcus of rheumatism is present in the brain and membranes of the cord as well as in the fringe of vegetation around the mitral orifice and in the mitral valve itself—so commonly found in chorea and in rheumatism. Thus, the same micro-organism has been found in various organs —brain, spinal cord and heart. This organism, termed the "*Diplococcus rheumaticus*," has been found in rheumatism and in chorea, and the toxin produced by it in proportion as it attacks the psychical or the motorial centres of the human subject so the case will be one showing great mental disturbance (mania) or violent choreic muscular movements, or both.

Dr. J. Craig said that chorea had scarcely yet got its proper place in the text-books. Some few years ago it was described under the head of diseases of the articulations; now it was described, rightly, as a specific fever. Associated with the toxæmia produced by the micro-organism, there was always a certain amount of acute dilatation of the heart in the early stage, with a cardiac murmur that would subsequently disappear. The communication had tended to associate in their minds the great connection there was between chorea and rheumatism; he had shown that chorea was merely a complication or manifestation of the rheumatic state. In treating cases of chorea he had retracted considerably from his belief in the administration of large doses of arsenic.

Dr. Spencer Sheill recalled a communication of his dealing with two cases of chorea, both associated with pregnancy, one of which ceased when the uterus was emptied, and the other of which was perfectly described by Dr. Finny's case, with the exception that there was no rheumatic history. He regretted that in the latter case the autopsy was incomplete and unsatisfactory.

The President of the Academy, in replying, said if they were agreed that the poison of rheumatism and chorea were identical, and affected different parts of the body through the toxin, it would help very much to explain some otherwise very difficult phenomena of clinical experience; it would make them very cautious of making little of cases of chorea which came into hospital. Choreiform movement was only a small expression of a serious poison which was intoxicating the patient and injuring the nervous and muscular system.

MOVABLE SPLEEN, WITH ACCOUNT OF A CASE.

Dr. Moorhead read an account of a case of movable spleen. He also gave a *résumé* of the literature of the subject.

BRITISH GYNÆCOLOGICAL SOCIETY.

Meeting held March 14th, 1907.

Mr. W. D. Spanton, F.R.C.S., President, in the Chair.

Specimens.

The President exhibited specimens of

(1) Sarcoma of the parovarium.

(2) Myoma of uterus with sarcomatous outgrowth removed by abdominal hysterectomy.

(Which will be found on page 337).

Dr. J. A. Mansell Moullin exhibited a fibroid uterus containing a fœtus of four months, removed by sub-peritoneal hysterectomy. The patient was æt 26, and pregnant for the first time.

The diagnosis was somewhat obscure. The patient complained of great abdominal pain during the last few days, and the tenderness on examining the tumour suggested that the gestation might be ectopic.

A large fibroid developing in the cervical region, rendered the possibility of delivering at full time very doubtful.

Under the circumstances Dr. Mansell Moullin decided to remove the tumour at once instead of waiting until the fœtus was visible. No obvious cause for the pain and tenderness was found. The patient was doing well.

Dr. Heywood Smith considered the pain might be due to compression. Fibroids of the uterus situated in the pelvis gave more pain than those which rose above it. When such a tumour became jammed it did not necessarily follow that it was adherent.

Dr. J. A. Mansell Moullin said there was no compression of the tumour at all. Moreover there was no sign of peritonitis or degenerative change.

Mr. Bowreman Jessett, referring to the second specimen shown by the President, said the outgrowth was sarcomatous and the tumour itself was not. This was an interesting point, as he believed that cases of fibroid uterus became sarcomatous far more frequently than was supposed.

Mr. Alban Doran said they were absolutely uncertain about those quasi-malignant or semi-malignant or entirely malignant fibroids. In 1902 he removed a fibroid that looked very malignant, and a few months later another. Dr. Cuthbert Lockyer made out that endothelioma was invading the fibroid in either case. In one case the patient died within five months from recurrence. The other patient was now alive and perfectly well, and had not had a stormy menopause.

Dr. C. H. F. **ROUTH** said he thought great credit was due to men who had the courage to remove these tumours and obtain a recovery afterwards. In his opinion, however, one of the greatest questions to discuss was not so much the structure of tumours as how to prevent their growth. In connection with these myomatous tumours and how they became infected with carcinoma he heard it stated that no instance was recorded in which cancer ever invaded the ureters, though it might surround them. He thought that probably there was in the ureters a particular element which prevented their being attacked by cancer. If that were true, then by the use of a serum obtained from the ureters the disease might possibly be prevented or cured. He thought that this question of trying to provide such a serum was one which should be investigated.

Dr. **MACNAUGHTON-JONES** read notes on a specimen which he showed of

CARCINOMA OF THE VAGINA,

which will be found on page 335.

Dr. J. H. **DAUBER** said squamous epithelioma of the vulva was sometimes seen on both sides of the vulva as if one side had infected the other, and he wished to know if carcinoma of one side of the vagina infected the opposite one.

Dr. **ETHEL VAUGHAN** thought the growth was an endothelioma and not a carcinoma, judging both from the naked eye appearance and the microscopic appearance which she had just seen. One reason why she thought that the specimen was an endothelioma and not a carcinoma was that in some of those cell masses there were definite spaces lined with endothelium. The cells were rather angular and characteristic of endothelioma. Secondly, there was no small cell infiltration which was usually present in rapidly growing carcinoma of the vagina.

Dr. S. **JERVOIS AARONS** said that many fibroid tumours which appeared to be malignant were not so. On the other hand there were many tumours which looked like ordinary fibro-myoma, but were found to be sarcomatous.

The **PRESIDENT** said the more they heard about cases of simple sarcomatous tumours the more they had to come to the conclusion that a microscopical appearance *per se* was not authoritative. They must watch the clinical progress of such a case before they could come to a definite decision.

Mr. **ALBAN DORAN** asked if it was not the case that they might take what was normal for what was abnormal. In fibroids of the uterus there was an enormous number of blood vessels and spaces. Then again there was a great deal of endothelium about, and they might mistake what was not a new growth for what might be a new growth.

Dr. H. **BECKETT-OVERY** said he examined one case of carcinoma of the vagina associated with a very definite adenoma of the kidney.

Mr. J. H. **TARGETT** said that he thought the first tumour shown by Dr. Macnaughton-Jones was probably glandular carcinoma. They knew that the vagina had no glands, but possibly the tumour might have originated in an acinus of the vulvo vaginal glands. It might have had its origin in some gland connected with the ureter. There was one other possible source of origin. The patient had carcinoma of the ovary, which they did not know about till a long time afterwards. But she presented herself as a case of carcinoma of the vagina. It was thought to be primary to the vagina, but it was really secondary to growth in the ovary. Endothelioma was not an uncommon event. One was as young as 36, and at the time she was examined the rectum was already invaded by the disease. In the other case the endothelioma was removed, but after about two years there was a recurrence of the malady in the iliac glands.

Dr. **SMALLWOOD SAVAGE** said he had a case under his observation some two years ago of sarcoma of the vagina. It was one in which there was a friable growth in the lower third of the vagina on the posterior wall. The growth bled profusely, and he removed it as far as he could, but he saw at the time that its removal would not prove of any great value. The patient died not long after the operation. On microscopical examination he found the growth to be a small round-celled sarcoma.

Dr. H. **MACNAUGHTON-JONES**, in reply to the various criticisms passed on his first mentioned specimen said, it was really most difficult to say whether a growth in the ovary or in the vagina or in the uterus was really primary or not, until a certain time had elapsed. Mr. Targett had described the carcinoma as possibly of glandular origin. In the vagina there were columnar tubules which Dr. Lockyer had referred to in these growths. He would say that to Dr. Mary Dixon Jones, of New York, was due the credit of having been the first to describe endothelioma of the ovary over twenty-five years ago. He himself had seen specimens of it, and he would not have thought that there was any difficulty in recognising an endotheliomatous tumour. He did not know there was any case on record of primary carcinoma springing from both sides of the vagina. He proposed that the specimen should be referred to a Pathological Committee.

Mr. F. **BOWREMAN JESSETT** seconded the proposition which was unanimously agreed to.

Mr. **BOWREMAN JESSETT** read notes on a specimen of "Carcinoma of the Ovary involving the sigmoid flexure."

This will be found fully reported on page 334.

Mr. E. **STANMORE BISHOP** read a paper on

MOBILE KIDNEY,

with a description of an operation for anterior nephropexy.

Mr. **HURRY FENWICK** said he had had about 500 kidney cases. One of the greatest bugbears was the movable kidney. He had never been satisfactorily able to fix it. He had come to the conclusion that in many cases the symptoms were not due to the mere mobility of the organ, because they fixed movable kidneys sometimes extremely well and yet the symptoms continued. He had had to remove some of them, and after removal the pain had gone on, which was a severe indictment against fixing certain cases of movable kidney. When he had a case of movable kidney he usually advocated, as a palliative measure, the wearing of a belt. If a patient was suffering from frequency of micturition he generally fixed the kidney. He found out the value of picking off the anterior layer and fixing it over to the incision and stripping the whole of the posterior layer.

Dr. **PARSONS** remarked that bad cases of floating kidney did have symptoms, and it was astonishing how well some of them became after operative treatment. He was interested to hear this new method of operation, and thought it was a thoroughly scientific one.

Mr. **CHARLES RYALL** said that some years ago he did a great many operations for movable kidney. But a great many of those cases had been most disappointing. One had to be careful in recommending operation in cases of floating kidney because if the operation did not cure the patient the surgeon had better not attempt a second operation. He was convinced that only where there were definite grave kidney symptoms should it be fixed. The conditions where an operation was indicated were severe renal pain, hæmorrhage, intermittent hydronephrosis, and renal colic. He himself certainly preferred the posterior or lumbar incision for most of the kidney operations.

Mr. **CHRISTOPHER MARTIN** said he believed that in the great majority of cases the dropping of a kidney was not the cause of a neurasthenic condition, but the neurasthenic condition was the cause of the dropping of the kidney. With regard to treatment he never advised operation unless palliative measures had failed. He had tried the use of belts, but had not found them beneficial at all, excepting a double belt was employed. In cases requiring operation he generally used the posterior vertical incision. At the present time he had in his private hospital a patient from whom he removed a kidney which had been operated upon in London some two years ago by a London surgeon, who put the stitches right through the kidney substance. The patient had three big stones in her kidney, and one stone was around the end of the suture. So that he thought it was very bad surgery to put sutures through the kidney substance; they should only go through the capsules. He did not see the object of stripping off the capsule from the lower end of the kidney. The capsule would have to support the kidney, and that, of course, could not be if it was stripped off. The sutures that Mr. Bishop put through the kidney would help to hold it up. The capsule should be stripped off towards the upper end of the kidney, so as to get adhesion between the raw surface on the kidney and the fascia at the back.

Dr. **Macnaughton-Jones** would like to know what were the permanent results in that operation as compared with those of the usual posterior operation. At the same time they must make a beginning in anything, and the operation brought before them that night was distinctly a new departure and therefore ought to receive full consideration. As regards movable kidney, if any woman came to him with any disease below the ensiform cartilage, the first thing that he examined her for was movable kidney. It occurred in a large number of women. He entirely and totally disagreed with the view put forward by Sir Frederick Treves that operation for movable kidney was one which should be discarded and was not a scientific surgical procedure. He believed that the loss of fat and the want of support to the kidney had a great deal to say to movable kidney, as patients were kept in bed for several weeks, fed and massaged, and they got up with the kidney in its proper position in certain cases, and yet no operation had been done. Whilst he believed in operation he was equally confident that there were some cases which would disappoint them. He tried belts in cases where there was not complete dislocation of the kidney. He showed a belt which he had used for years and found most satisfactory. A woman with a movable kidney should be measured for it or its position and the support adjusted accordingly. He knew people with loose kidney who were using that belt at the present day and had never been operated on.

Dr. **Heywood Smith** said that an important factor in the production of movable kidney was tight lacing, and it would be instructive to compare the results observed in different countries whether it was injurious or not.

The **President** said it was a recognised fact that tight lacing had a good deal to do with movable kidney. He thought a protest ought to be made against ascribing symptoms of the most varied type to mobile or movable kidney, the latest being that of insanity.

Mr. **Bishop** replied to the various criticisms, and the meeting adjourned.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held in the rooms of the Medical Society of London on Friday, March 15th.

Dr. G. A. **Sutherland**, in the Chair.

Mr. G. **Russell Howard** read a paper on

Tuberculosis of the testis in infants.

The condition, he remarked, is rarer in infants than in adults, the percentage compared to all surgical cases in the London Hospital during ten years being .07 per cent. in infants and .33 per cent in adults. The disease is primary in the epididymis and spreads to the body of the testis, while the resicular seminales and prostate are rarely affected in the early stage. It affects chiefly the left testis, and is rare in the undescended testis. Hydrocele occurs in a third of the cases. The diagnosis from syphilitic disease is difficult and chiefly rests on other evidence and the result of treatment. Tubercular peritonitis is a frequent complication. If only one testis be affected and general treatment be not successful the testis may be removed without bad effect on the mental and bodily growth; if both testis are diseased they must only be removed as a last resource, owing to the impairment of mental and bodily vigour produced by their ablation. Concluding notes on a case of biliary cirrhosis was read by T. E. Holmes.

A specimen of teratoma from the back of a child, æt. 6, was shown by J. Russell Howard. The tumour was 5 inches by 3 inches and extended from the upper part of the saccum to the tip of the coccyx. The upper part of the tumour consisted of a collection of small cysts and a quantity of vascular fibrous, fatty and cartilaginous tissue. Bone was also found. In the lower part of the tumour was a mass lying in a serous sac which was reflected round it. This mass was of the size and shape of an adult kidney with a semblance of a pelvis, but the microscopic examination showed none of the normal kidney structure. The tumour was evidently derived from all the three layers of the embryo, the ectoderm, mesoderm and endoderm, and therefore must be considered a teratoma.

A large abdominal tumour in a boy, æt. 3 years, was shown by Dr. Cantley. It was probably a congenital hydronephrosis.

He also showed a boy, æt. two years, with a large solid tumour in the left lower quadrant of the abdomen. The spleen and liver were somewhat enlarged. He regarded it as sarcomatous in character.

A case of central tumour in a girl, æt. 7 years, was shown by Dr. Porter Parkinson. There was a history of general convulsions on and off for eighteen months. Two months weakness of the right side of face and limbs. Latterly headache and vomiting had occurred. There was double optic neuritis. In one fit which had been observed the movements were chiefly of the right limbs. Dr. Parkinson considered that there was a subcostical tumour on the left side, probably gliomatous in nature, and he proposed to have the child trephined with the object of preserving the sight.

The case of multiple lupus vulgaris in a boy, æt. 10 years, was shown by Mr. G. Pernet. The patches which were on the chin and right shin followed an attack of measles. The disease had improved considerably by three months' treatment by X-rays, preceded by scraping.

Specimens of infective endocarditis was shown by Dr. Cantley, and of cirrhosis of the liver with obliteration of the bile ducts by Dr. Porter Parkinson.

Cases were also shown by Mr. Sydney Rumbolt, Mr. Milner Burgess and Dr. Sprigge.

CENTRAL MIDWIVES' BOARD.

Meeting held March 21.

The President, Dr. **Champneys**, in the Chair.

At the commencement of the meeting the President expressed his great regret that Dr. Dakin, owing to professional engagements, could no longer be on the Board. His help had been much appreciated. Dr. S. B. Atkinson, Barrister-at-Law, had been elected in his place.

The **Secretary** then read a letter from the Privy Council as to the Board's power to remove names from the Roll without allegations of misconduct—*i.e.*, when old or infirm.

The **President** said this was a power which had long been required. They had many such nurses on the list with old age, defects of hearing, seeing, &c.

It had been decided by the Standing Committee to refuse the application of the Leeds Maternity Hospital as a training centre, and on this being confirmed, Miss Paget proposed that some reason for refusal be given, in order that failures to meet requirements might be mended.

Mr. Parker Young answered he did not think it wise to give reasons. They were not obliged to, but it was agreed when, as in this case, the only reason being that the hospital was new, to request the Secretary to forward reasons for decision.

The following applications for teaching were granted: Mr. S. Craddock, of Bath, and Dr. G. M. Fox, but Miss Wilson rose to protest against the acceptance of some teachers when others had been waiting months and were equally well qualified. The acceptation was therefore postponed for re-decision, as the President considered it only fair to deal first with men who were in suspense.

With regard to the situation of the Board with the Privy Council Mr. Fordham will move at the next meeting that a sub-committee, consisting of the President, Mr. Fordham and Miss Paget prepare a statement concerning amendments to the 1902 Midwives' Act to be laid before the Council.

THE BOARD'S POSITION IN REGARD TO POOR-LAW INSTITUTION.

Mr. Parker Young then moved that question should be put to the President as to the exact position the Board stood in reference to training in Poor Law institutions. There had been many meetings *in camera*, but it was his opinion some explanation, even one for the public, should be given.

The President answered he was quite prepared to say how far matters had progressed and proceeded to do so on the points of matrons of Poor Law institutions signing certificates, compulsory notification of birth by midwives, &c., and points on which the Board did not yet see their way to agree to. The principal points are contained in a memorandum, an abstract of which is appended.

Before the meeting adjourned the Secretary asked if a special meeting could not be held for the hearing of penal cases? These were ever increasing, and there were now fifty waiting.

Abstract of Memorandum on the Course of Negotiations between the Privy Council and the Board on the subject of Training in Poor Law Institutions.

On May 9, 1906, the C.M.B. submitted their revised rules to the Privy Council for approval. Rule D 1 omits the special exceptions in favour of Poor Law Institutions contained in the present rule. These exceptions permit the matron or a superintendent nurse (being certified midwives) of a Poor Law institution to sign the certificates of attendance on cases and attendance during the lying-in period, without requiring the approval of the Board. Rule E 24 limits to certain specified cases the exemption of Poor Law institutions from the whole of Section E as conferred by the present rules.

On July 24, 1906, the Privy Council replied transmitting certain amendments "that are deemed necessary." These alteration transfers are the supervision of the course of training in a Poor Law institution from the Central Midwives' Board to the Local Government Board. They permit the duly appointed chief medical officer of a Poor Law institution to sign the certificate of instruction without requiring the approval of the Board. The Privy Council added that they thought that the existing exemption of Poor Law institutions from the whole of Section E should be maintained.

On October 4, 1906, the C.M.B. resolved that they "do not see their way to acquiescing in the amendments suggested by the Privy Council," and asking for a conference.

On January 24th, 1907, the Board amended Rule D 1 so as to authorise training in a Poor Law institution originally approved by them, where the Local Government Board declare the training to be carried on in conformity with the rules of the Central Midwives' Board. They accepted the duly appointed chief medical officer of a Poor Law institution as qualified to sign the certificate of instruction without requiring their approval. A new rule (E 25) was also framed exempting Poor Law institutions from the whole of Section E, with a note declaratory of an undertaking by the Local Government Board to carry out the rules of the Central Midwives' Board in institutions under their authority. The Board unanimously resolve that special treatment of Poor Law institutions would be detrimental to the efficient training of midwives.

On February 26th, 1907, the Privy Council replied transmitting the observations of the Local Government Board on the revised Rules. With regard to Rule D 1 the Local Government Board accept the approval of the Central Midwives' Board as a condition of the recognition of a Poor Law institution as a training school, provided the Central Midwives' Board "will consent to approve, for the purpose of this rule, every Poor Law institution the arrangements of which are certified by the Local Government Board to be satisfactory." With regard to Rule E 25 the Local Government Board object to the note binding them to carry out the rules of the Central Midwives' Board in institutions under their authority. The Lord President concurred with the Local Government Board on both the above points.

On March 8th, 1907, the C.M.B. resolved that they are unable to delegate the duties imposed upon them by the Act "to secure the better training of midwives," and regret that they are unable to give the Lord President their assurance of approval of "every Poor Law institution the arrangements of which are certified by the Local Government Board to be satisfactory." They also deleted the note to Rule E 25, objected to by the Local Government Board.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 23rd, 1907.

Asthma or Cardio-Sclerosis.

In text-books distinguishing certain characters separating true asthma from other forms of dyspnœa, such as uræmic, cardiac, pseudo-asthma, patients are frequently considered as asthmatic who suffer in reality from anything but true asthma, and this error may be attended with disastrous consequences, says Prof. Huchard.

To a toxic phenomenon is attributed a nervous affection. and a series of sedatives and anti-dyspnœic remedies are prescribed, adding their baneful action to the intoxication, the very cause of the trouble. The symptom is taken for the cause and alone treated. The patients' breathe with difficulty, consequently opium, belladonna, bromide of potassium are prescribed. To guard against the exhaustion produced by the attacks, a substantial regimen is advised. But the desired effect is not produced, on the contrary cardiac troubles set in and digitalis is prescribed. Thus the patients succumb more as victims of the treatment than of the malady.

However, a little attention would be sufficient to avoid the therapeutical error. Asthma is hardly ever a malady of advanced age. It is exceptional to find it for the first time after forty or fifty years of age. It is above all observed in adolescents or even in young children, in whom it is frequently overlooked, and yet asthma is distinctly hereditary.

Consequently each time that a patient of a certain age presents attacks of dyspnœa resembling asthma, and to which he was not previously subject, the cause must be sought for elsewhere. Prof. Huchard insists strongly on this fact. A patient, he says, does not become asthmatic at fifty or sixty years of age, he suffers rather from arterio-schlerosis, which provokes attacks of toxic alimentary dyspnœa resembling much true asthma. It is not the lung that is at fault, but the kidney (arterial tension, bruit de Galop, albuminuria, retention of chlorides).

The indications of treatment consequently are very simple :—Diminish the existing intoxication by diuretics (theobromin) drastic purgatives (tincture of jalap) blood letting or wet cupping. Prevent as much as possible a repetition of intoxication by placing the patient on a strict lacto-vegetarian diet, meat being absolutely prohibited. Under the influence of this treatment the condition of the patient improves very rapidly, giving him rest for many months.

ENTERO-COLITIS.

Muco-membranous colitis should not be considered as a malady, but as a clinical syndroma characterised by disorders bearing on the triple domain of the function of the large intestine—mobility, sensitiveness, and secretion. The affection is essentially constituted by abdominal pain, habitual spasmodic constipation with periodic diarrhœa and by the presence of mucous in the excretions. Concurrently exists also hyperæsthenic gastric dyspepsia with spasm of the pylorus and glanular hyper-secretion. The provoking cause of the dyspepsia is the irritation of the colic of the mucous membrane which in its turn is under the influence of the nerve supply irritated from some central cause (neurasthenia) or a peripheric cause where it, by a kind of mechanical reflex, as in certain lesions of the visceræ (uterus, kidneys, liver, etc.).

The medical treatment of the muco-membranous entero-colitis is not very complicated, and if the patient observes faithfully the prescription of his attendant he may be assured of success.

One of the main points lies in the regimen. During the attacks milk alone should be taken, but in the interval a mixed diet may be permitted to the exclusion of soups, pork, shell fish, game, hard eggs, omelettes, salads and all kinds of sauces and spices; pure wine, spirits, coffee, tea. Otherwise the food may be taken in quantities.

The patient, where possible, should spend a few weeks in the country and preferably in the mountains. Dry friction, or with lavender spirits, is useful in asthenic patients, while the warm bath or douche has a good sedative effect. Enemas should be used with caution, either with pure water or with water to which has been added bicarbonate of soda. Enemas of warm olive oil administered at night, where constipation exists, have a very salutary action on the intestine. Purgatives should not be abused ; castor oil in small doses (one or two teaspoonsful) should alone be tolerated. But small doses of belladonna given every day are frequently sufficient to regulate the bowels.

Ext. of belladonna, Powder of belladonna	āā gr. 1-5.

For one pill, to be taken at bed-time.

To relieve the pain during the attacks of colic a half a grain of cocaine might be given, or one of the following pills :—

Ext. of belladonna, gr. 1-10.
Ext. cannabis indica, gr. ½.
Ext. of hyosciamus, gr. ½.
Powder of valerian, q.s.

GERMANY.

Berlin, March 24th, 1907.

At the Medizinischi Gesellschaft Exc., v. Bergmann showed a young woman with

SARCOMA OF THE SKULL.

The tumour was very vascular and showed fluctuation in every part. There were no signs of central pressure, notwithstanding the size of the tumour. In another case, the preparation from which was shown, the tumour was extirpated. At the operation, in spite of the use of Esmarch's bandages and the great rapidity with which the operation was performed, the loss of blood was so great that the patient bled to death. In spite of this danger, there was really nothing else that could be done.

Hr. Muskat showed two cases of

ISCHIAS SCOLIOTICA.

In both cases the scoliosis arose through the sciatica, the degree of it was excessive, the spinal column being flexed and stiffened in that position. The treatment consisted of suspension, massage, exercise, and the wearing of a supporting corset. In this way, at least, the pain might be mitigated.

Hr. Davidsohn showed a woman, æt. 71, who, thirty years ago, was suddenly attacked with loss of breath and cardiac spasms, which even extended to the muscles of the face. After that she lost her speech for a long time. Then her speech returned in a jerking fashion, but from time to time she had her attacks of shortness of breath. These attacks came on now only when she exerted herself in talking, or was otherwise excited, or when the laryngoscope was being used. The voice was even now peculiarly hoarse. The internal organs were sound. So long as the breathing was quiet the laryngoscopic appearance was normal ; on phonation, however, spasm of the muscles of the fauces came on, the vocal cords lay so close together that nothing below could be seen at all. The case was one of spastic dyspnœa and aphonia, and the origin of all was hysteria. The question was whether in this case there was spasm of the glotins contraction or paralysis of the glottis dilators. The first supposition was the more likely to be the correct one, as the condition was entirely changed under narcosis.

Hr. Lassar showed two cases of

PERMANENT RECOVERY FROM CANCROID OF THE LIP

by means of Röentgen or Radium Rays. Both cases were still free from glandular swellings. They were treated three years ago, the parts had cicatrised, and there was no sign of recurrence.

CONTUSIONAL PNEUMONIA. (*a*)

Hr. Finbringer said that he had seen scarcely half a dozen cases, but he had passed about thirty "opinions" under the Acts. They were, of course, all very severe cases. He must emphasize one point, viz., the significance of the period between the injury and the commencement of the pneumonia. Stern, in his well-known book, gave from a few hours to three to four days. The speaker at first was in accord with this but he had now recognized that there might be a longer interval—five to six days. No time could be fixed as exception occurred as they also occurred in other infectious diseases. In rare cases the injury might furnish a soil suitable for the development of germs already present, but the interval must not be stretched too far. The condition under which he should be in favour of a longer interval would be some weakness on the part of the patient, especially some chest trouble during the period. Sometimes some contusional trouble lasted weeks before the pneumonia appeared, as in one of his cases, when there was an interval of eight weeks before the pneumonia developed.

Hr. Westenhoeffer said that the most important material for a decision lay in examination and not in the Acts. Laceration of the lungs with hæmorrhage was frequently predisposed to by already existing disease of the vessels. The medical expert could not give a decision, we could only place the authorities in a position to give one.

Hr. Plehn said there was not much difference between injuries to the lungs from overstrain of direct violence. With a closed glottis and compression of the throat considerable lesions might take place.

Hr. Stadelmann, in forming a judgment of cases, always found himself on uncertain ground, so much was left over for subjective estimation. Different people thought differently. The length of time between the injury and the pneumonia was of the greatest importance. The ten days given by Litten could not be accepted as a rule. The individual case must be considered in the light of the sequence of events followed, and if the continuity could not be strictly proved, no decisive judgment could be given. But even after

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(*a*) Discussion on Hr. Litten s Paper, March 4th.

a still longer period, a continuity might be proved as in Finbringer's case. A second question was how soon could a pneumonia develope on a contusion. There might be coincidence to time without there being any connection between the two. This was seen not infrequently in drunkards, who sometimes wandered about or worked whilst suffering from the disease. A man was carrying a heavy beam of wood on his back; he felt pain in his left side, and on the eleventh day after the accident died of pneumonia. He therefore had pneumonia whilst at work, and it was made worse by the injury.

Hr. Keans thought it best to take a stand midway between Westenhœffer's "Skeptizismus" and Litten's "Optimismus." Compression of the thorax might cause hæmorrhage, as was seen in the case of youthful healthy epileptics who, from their attack, had hæmorrhage in the neck and from the lungs. In this case mentioned by Litten, in which V. Leydon and Kraus had delivered "opinion," he could even now give no decisive judgment, he could only concede the probability of a connection between the trauma and the pneumonia.

Hr. Litten, in reply, did not know why he should be accused of optimism. He had only stated that in proper cases a connection between the trauma and the pneumonia should be conceded, and for this the physician was a more proper judge than the lawyer. When pneumonia was diagnosed only a few hours after the accident, it was probable, but it already existed before the injury was inflicted.

AUSTRIA.

Vienna, March 24th, 1907.

Multiple Fungoid Swellings.

At the "Gesellschaft" Goldreich showed an infant, 7 weeks old, with fungoid swellings over the joints, which appeared to be of a hereditary character. Over the twelfth dorsal vertebra a soft livid-coloured swelling about the size of a five shilling piece formed a "cold abscess." The right leg was œdematous; over the instep of the right foot a similar abscess had formed and was discharging serous pus. Over the malleolus medialis another livid fluctuating tumour was present, while the third, tce, of the left foot had another boggy swelling.

Such a state of affairs in a 7-weeks' child forced us to conclude that the primary cause was tubercle as Baumgarten had pointed out some time ago in a monograph on intrauterine tuberculosis, wherein he pointed out that the infecting tubercle bacilli must be transmitted to the germ in utero. This condition is certainly rare and possible only in a latent stage of the disease. This opinion is supported by the seat of the disease being situated on the fœtus most distant from extrauterine infection, viz., the legs and lower part of the spine.

Facial Asymmetry.

Rie showed a child with progressive hemiatrophy of the left side of the face, which he said was unusual inasmuch as the process was an inhibition or arrest of growth after birth. The right side had all the convexity of a child of its age, but the left was infantile from the left side of the nose over the same side of the head. The zygoma and bony portion of the left side, even the teeth, with the ear, were equally arrested in growth.

This asymmetry he affirmed was central, although the sensibility and motility were normal. The child was brought to hospital on account of chorea and for this defect. In discussing the aetiology he was firmly of opinion that only two causes were reasonable, viz., primary cerebral aggenesia, or an intra uterine lesion of a mechanical nature such as an ammotic band.

Neurath thought the difference in the sides of the head did not amount to more than a dysplasia. If we accept of the larger side as normal, the lesser may be accepted as a partial atrophy, or the opposite may be accepted making the right slightly hypertrophic, which frequently occurs in other parts of the body. and is everywhere borne out by testimony often repeated in medical literature. The extremities frequently suffer from this dysplasia.

Rie thought this opinion could not be supported in this case, as the asymmetry was so general, even the half of the tongue, teeth, and jaws were involved—not one single member as Neurath suggests.

Gall Stones.

Bakes gave the members a long account of the spontaneous fracture of gall stones in the gall bladder. In many operations he has found stones recently fractured, but whether this has been done by chemical or mechanical means he would not venture to say. He showed a gall bladder with stones taken from a patient which could be easily broken by pressing the bladder. This friable condition was not confined to the gall bladder, but was often met with in the urinary bladder as well.

He also recounted the history of a recurring gall stone in the bladder. A female, æt. 38, came to him suffering from cholecystitis hæmorrhagica, for which he operated on the 23rd of January, 1906. The gall bladder was found to have a normal calibre, which was opened and the bladder sounded. A few concretions and gall stones were found, that were easily removed, and the whole carefully washed out.

She recovered speedily, and remained perfectly well till January in the present year, when all the typical symptoms of cholelithiasis recurred. The pain was so excessive that another operation was inevitable. After narcotising with ether and opening the gall bladder, a number of small stones and a few larger ones about the size of hazel nuts with four other concretions were found blocking up the canal. His object in bringing this case forward was his conviction that this was a genuine recurring case. He suspected this in others he had operated, but always supposed he had left a nidus that provoked recurrence. In this case he was perfectly convinced that no concretion or any part of a concretion was left in the first operation.

He related an idiopathic retention cyst he met with in the gall duct of another case, where an anomaly of the valve in the canal existed. It was a congenital malformation, and the first he knew of that had been successfully treated by operative means or by performing chole-duodenostomy.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

Belfast Ophthalmic Hospital.—The annual meeting of this hospital was held last week, the President of the Hospital, the Earl of Shaftesbury, K.C.V.O. in the chair. The medical report was read by Dr. Cecil Shaw, and spoken to by Dr. Walton Browne. It showed an increased number of patients, both in extern and intern departments, the former numbering 2,246, and the latter 174, while the total visits numbered 7,011. An appeal was made by Dr. Cecil Shaw for the sum of £250 or £300 for renovating the extern department, and Dr. Walton Browne in supporting this appeal said that he had a promise of £50 to start with. Lord Shaftesbury very generously offered another £50, and expressed the hope that the balance would soon be raised.

A Curious Poisoning Case.—At an inquest held near Portadown last week some curious facts transpired concerning the drinking habits of the deceased, a labourer, 45 years of age. He had been in the habit for the past twelve years of drinking methylated spirit, which he mixed with tea, and for some weeks seemed to have drunk this mixture constantly, with the result that he was found dead by his wife on Sunday morning, lying in the kitchen, where she had left him asleep on Saturday night. The verdict was death from excessive use, and an overdose of methylated spirits. Ether drinking is a recognised form of dissipation in parts of Counties Antrim and Derry, but methylated spirit has not yet been recognised as a popular drink.

The Health Commission.—Owing to the Assizes being on the Commission did not sit this week as had been intended. They held one evening sitting to allow members of the working classes who might wish to give evidence to appear. but only two persons came forward, and their evidence was not of much general interest. Next week the morning sittings will be resumed, and some important medical evidence is expected.

Cerebro-spinal Meningitis.—The epidemic of this disease continues to spread slowly, a few new cases occurring each day last week. The total number of cases in Belfast now reaches 207, with 110 deaths. There have also been a good many cases in the smaller towns of Ulster and in the surrounding country districts. In Lurgan, for instance, there have been five cases, two of which have proved fatal.

Nothing more has been heard of the serum treatment, the material for which was procured from Switzerland, and it is to be presumed that it has not proved a success.

Ulster Eye, Ear and Throat Hospital.—The annual meeting of this Hospital was held last week, being presided over by the Lord Mayor, the Earl of Shaftesbury, K.C.V.O. The report showed that 2,170 new cases had been seen in the extern department, and 340 treated in the wards, of whom 38 were private patients. The late Dr. McKeown advocated this system of having a certain number of private wards in the hospital, and his successors, Drs. Killen and Allen adhere to it, though most of the Belfast surgeons prefer to send private patients to some of the many private hospitals or nursing homes. It is one of those questions which admit of a good deal being said on both sides. for there certainly is a class of patients who can pay enough to repay the hospital for their keep and nursing, but not enough to yield a profit to the proprietor of a nursing home.

LETTERS TO THE EDITOR.

THE PALL MALL GAZETTE ON INSANITY.

To the Editor of The Medical Press and Circular.

Dear Sir,—The notice in the *Pall Mall Gazette* took me by surprise, but I thought that the wording of it was quite sufficient to indicate that I had nothing to do with it. It is the journalistic tendency of the age to create " sensations," hence any apparent novelty is seized upon, and it is for the Ethical Committee of the British Medical Association to consider what steps can be taken to prevent such occurrences.—I am, Sir, yours faithfully,

Bernard Hollander.

THE DEATH OF DOWIE.

To the Editor of the Medical Press and Circular.

Sir,—The papers of last week announced the death of Dowie, the self-proclaimed " Divinely commissioned First Apostle of the Church "—to use the least blasphemous of his titles—the founder of Zion city on Lake Michigan. and the renowned wholesale medical miracle monger. If ever there were cases in which the usually respected maxim " de martriss se " should be set aside they must be those in which blatant impostors like Dowie end their career. Dowie was the most prominent among the army of pretenders who find an inexhaustible field for their enterprises in the United States ; and we may be certain that so long as the game continues profitable, successors capable of working on a similarly large scale, if not in the same position, will always be forthcoming. If men of Dowie's pretensions led lives of poverty and self-sacrifice they might be chargeable only with religious fanaticism, but there exists always an easily discoverable sordid side to their lives which makes plain the true aim of their performances. The exposure in Dowie's case which led to his downfall and death proved, among other amazing things, that since 1899 he had used $84,000 a year for his personal expenses, and that these expenses were incurred in extravagant living, and in " the teaching of polygamy." The interesting questions for the psychologist and the sociologist—questions I should much like to see fully discussed in your paper— seem to me how to account for the gross credulity of masses of the people at this period of the twentieth century in a nation supposed to stand in the very front of civilisation and enlightenment. Grotesque forms of theological and medical quackery flourish more in the United States than among any other people of European blood ; nowhere are there to be found multitudes so ready to subject themselves to, and sacrifice themselves for, impostors who will not stand the superficial scrutiny of the average man of the world, much less the scientific tests that might be so easily applied to them. The sale of quack medicines (the belief in which is hardly less gross than the old belief in witchcraft) is vastly greater in the United States than in these Islands, enormous as this is, yet the Americans have the best school education in the world. They have what ought to be the best character education through the strenuousness of the natural life, and the necessity for every citizen to be able to take care of himself if he is to remain erect in the struggling crowd. The enormous scale on which schemes of imposture are worked, often under the mask of religion and the cloak of hypocrisy is suggestively referred to in Mr. Wells's recent book " The Future in America." What do these things all mean as phenomena in the process of evolution (or is its decay) which we are witnessing among all the leading nations of our time ?

I am, sir, yours truly,

A Student of Psychology.

March 15th, 1907.

POLITICIANS AND ANTI-SCIENTIFIC FANATICISM.

To the Editor of the Medical Press and Circular.

Sir,—At a large meeting of the Liberal Party in this district last week Mr. W. Tebb was to have taken the chair. In a letter excusing his absence the following was the most important passage :—" I should like to have said a few words on two burning questions—the twin monsters, vivisection, with its unspeakable tortures of animals in the name of science, and the other the State blood-poisoning of helpless and defenceless children, known as vaccination. High authorities maintain that no benefit has ever come of vivisection, and the evidence of all trustworthy statistics show that vaccination is no preventive of smallpox. In the epidemic of 1871 the *Lancet* reported ten thousand deaths and 122,000 cases of smallpox amongst the vaccinated. Here were 122,000 failures ! At the same time it must not be forgotten, as proved before the Royal Vaccination Commission that vaccination has often been attended with the inoculation of repulsive and incurable diseases. No amendment of the law will render it tolerable. It must be swept from the Statute Book." The reading of this letter was " punctuated with applause." Mr. Harry Brodie, the member for the Reigate Division, then delivered a lengthy address in which he dealt with every prominent question of the day with the exception of the two broached by Mr. Tebb. These he passed over in complete silence. The inference is that Mr. Brodie does not sympathise with the grotesque utterances of his fanatical supporters, but has not the courage to express his opinions. He is afraid to lose a few votes, and gives tacit support to views which very probably are odious to him. In a constituency of upwards of 15,000 electors Mr Brodie won the seat by some 30 votes only. If he imagines that his attitude on the questions I refer to is likely to increase his slender majority I fancy he may be disappointed at the next election. I enclose my card.

I am, sir, yours truly,

A Surrey Doctor.

Near Reigate, March 15th, 1907.

SHOULD RAYNER BE EXECUTED?

To the Editor of The Medical Press and Circular.

Sir,—In common I hope, with many other medical men who believe that we are approaching a more scientific and a more humane ideal in the treatment of criminals, I was surprised and shocked to read the words addressed by the Lord Chief Justice to the unfortunate Horace George Rayner, when the jury returned the verdict of "Guilty." His lordship said that he could hold out no hope of reprieve; words of ominous significance, and words which in his judicial capacity he had no right to utter. The quality of mercy is one to be exercised by the people of this country through their elected representatives, and it is a cruel and shameful thing that the Lord Chief Justice should allow his great position to prejudice opinion in a matter of life and death, even if the victim is an unimportant unit in the great mass of humanity. And what of this unfortunate victim? What has he done that he should be coldly and deliberately executed? What chance has he ever had of becoming a decent citizen? An illegitimate child, the offspring of the sportive lust of a rich man who disputes his paternity and an alcoholic mother, brought up in a coterie of harlots and in an atmosphere of vice, flung into the world without position or principle, and left to fend for himself—what chance has such a one to acquire the bearing and moral ideas of civilised man? His heredity was nearly as bad as it could be, there was a strong alcoholic taint in his mother's family, and it is a matter of doubt whether his maternal grandfather did not destroy himself. His environmental influences were likewise execrable, and his mind had early been set against the rich tradesman who gave up a wife's love to seduce his employée. The lad was reduced by bad luck and adverse circumstance to a state of depression, which bordered on, if it did not cross the line of insanity, and in his desperate state, determined on self-destruction, he was sneered at by the very man of all others whom he believed he had the greatest claim on. If he had succeeded in killing himself, there is no doubt that the coroner's jury would have pronounced him temporarily insane, as so, Sir, he undoubtedly was. As his intention was frustrated by chance, he is considered fit to be the object of a society sensation—and in a thronged court he is coldly sentenced to death for becoming in a mad moment the instrument of death to a dissolute millionaire. Can you, Sir, not do anything to rouse your readers to put the scientific aspect of his case before the Home Secretary?

I am, yours truly,
M.D., D.P.H.

THE MENTAL CONDITION OF "DR. DOWIE."

To the Editor of The Medical Press and Circular.

Sir,—There can be no doubt, I think, that this remarkable case of mental aberration to which you so pertinently refer, would be regarded by the majority, if not all, lunacy experts as one of those unfortunate instances of genius and insanity at play in the same mind, and which agitate and administer to the weaknesses of common humanity. When criminal or moral perversion strongly taints a mind such as the deceased appeared to possess, the prejudices of the general community become so inflamed and exasperated, except such as bestowed by the veritable dupes themselves, that all commisseration is absorbed in emotions of recrimination and indignation (*De mortins nil nisi bonum*). Nevertheless a case of this character affords to the psychist and alienist, if not to the theologian, hints which the world at large can ill afford to lose sight of, because we see how easily the public mind even at the present hour is betrayed and readily falls a victim and prey to fanaticism, be it in any shape or form, whether such find vent in Welsh revivals, spiritualism, Christian science, the "New Theology," and may be tossed about by any other conceivable wind or doctrine. It cannot therefore be wondered that they are amongst the community, and it is an open secret that the majority of our profession represent those who possess minds which insist upon definite and coherent thought, urging that this can only be attained through the medium of the special senses, beyond which physical science and human capacity does not venture to encroach. Such as these regard all extraneous ideas as spurious, relegating all other ideas to the region of poetry and imagination.

I am, Sir, yours truly,
Clement H. Sers.

Brighton, March 23rd, 1907.

OBITUARY.

HENRY ST. JOHN BROOKS, M.D., D.Sc. (Dublin).

It was probably with a feeling of surprise that many to whom his name was familiar fifteen years ago read of the death last week of Henry St. John Brooks. He had lived of late years in such complete retirement, except for a small circle of friends, and had so completely severed himself from his scientific work, that he seemed almost of a past generation.

A native of South Africa, Brooks was educated at Trinity College, Dublin, where he had a distinguished undergraduate career, culminating in a Senior Moderatorship and Gold Medal in Natural Science in 1881. A pupil of Professor Macalister's, he soon became Chief Demonstrator of anatomy, and for the next ten years he devoted all his time to that branch of service. As an anatomist he combined in an unusual degree an enthusiasm for accurate detail learnt from Macalister, and an interest in comparative anatomy at that time somewhat uncommon. As a teacher he had the gift of inspiring keen interest in his subject, and his pupils learnt from him the great importance of thorough work. During this period he made many contributions to knowledge, of which perhaps the most important were those bearing on the minute distribution of nerves in the hand. He also wrote the chapter on the Nervous System for the first edition of Morris' *Anatomy*. In 1891, on the death of Dr. Thomas Little, he succeeded to the post of University Anatomist, which at that time combined duties in the dissecting room with surgical work in Sir Patrick Dun's Hospital. The clinical part of his work proved, as his friends expected, uncongenial, and a few years showed him that he had undertaken work for which he was unfitted. His health at the same time giving reason for anxiety, he determined on going to Australia, where for some years he worked in general practice. Unfortunately, his health became worse, and some six or seven years ago necessitated his complete withdrawal from active work. He therefore returned to Ireland, spending his time since in the study of languages, for which he had a marked aptitude.

There is no doubt that had fortune been kinder, Brooks would have obtained first rank as an anatomist. His gifts were for original research, and the necessity which forced him to undertake surgical work, blocked his career. As a teacher he is still kindly remembered in Dublin, and not a few Trinity men throughout the world remember with gratitude the ready help given them by a keen man of science at the outset of their medical career.

SPECIAL ARTICLE

THE UNIVERSITY QUESTION IN IRELAND.

A series of meetings have been held during the past week at most, if not at all of which, resolutions opposing the present scheme of the Government were adopted. The most important of these meetings was held in Trinity College on Friday last, and consisted of the graduates of the University. Owing to the very large numbers of graduates who attended, the meeting was divided into two sections, one of which occupied the Examination Hall, the other the Dining Hall.

The principal speakers were the Provost, the Right Hon. James H. Campbell, K.C., M.P.; the Right Hon. Sir E. Carson, K.C., M.P.,; the Bishops of Ossory and Derry, Lord Iveagh, Lord Ashbourne, Sir James Henderson, and the Rev. Dr. Prenter.

The following resolutions were unanimously adopted at both meetings, and copies were ordered to be sent to the Prime Minister, the Chief Secretary, and other members of the Cabinet:—

"That this meeting protests against the scheme put forward by Mr. Bryce in his speech of January 25th, 1907, as a grievous injustice to this University, and disastrous to the best interests of higher education in Ireland."

"That the prestige of the University of Dublin would not survive a process which abolishes the old University of 300 years, and transfers its name to a new and different institution."

"That the enforced alliance, within the same University, of Trinity College and a College specially designed for Roman Catholics, would be followed by sectarian strife, and must entail serious limitation to liberal education and free inquiry, not only in the University, but in Trinity College, the educational ideals of the two Colleges being incompatible."

The Provost who presided at the principal meeting in the Examination Hall announced that 3,866 graduates had signed a protest against Mr. Bryce's scheme. He also referred to a number of distinguished men who had also protested, and amongst these he mentioned Lord Kelvin, Sir William Crookes, Sir William Ramsay, Sir Archibald Geikie, Sir Joseph Hooker, Sir William Turner, Professor Bonney, Sir James Dewar, and Sir Robert Ball. He also stated that "resolutions, memorials, and protests on our behalf against any proposals which would hamper our teaching or destroy our autonomy have been extensively signed in Oxford, Cambridge, Manchester, Liverpool, Birmingham, and other English universities, the Scottish Universities, and the University of Wales. In five days since the protest was distributed, 127 signatures of Fellows of the Royal Society have been received, in addition to many letters of sympathy from Fellows, who are precluded by their relations with the Government from signing. A large additional number of Fellows have also signed in connection with academic protests."

Want of space prevents us from reporting at any length the remarks of the different speakers, but the following extract from the speech of Sir Edward Carson seems to us to place the case for Trinity College in the clearest light and with the strictest fairness to the claims for Catholics, which have been made on behalf of University Education for Roman Catholics in Ireland, that we believe it will be of interest to our readers. After referring at some length to the proposal of the Government, Sir Edward Carson continued:—

"Who has asked for this solution? I have gone through the evidence given before the Commission, and so far as I can see I can only find this solution, suggested by one single witness. And he was a noble lord, who never was at a University, and who prefaced his evidence by saying that he thought it right to say he approached the matter from a political rather than an academic point of view. The Presbyterians don't ask for it, the Methodists don't ask for it; Dr. Delany, the President of the University College, doesn't ask for it; on the contrary, he pointed out it was impossible. Nobody, so far as I know, asked for it in his evidence before the Commission, and certainly the demands put forward were of a far different character. To what then, do we owe this extraordinary evolution of the University question in Ireland? For what are we asked to do this? Not only are we asked to make concession to our Roman Catholic fellow-countrymen of endowing for them a separate establishment suitable to their needs, to which most of us, if not all of us, are willing to accede, but in addition to that, we are asked, to add to the difficulty, by mortally wounding the one institution in Ireland, of which every man, no matter what his religious or political views, is proud.

"I make an appeal solemnly to His Majesty's Government. A golden opportunity exists at the present moment for a settlement of this question. Not often has there been an occasion upon which so many minds differing to such an extreme extent have come together in a desire to appease those from whom they differ. Are the Government going to grasp the opportunity or are they bent on persisting in a course which, whatever the result, must lead to bitterness and sectarian strife, and at the end the ruin of this University by the success of the Government policy. And what out of that will arise for Ireland? Bitterness, hatred, all uncharitableness. Whereas, upon the other solution you may have a send off for education, which may lead to heights and delights for our country far away and above and beyond what any of us even dreamed of—a solution to which we will all give a willing accord, in which we will all, I think, unanimously join. If the Government adopt one and not the other, upon the head of the Government be the failure of their policy."

In the House of Commons on the 20th inst., Mr. Birrell, in answer to Mr. Sloan, said that he was not at present in a position to name a date for the introduction of legislation upon the subject of University Education in Ireland.

NEW BOOKS AND NEW EDITIONS.

The following have been received for review since the publication of our last monthly list:—

Sidney Appleton (London).
- Tics and Their Treatment. By Henry Meige and E. Feindel. With a Preface by Professor Brissaud. Translated and Edited by S. A. R. Wilson, M.A., M.B., B.Sc. Pp. 386. Price 9s. net.

J. B. Bailliere et Fils (Paris).
- Formulaire des Médicaments Nerveux. Pour 1907. Par H. Bocquillon-Limousin. P. 328.

Bailliere, Tindall and Cox. (London).
- The Röntgen Rays in Medical Work. By David Walsh, M.D.Ed. Part I.—The Electrical Apparatus. By H. Lewis Jones, M.D. F.R.C.P. Part II.—Medical and Surgical. By the Author. Fourth Edition, Illustrated. Pp. 433. Price 15s. net.
- Cancer: Its Treatment by Modern Methods. Being the Bradshaw Lecture for 1906. By Edmund Owen, Hon. LL.D., Aberdeen. Pp. 31. Price 1s. net.
- Antiseptic Methods for Surgical Nurses and Dressers. By Harold Upcott, F.R.C.S. Illustrated. Pp. 51. Price 2s. 6d. net.
- The Prevention of Cancer. By C. B. Keetley, F.R.C.S. Pp. 38 Price 1s. net.
- Aids to the Diagnosis and Treatment of Diseases of Children. By John McCaw, M.D., &c. Third Edition. Pp. 383. Price 4s. 6d. cloth; 4s. paper.
- Organic and Functional Nervous Diseases. By M. Allen Starr, M.D., Ph.D., &c., &c. Second Edition, thoroughly Revised and Illustrated. Pp. 816. Price 25s. net.

John Bale, Sons, and Danielsson, Ltd. (London).
- The Past, Present, and Future of the School for Advanced Medical Studies of University College, London. By Rickman John Godlee. Pp. 46. Price 2s. 6d. net.

Cassell and Co., Ltd. (London).
- Elements of Physics for Medical Students. By Frederic James M. Page, B.Sc. Illustrated. Pp. 288. Price 5s.

J. & A. Churchill (London).
- The Need, Objects, and Method of the Medical Inspection of Primary Schools. By Ralph H. Crowley, M.D. Pp. 24. Price 1s. net
- The Refraction of the Eye. A Manual for Students. By Gustavus Hartridge, F.R.C.S. Fourteenth Edition. Illustrated. Pp. 273 Price 5s. net.

Henry Kimpton (London).
- A Treatise on Orthopædic Surgery. By Royal Whitman, M.D. Third Edition, Revised, Enlarged and Illustrated. Pp. 871. Price 28s. net.
- Degeneration in Families: Observations in a Lunatic Asylum. By Fr. Lange, M.D. Authorized Translation from the Danish by C. Chr. Sonne. Pp. 207. Price 3s. 6d. net.

H. K. Lewis (London).
- Anæsthetics: Their Uses and Administrations. By Dudley Wilmot Buxton, M.D., B.S. Fourth Edition. Pp. 415. Price 7s. 6d.

J. B. Lippincott Co. (London).
- International Clinics: A Quarterly. Edited by A. O. J. Kelly, A.M., M.D. Vol. 4, Sixteenth Series, 1906. Pp. 322.

Longmans, Green and Co. (London).
- Notes on the Care of Babies and Young Children. By Blanche Tucker. With an Introduction by Dr. Hope, M.O.H. for Liverpool. Pp. 68. Price 1s.
- The Essentials of Histology for the Use of Students. By E. A. Schäfer, LL.D., Sc.D., F.R.S. Seventh Edition, Illustrated Pp. 507. Price 10s. 6d. net

Macmillan and Co., Ltd. (London).
- A System of Medicine by Many Writers. Edited by T. Clifford Allbutt, M.A., M.D., &c., &c., and H. D. Rolleston, M.A., M.D., F.R.C.P. Vol. II., Part 2.—Tropical Diseases and Animal Parasites. Illustrated. Pp. 1,055. Price 25s. net.

Some Points in the Surgery of the Brain and Its Membranes. By Charles A. Ballance, M.V.O., M.S., F.R.C.S Illustrated. Pp. 405. Price 15s. net.

Methuen and Co. (London).

The Drink Problem in its Medico-Sociological Aspects. By Fourteen Medical Authorities. Edited by T. N. Kelynack, M.D., M.R.C.P. Pp. 300. Price 7s. 6d. net.

The Evolution of Life. By H. Charlton Bastian, M.A., M.D., F.R.S. Illustrated. Pp. 319. Price 7s. 6d. net.

James Nisbet and Co., Ltd. (London).

Gall Stones and Diseases of the Bile-Ducts. By J. Bland-Sutton F.R.C.S.Eng. Illustrated. Pp. 233. Price 3s. 6d. net.

Young J. Pentland (Edinburgh).

The Diagnosis and Treatment of Intussusception. By Charles P. B. Clubbe. Pp. 92. Price 3s. 6d. net.

Rebman, Ltd. (London).

Monism: Thoughts Suggested by Professor Heackel's book, "The Riddle of the Universe." By S. Ph. Marcus, M.D., Translated by R. W. Filkin, M.D., F.R.S.E., &c. Pp. 144. Price 1s. net.

W. B. Saunders and Co. (London).

The Elements of the Science of Nutrition. By Graham Lush, Ph.D., M.A., F.R.S.Edin. Illustrated. Pp. 326. Price 12s. net.

A Manual of Pathology. By Guthrie McConnell, M.D. Illustrated. Pp. 523. Price 10s. net.

The Immediate Care of the Injured. By Albert S. Morrow, A.B., M.D. Illustrated. Pp. 340. Price 12s. net.

Atlas and Text-Book of Human Anatomy. By Dr. Johannes Sobotta. Edited with additions by J. Playfair McMurrich, A.M., Ph.D. Vol. II.—The Viscera, including the Heart. Illustrated. Pp. 194. Price 25s. net.

The Scientific Press, Ltd. (London).

The Care and Nursing of the Insane. By Percy J. Baily, M.B., C.M.Ed. Part I. Pp. 97. Price 1s. net.

Skin Diseases: Their Nursing and General Management. By G. Norman Meachen, M.D., B.S., &c., &c. Pp. 134. Price 2s. 6d. net.

A Manual for Nurses, on Abdominal Surgery, by Harold Burrows, M.B., F.R.C.S., Pp. 142. Price 2s. 6d. net.

Smith, Elder and Co. (London).

Saint Bartholomew's Hospital Reports. Edited by A. E. Garrod, M.D., and W. McAdam Eccles, M.S., F.R.C.S. Vol. 42. Pp. 463.

Elliot Stock (London).

The Functions of Food in the Body. By A. Rabagliati, M.A., M.D. Pp. 46. Price 1s. net.

John Wright and Co. (Bristol).

The Medical Annual: A Year-Book of Treatment and Practitioner's Index, 1907. Pp. 863. Price 7s. 6d. net.

The Year Book Publishers (Chicago).

The Practical Medicine Series. Edited by Gustavus P. Head, M.D. Vol. X.—Skin and Venereal Diseases, Nervous and Mental Diseases. Edited by W. L. Baum, M.D., Hugh T. Patrick, M.D., and Wm. Healy, A.B., M.D. Pp. 254.

REVIEWS OF BOOKS.

THE CHLOROFORM PROBLEM. (*a*)

Ever since Simpson demonstrated the anæsthetic properties of chloroform, just sixty years ago, this problem has been a fruitful source of discussion among medical writers. The aspect of the question has changed from time to time, but to this day the problem awaits solution. In the past the chief discussion was as to the relative merits of ether and chloroform as anæsthetic agents, and resulted in a compromise, each drug being granted its own sphere of usefulness. Recently the problem has assumed a form from which one may expect more instructive results, for workers are now endeavouring to establish the physiological properties of the drug and the proper method for its administration. In regard to the physiological action of almost any drug, there is still much to learn, and though one may regret, one should not complain because our knowledge is not complete. With chloroform, however, the case is somewhat different, for the anæsthetist who wishes for or seeks for a good working hypothesis as to the physiological action of this drug is at once met with a mass of conflicting statements, some of which, even when dealing with the most fundamental points, are directly contradictory of each other, though each appears to be vested with a reliable authority. If we take as an example the action of the drug on the heart, we are told by such respectable authorities as Gaskell, Shore, and Hill that chloroform has a direct paralysing influence on the heart and blood-vessels, while others assure us that chloroform has not been proved to act directly on the heart. Similar contradictions may be found between other statements concerning the physiological action of the drug and it is not to be wondered at if clinical anæsthetists sometimes look with grave suspicion on the statements of physiologists. Dr. Gill proposes in the volumes before use to examine the problem afresh from the clinical standpoint and using for his examination a strict logical analysis.

In the investigation of the phenomena attending the administration of chloroform three distinct actions of the drug may be recognised and must be differentiated. These three actions are its negative, its physical and its physiological action respectively. Chloroform vapour displaces air and consequently interferes with the function of aeration; this is its negative action. When present in excess in the airway its weight opposes abnormal resistance to the muscles of expiration; this is its physical action. When absorbed it is associated with a set of phenomena or a state which is the manifestation of its physiological action. According to Dr. Gill much confusion has been introduced into the study of the problem by not recognising these three factors and attributing to the physiological action of the drug results which are really due to one or other of the actions associated with it. Both the negative and physical action lead, of necessity, to a certain amount of asphyxia, and their effect will be markedly increased by anything which impedes free respiration or free circulation of the blood through the lungs. As soon as any asphyxial element is introduced into the administration it immediately becomes a most important causal factor of a set of phenomena which, though co-existing with those which result from the physiological action of the chloroform, are quite distinct from it, and should not be attributed to it. We can thus see how complex the problem is, and how much care is necessary before one attributes any phenomenon in the course of an anæsthesia to the physiological action of the drug used. In discussing the commonly received chloroform hypothesis, Dr. Gill has no difficulty in showing that this care has not been always taken, and consequently that the propositions on which this hypothesis is founded are not always reliable. Having in this manner cleared the way our author then proceeds to investigate the problem on the lines he has laid down. The state of unconsciousness induced by chloroform he divides into two degrees—"anæsthesia," *i.e.*, the lowest degree of chloroform unconsciousness, and "narcosis," or the deeper degree. The state of anæsthesia is sufficient for all the requirements of surgery, and the state of narcosis is to be avoided as tending rapidly to the region of danger. Anæsthesia is characterised by free respiration, normal colour, muscular relaxation and a contracted pupil. With a constant chloroform-air atmosphere this condition remains stable for a time, but in order to maintain this state constant the proportion of chloroform in the atmosphere must be methodically reduced, for some part or parts undergo a change of condition in the course of chloroform action in the way of opposing less resistance to its influence. The state of narcosis differs from the state of anæsthesia chiefly by a certain duskiness of the colour of the patient and by a dilated and sluggish pupil. In the former state normally the negative action of the drug produces little result and the physical action is compensated for by the increased action of the respiratory pump, but in the latter state both negative and physical actions produce important modifying results. Dr. Gill is no advocate for elaborate appliances for the administration of chloroform, but recommends the use of a twofold piece of lint turned into half a cone and so placed on the face that the apex is at the top of the nasal ridge and all communication with the external air shut off except at the base, which remains permanently open; on this lint the drug is dropped from a drop bottle.

We have said enough to indicate the nature of the solution which Dr. Gill is prepared to offer of the chloroform problem, and we believe he has done signal service in insisting on the complex nature of the problem to be solved and the necessity of taking into consideration all the factors and apportioning to each its proper place.

(*a*) "The $CHCl_3$ Problem." By Richard Gill, F.R.C.S., Chief Chloroformist to St. Bartholomew's Hospital. Vols. I. and II. 8vo., pp. lxxvi., 304, and 293. Edinburgh and London: William Blackwood and Sons. 1906.

How far his final conclusions will be accepted we are not prepared to say. He seems inclined to believe that the phenomena of chloroform anæsthesia are to be explained by the interference with tissue nutrition resulting from the deprivation of the blood of some of its oxygen by the chloroform, but it is difficult to accept this conclusion in view of his own admission that normal anæsthesia should not be accompanied by any apparent change in the colour of the blood. The book will well repay a careful study, but its length and the many repetitions which it contains will, we fear, prevent many from devoting the time to it which is necessary for mastering its contents.

SYPHILIS AND SMALL-POX. (*a*)

THE subscribers to the New Sydenham Society will have no cause to be dissatisfied with the volume presented to them by their council this year, for it contains a collection of papers which for scientific study, for practical importance, and (may we add ?) for romantic interest, would be hard to beat. For we have here the translations of all the original papers of Schaudinn and Hoffmann on the Spirochæta Pallida, and we are able to go through all the steps which enabled those investigators to make the most momentous pathological discovery of recent years. Then are given Metchnikoff's and Roux's four communications on their experimental inoculation of apes with syphilis, and the results they obtained. Then follow some studies on small-pox, which if not of quite the same sensational character, are at the same time profoundly interesting. The first of these is "The Life History of Cytoryctes Variolæ Guarnieri," by Professor Calkins, of Columbia University. This observer is convinced that he has worked out the parasitic cause of variola and vaccinia by tracing the development of the life-cycle of certain bodies observed in the lesions of those diseases by Guarnieri in 1892, and called by him Cytoryctes Vaccinæ. These bodies are regarded by Professor Calkins as sporozoa, and he gives in detail his grounds for the opinion. These conclusions are confirmed in the next paper, "Epicrisis," by Dr. W. T. Councilman, who brings additional evidence to support the view of Professor Calkins. A short paper of clinical observations on small-pox by Dr. I. R. Bancroft concludes the volume. We heartily thank the council of the Sydenham Society for this exceptionally valuable book.

THE YEAR-BOOK OF PHARMACY. (*a*)

THE small size of the present volume, which at once attracts the reader's attention, is due to the reduction in the number of pages of the Year-Book, which reduction the editor explains was necessary. But we regret to find that the parts deleted include the introduction which for forty odd years gave such an excellent summary of the progress of pharmacy and the collateral sciences during the year. The chemical abstracts are also abridged and the "Notes and Formulæ" left out. We would have preferred to see the price of the volume raised, say, to 10s. 6d., to this excision of so much valuable material. We have, however, to deal with the book as we find it, and we are free to say that in what it does contain, and it is two-thirds the size of preceding volumes, it remains unequalled as a Year-Book on the subject of Pharmacy. The selections are very happily made and the literature of Europe and America on the subject is laid under tribute. If we have a fault to find it is at the space given to the proceedings of the Congress ; by judicious deleting we think this action might be reduced one half and space found for the much more interesting preface the absence of which so many must regret.

HEBBLETHWAITE'S NOTES ON GENERAL PRACTICE. (*a*)

UNFORTUNATELY at the present time many men enter upon general practice without any real experience, save what has been picked up at odd times. Hospital training alone will not make one a good family doctor. The gold medalist of to-day may be a total failure to-morrow when confronted with a case of measles or a difficult midwifery case. To all such Dr. Hebblethwaite's little book appeals. Within its pages he gives an account of his own experiences, which after all are those of everyone of us. He starts with the consideration of what he terms "peritoneal catastrophies." In this chapter he deals with perforation cases and ruptured ectopic gestation. He emphasises the importance of sudden acute abdominal pain in such cases. The chapter of medical notes is brimful of useful hints, and contains many facts known only to the practitioner of long experience. Some are not to be found in text-books, and can only be gathered out of a vast accumulation of literature after much searching. His treatment of gastric ulcer is to be commended. It is simple and most explicit. He does not content himself with mere generalisations, but goes into detail, and states what exactly the patient is to have, when and why. Another useful paragraph is the one on the diagnosis between modified small-pox and varicella. He has also something to say on the subject of urine testing, and insists on the great importance of this in practice.

The chapter of surgical notes is also excellent, as may be said of that containing notes on infants and children. In the latter section we find directions for infant feeding which are sound and practical. The last chapter is devoted to midwifery and has but one fault: it is far too brief. In fact, this is the only defect in this interesting and instructive notebook, which book we have read with pleasure.

THE FROG. (*a*)

PROFESSOR MARSHALL'S wonderful little book on the frog is so very well known and so much appreciated that it is needless to comment on its merits. It has now reached the ninth edition, edited by Dr. Gamble, who has revised the chapter on development, and added some figures. Very fitting and amply justified is the tribute which the present editor pays to Dr. Marshall's capabilities: "The late Professor Marshall had so complete a grasp of the difficulties which confront the student of elementary zoology, and so great a sense of proportion and arrangement, that no substantial alteration can increase the educational value of his work." There are now thirty-eight illustrations, and we are glad to see that many of the fresh ones are given as plates, and being drawn on a large scale, the student is put to the minimum of trouble in differentiating the various features. The book is now provided with a most serviceable cover, which will stand an enormous amount of wear, and finally, there is a most comprehensive index. We think that everything has been done by Dr. Gamble and his coadjutors to render the book as valuable as possible, and the only direction in which we think an improvement possible is for the skeletal illustrations to be coloured so as to show the cartilage, cartilage-bones and membrane-bones, as some students are put to a considerable amount of trouble in ascertaining the nature and development of the various portions of the skeleton.

(*a*) "Selected Essays on Syphilis and Small-Pox." Translations and Reprints from various sources. Edited by Alfred E. Russell, M.D.Lond. M.R.C.P. With illustrations and charts. London : The New Sydenham Society. 1906.

(*a*) "The Year-Book of Pharmacy." Comprising Abstracts of Papers relating to Pharmacy, Materia-Medica, and Chemistry, Contributions to British and Foreign Journals from July, 1905, to July 1906, with the Transactions of the British Pharmaceutical Conference held in Birmingham, July, 1906. Editor of the Year Book, J. O. Braithwaite ; Editors of the Transactions, E. Saville Peck, M.A., and Edmund White, B.Sc., F.I.C. London: J. and A. Churchill. 1906,

(*a*) "Notes on General Practice." By S. M. Hebblethwaite, M.D. Lond., etc. London : The Scientific Press, Ltd. 3s. 6d.

(*a*) "The Frog : an Introduction to Anatomy, Histology and Embryology," by the late A. Milnes Marshall, M.D., D.Sc., M.A., F.R.S. Ninth edition. Edited by F. W. Gamble, D.Sc., Assistant Lecturer and Demonstrator in Zoology, University of Manchester. Price 5s. Pp. 172 and x. ; 38 illustrations. London : David Nutt. 1906.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

The Mechanical Effects of Lessened Atmospheric Pressure upon the Organism. Jacobi (*Deutsche. Med. Woch.*, 1907, No. I.), starting from the fact that all the influences of a mountain climate upon invalids and upon healthy persons cannot be explained as due to a lessened intake of oxygen, has investigated the above indicated problem. Weber had previously shown that the lessened air pressure at a height of 1,300 metres tended to increase the pliability of the muscles. By the help of some very ingenious apparatus, Jakobi now shows that of necessity important changes must similarly take place both in the lungs and in the circulation, more especially, as far as the latter is concerned, in the great veins. He shows that the increase of the red cells is the result of an impoverishment of the circulating blood of these cells, which in fact become accumulated in the dilated veins of the systemic circuit, and in the pulmonary circuit. From this it follows, as after a hæmorrhage, that a rapid new formation of red cells takes place. M.

Relation of the Thymus to the Reproductive Organs.—According to the investigations and experiments of several authors, there appears to be a certain functional relation existing between the thymus gland and the testicle. In fact, an antagonism appears to exist between the two organs in the sense that the development of the one hinders the development of the other. Soli (*Policlinico*, 1906, *Ser. Med.*, No. 12) reports the result of his investigations, made at the Institute at Modena, in connection with this matter, and formulates them as follows: (1) Under similar conditions the thymus of the capon is larger both in weight and volume than that of the cock; sometimes, indeed, it is double the weight in the former. (2) On the other hand, in young cocks, from whom the thymus gland has been removed, the testes become considerably less both in weight and size. M.

Dulness Behind the Inner Third of the Left Clavicle.—The current number of the *Archives of Pediatrics* (February, 1907, p. 92) contains a short paper by Dr. Hamill, in which he maintains that in normal children an area of dulness can almost invariably be found behind the inner third of the left clavicle. The authors' attention was first attracted to the subject by his endeavour to find evidence of enlarged bronchial glands in children with bronchopneumonia. He found in almost all cases the above-described patch of dulness, and then, on extending his observations, found it also in cases without pulmonary trouble. The area varies in extent, but usually is limited to the inner third of the clavicle, and the first intercostal space immediately below it. Dr. Hamill believes its presence to be accounted for by the posterior position of the lung in early life, which enables the great vessels to come into more intimate contact with the anterior chest-wall. M.

The Parathyroid Glandules in Paralysis Agitans.—**It has been suggested that the cause of paralysis agitans might be** found in some pathological alteration of the parathyroid glands, owing to the changes that are found in animals after removal of these structures. These changes consist, in the first place, of a fibrillary tremor, followed for some days by persistent clonic spasms in the voluntary muscles, and occasionally by symptoms of tetany. To settle the question, Thompson (*Journal of Med. Research* December, 1906) has examined the parathyroids obtained from nine cases of Parkinson's disease, and has compared the material obtained with the glands removed from forty other autopsies. As a result of this investigation, he is able to state that there is no morphologic ground for the assumption that the parathyroid glandules are insufficient in paralysis agitans. Although the glands in the nine cases were from individuals of advanced age, they did not show any alteration either macroscopic or microscopic, as compared with those obtained from individuals who had died of other diseases. M.

The Blood in Jaundice.—Morawitz and Biereh have investigated the blood in cases of icterus (*Archiv. fur Exper. Path. u. Pharm.*, Bd. 56). They point out that in the majority of icteric patients there is no tendency to the occurrence of hæmorrhages. In these cases the coagulation time of the blood is normal. When the tendency exists, the coagulability is greatly diminished, often down to one-third of the normal. This inhibition of coagulation is not attributable to the direct action of the bile salts, nor does it arise from any defect in the fibrinogen; but rather from the tardy formation of the fibrin ferment, perhaps due to some defect in the thrombo-kinase. In the severe types of the icteric hæmorrhagic diathesis, some defect of the blood vessels is also present. M.

New Researches on Treatment of Epilepsy.—Voisin and A. Rendue (*Archiv. de Neuralgie*, December, 1906) describe extensive experiences with the administration of bromides and deprivation of salt in the treatment of epilepsy. Their conclusions are to the effect that the interposition of a period of deprivation of salt and of bromide, in the midst of treatment with large doses of bromides, has a very beneficial effect in cases of "essential" epilepsy with numerous seizures. These brief periods of dechloridation rest the organism without entailing the inconveniences observed with other techniques. They also prevent too intense action of the bromides, which in time does more harm than good as the necessary nervous reaction becomes exhausted. Increasing the amount of the bromides on an ordinary diet gives the same results as are obtained with small doses of bromides on a salt free diet. They give four grammes of Pot. Brom. for ten days, then ten grammes for ten days, with the ordinary diet during these two periods, followed by ten days without either salt or bromide. These doses apply to adults, and generally also to young people from 16 to 18. The various details of their experiences are tabulated showing that this dosage was worked out as the basis of wide experience with larger and smaller doses—the former proving unnecessary, and the latter inadequate. D.

Rudimentary Eventration of the Diaphragm.—Hoffman, *Mun. Med. Woch.*, January, 1907). Eventration of the diaphragm is a condition in which, owing to weakness of the diaphragm, its position is very high on one side, usually the left, the lung is compressed, the heart displaced and tympany due to the stomach or intestines may extend up to the second rib. Hoffman has observed a number of cases in which this condition was present in a rudimentary form, and believes that it is not infrequent. The diagnosis is best made by means of the X-Rays, which shows the high position of the diaphragm, and just beneath it a rounded, bright area due to air in the stomach. The symptoms occur chiefly after meals, and consist of pain in the region of the stomach and palpitation. The treatment includes small frequent meals, and breathing exercises to strengthen the diaphragm. D.

Functions of the Pancreas and Influence of the Character of the Food.—Wohlgemuth (*Berlin, Klin Woch.*, 1907) reports the findings in the case of a young man left with a fistula into the pancreas after rupture of the organ in a bicycle accident. Experiments with various kinds of food to determine which kind induced the least secretion of pancreatic juice, and this had a tendency to promote the healing of the wound, showed that the production of the pancreatic juice could be readily controlled by care in selection of articles of food. Fats and albumin checked the production of the pancreatic juice, while the carbohydrates induced a copious secretion. The secretion could be further reduced in amount by frequent administration of moderate doses of sodium bicarbonate, especially during the meals. It was also found possible to substitute the loss of pancreatic juice through the fistula by administration of a pancreas preparation by the mouth several times a day. When the patient ate fat in the form of cream and milk the pancreatic juice ceased to flow from the fistula. After eating meat, it flowed again, but on a carbohydrate diet an actual stream poured out of the fistula. D.

The Reflexes During Sleep.—R. Kutner (*Deut. Med. Woch.*, January, 1907). It has been claimed that the tendon reflexes are decreased and often absent during sleep. Kutner found this was not the case. In a large proportion, however, of cases of general paresis and of delirium tremens he found a positive Babenski only during sleep. This he attributed to a slight lesion of the pyramidal tracts, not sufficient to cause a positive Babinski when the patient was awake. D.

Myxœdema Following Bullet Wound of the Neck.—Gottell (*Journ. R.A.M.C.*, March, 1907) describes the case of a man who was wounded by a bullet during the South African war, and who on recovery developed well marked symptoms of myxœdema. It does not appear that the bullet wounded the thyroid gland itself or damaged its blood supply, but there is evidence that it damaged the left inferior and probably the middle cervical ganglion, and many of the nervous connections of the left lobe of the gland. The symptoms of myxœdema appeared some six months after the injury and persisted for nearly six years, and then disappeared after a three months treatment by thyroid extract. K.

Use of X-Rays in Unresolved Pneumonia.—Esdall and Pemberton (*Amer. Journ. Med. Sciences*, February, 1907) record their experience of this form of treatment of unresolved pneumonia. Previous investigations of the effect of X-Rays had suggested the probability that their action was really due to some stimulant effect on the ferment processes normally resident in the tissues. It is now generally admitted that the resolution of the exudate in ordinary pneumonia is the result of some fermentation processes, and according to Flexner lack of resolution is often due to insufficiency or absence of this ferment. The authors point out the importance when estimating the value of this treatment to exclude those cases which are due to a persistance of the inflammation, or those in which resolution has been so long delayed as to permit of organisation of the exudate. In all five cases were submitted to the treatment, ten days or a fortnight at least having in each case been allowed to elapse after the disappearance of the fever and signs of toxæmia with the persistence of the signs of consolidation in the lung before the treatment was commenced. In the first case the affected area was exposed to the rays for five minutes on four consecutive days, and a week later the man left the hospital with practically no abnormality to be detected in the chest. The second patient was exposed daily for seven days, and three days after the completion of the treatment the merest trace of dulness was to be detected over what had been previously a completely consolidated lobe of the lung. In the other cases equally satisfactory results were obtained. In two cases elaborate metabolism experiments were carried out. In one of these cases after the first exposure to the rays, "the nitrogen increased to more than double what it had been before, and the chlorides showed an almost equally striking increase; the phosphates were somewhat less decidedly increased, while the uric acid showed relatively little change. The increase persisted in less marked degree, gradually decreasing coincidently with the decrease of the solidification, and when the latter had disappeared, excretion had reached about its former level." The other case in which metabolism experiments were made showed similar results. These effects on metabolism are very similar to those noted by these authors in a case of leukemia treated in this manner, in which there was extremely rapid improvement in the general condition, in the splenic tumour and in the leukocytosis. K.

A Case of Loss of Memory.—Burr (*Amer. Journ. of Insanity*, January, 1907) records an interesting case of loss of memory in a man of about sixty years of age. Some six years ago the man was found wandering about the streets confused and unable to give any account of himself. He knew his name and occupation, but did not know where he lived. He was sent to hospital, where for the first few days he was quiet and well behaved, and then suddenly became so violent that it was necessary to transfer him to the asylum. In a few days the attack of violence ceased and he passed into the condition in which he has remained ever since. At present he appears to be in perfect physical health, but has complete loss of memory of many years of his life, and an absolute inability to remember anything happening at the present time for even a few minutes. There is little evidence besides this of any mental disease, there being no disturbance of the moral sense and his conduct being irreproachable, and there is no failure in his knowledge of his personality. He appears to be able to reason correctly, and never starts from any false (insane) premise, nor has he any delusions or hallucinations. He reads aloud fairly well and understands what he reads, but forgets the beginning of a paragraph before he gets to the last sentence. K.

Medical News in Brief.

The Medical Golf Tournament.

We are asked to announce that this event will take place on Thursday, May 30th, and that application has been made to the Burnham Beeches Golf Club for permission to play off the event on their links. To secure the continuity from year to year of this popular fixture and to promote the interests of golf among practitioners, there has been founded a Medical Golfing Society with an annual subscription of 4s., the payment of this sum including entrance to the tournament. Any person on the medical or dental registers can join by sending 4s. to the Honorary Treasurer, Medical Golfing Society, 1, New Cavendish Mansions, New Cavendish Street, London, W.

Alleged Assault by an Asylum Nurse.

Bertha Ollier, of Lawton, Staffordshire, was summoned at Lancaster for assaulting Agnes Cooper, a patient in the County Asylum. For the prosecution, which was at the instance of the Director of Prosecutions, it was stated that whilst attempting to brush the hair of Cooper defendant was assaulted, and in a subsequent struggle lost her temper and struck the patient twice with a slipper. Bridget Dowsey, who until recently was a nurse at the asylum, said defendant struck the patient with a felt slipper, but only in order to release herself from the woman's grasp. Cooper was a violent patient, and this was not the first time she had attacked a nurse. Dr. Cassidy medical superintendent, stated that the defendant admitted to him that she had done wrong, and expressed her sorrow. He complimented her on telling the truth, and dismissed her on the spot. The reason the Asylum Court had not prosecuted in this case was because he advised them not to, deeming that summary dismissal was a sufficient punishment. Mr. J. C. Jackson, for the defence, submitted that he had no case to answer, and the Bench, after a short retirement, dismissed the case.

Ptomaine Poisoning.

On March 13th a case of fatal ptomaine poisoning as the result of eating tinned salmon came before the Manchester City Coroner. The victim was a four-year-old girl named Hilda Jackson, of Embden Street, Hulme. On Saturday week five members of the family and a friend had some salmon which had been purchased the same day. Four of them became unwell and the girl Hilda, after a week's illness, died on Saturday. The shopkeeper told the coroner that the salmon had been in stock three months, which was not considered a long time. Tinned goods could be kept in stock for years and still be all right. "Death from ptomaine poisoning," was the verdict.

Spotted Fever.

At the meeting of the Brampton District Council on March 13th, Dr. Symington reported that a girl had died from cerebro-spinal meningitis at Little Corby, midway between Brampton and Carlisle. The girl had come home ill from Whitehaven, where she had attended to a boy who had been unwell, and had since gone to school at Wallsend. After the departure of this boy for Wallsend she had occupied the bed in which the boy had slept at Whitehaven. No case of spotted fever had, however, been notified at Whitehaven. The Brampton Council decided to hold a special meeting to make spotted fever notifiable.

Asylum Doctor Threatened.

A German, named George Beck, living at Upton Park, was charged at Stratford on March 8th, with feloniously causing Dr. David Hunter to receive a letter threatening to murder him. Mr. G. E. Hilleary who prosecuted, said that towards the end of August of last year the prisoner's wife was admitted to the Goodmayes Asylum, and shortly afterwards the prisoner went there and demanded her release. He made serious allegations as to the ill-treatment of the patients, and said that horrible cruelties were practised at the asylum. Subsequently he sent letters to the infirmary in which, referring to the medical superintendent, he said, "Dr. Hunter . . . If he is not careful he will be in his wooden box soon. I am after his body." Prisoner, who contended that his wife was quite sane, was remanded.

Dublin Hospital Sunday Fund—Annual Meeting.

The annual meeting of the supporters of the Dublin Hospital Sunday Fund was held last week in the Molesworth Hall, Sir Robert Jackson presiding.

Mr. William Perrin, Hon. Secretary, submitted the report, which stated :—" The collections were made on November 11th, 1906, in 272 places of worship. Ten congregations, which in 1905 had collections, producing the sum of £28 5s. 3d., did not join in 1906. On the other hand, collections, amounting to £26 3s. 5d., were made in eight places of worship which had not any collections in 1905. The amount contributed to the Fund for 1906 was £3,767 11s. 3d. (which includes a generous donation of £100 from R.P.), being an increase of £2 9s. 4d. as compared with 1905. The Council observe that while there was a reduction in the amount collected in 126 places of worship, there was an increase in 136. In ten cases the amounts were the same as in 1905. The expenses for the year amounted to £234 0s. 10d., being £3 15s. 4d. less than in the preceding year, or 6.21 per cent. on the total sum collected. The total amount to the credit of the Fund for the year 1906 was £3,887 1s. 6d., including a balance from the previous year of £104 15s. 8d., and £14 14s. 7d., interest allowed by the Royal Bank.

Annual Meeting of the British Medical Association.

The local arrangements for the visit of the British Medical Association to Exeter in the summer are making satisfactory progress. The South Western Branch of the Association, by whom the invitation to hold the annual Congress at Exeter was given, have raised a guarantee fund, and the members of the profession are sparing no efforts to make the gathering a success. It is thirteen years since the Association visited the West of England, and its members have not foregathered at Exeter since 1842, ten years after the foundation of the Association. On that occasion Mr. J. H. James, the principal surgeon on the honorary staff of the Devon and Exeter Hospital, was president. In 1864 the annual meeting was held at Torquay, and Plymouth was the place of meeting in 1871. The 1894 assembly was held at Bristol, where the Association was started in 1833.

Malta Fever.

A further report of the commission appointed by the Admiralty, the War Office, and the Civil Government of Malta for the investigation of Malta or Mediterranean fever has lately appeared. In this Staff-Surgeon E. A. Shaw details experiments relating to various possible paths of infection by the micro-organism of the disease. Major W. H. Horrocks supplies a valuable contribution on outbreaks of the fever in Gibraltar and the general question of infection by goats. The opinion is expressed that the rapid disappearance of Mediterranean fever from the Rock, which commenced in 1885, was intimately associated with the greatly-lessened importation of goats from Malta. At the present time the goat-keepers introduce Spanish goats, but, in the interests of the public health, it is held that, notwithstanding the healthy conditions now prevailing, all goats brought to Gibraltar should be quarantined until examinations of the blood have shown them to be free from infection. Dr. J. W. H. Eyre describes experiments made by him with the object of obtaining a bacteriological serum suitable for therapeutic purposes in cases of Malta fever. The results were not, however, of a character to warrant belief that an "anti-serum" had been secured possessing the requisite properties. A useful bibliography of works and papers on Malta fever proceeds from the same writer.

Trinity College, Dublin.

During Hilary Term, 1907, the following candidates passed :—

Intermediate Medical Examination (Part I.).—Robert E. T. Tatlow, Victor B. Kyle, Hugh S. Metcalfe, William P. H. Smiley, Charles D. Hanan, Charles B. Jones, Desmond Drew, James D. Murphy, Alexander K. Cosgrave.

Final Medical Examination (Part II. Surgery).—Frank R. Seymour, John Gray, Ernest Jameson Edward C. Stoney, George G. Vickery, Francis W. H. Bigley, Henry P. Hart, Albert T. J. M'Creery, Arthur E. Knapp, Rev. Richard B. Bryan, John W. Lane, George H. Stack, John H. Morton.

Diploma in Public Health. (Part I.).—Cecil Scaife.

Previous Dental Examination (Anatomy and Institutes of Medicine).—Arthur A. Campbell ; Chemistry and Physics, George Elliott.

A telegram from Tangier dated Saturday last, mentions that Dr. Manchamp, a resident physician at Marrakesh, has been brutally murdered by natives. He had hoisted a white flag over his house in order to distinguish it, and the Moors, thinking it indicated an intention to install wireless telegraphy, went to the house in a body and stoned him to death, stabbing the body afterwards in their frenzied rage. The French Government is reported to be taking energetic action in the matter with the object of punishing the ring-leaders of the outrage and obtaining substanitial damages for those dependent on our ill-fated *confrere.*

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Original Articles or Letters intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

ADVERTISEMENTS.

For One Insertion:—Whole Page, £5; Half Page, £2 10s. Quarter Page, £1 5s.; One-eighth, 12s. 6d.

The following reductions are made for a series:—Whole Page, 13 insertions, at £3 10s.; 26 at £3 3s.; 52 insertions at £3, and pro rata for smaller spaces.

Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

D.M.R.—It does not follow that because a patient is of good mental power that the cerebellum is not affected. In adults the mind is not affected in cerebellar disease, as a rule, though in children defective cerebellar development is a common cause or accompaniment of idiocy.

Jahr.—An anti-gonococcic serum has been prepared in America, where it has been employed by Dr. J. Rogers. He reports very good results from its use in small quantities. Twenty to sixty minims are injected subcutaneously every day or every other day in gonorrhœal rheumatism, and in early cases the acute symptoms are said to have subsided in a week or ten days. We do not know of any available serum manufactured in this country.

Coccus.—Sabourand's seborrhœa bacillus may be demonstrated by squeezing out the contents of a sebaceous follicle, squeezing them between two slides, dissolving the fat in ether and staining with methylene blue.

A Yorkshire Subscriber.—Your surprise is well founded; the strange part of it is that no one thought of writing on the subject in the same attractive way previously. We understand the success of the book is almost phenomenal.

THE FLOWING TIDE OF CHARITY.

According to the annual report of the Charity Commissioners, upwards of one thousand new recognised charities have been established in England and Wales during the past four years, with a cash value of £2,640,387 and producing a yearly income of £84,568. The total number of charities now under the control of the Commissioners is 26,497, with an aggregate value of £25,472,703. Of the objects to which the new charities are applicable, what may be called medical charities predominate, while a considerable proportion of the miscellaneous charities are applicable for nurses, nursing homes, dispensaries, and the like.

Mr. S. (Thomas's).—We quite agree with you that there is room for a book giving the student in a plain and practical way the fundamental principles upon which medical language is built, because many have had no real early training in Latin.

Dr. G. (Skye).—According to Conrath, the ileocæcal region is the seat of election of intestinal tuberculosis, and is affected in 85 per cent. of all cases.

M.D. (Ilford).—"Nature healers" are also included under the law in Germany. Dr. G. Siefart, Hardenbergstrasse 39 Charlottenburg is the editor of the anti-quack journal, "Gesellschaft zur Bekämpfug das Kurpfuschertums."

L. L.—We are much obliged for your kind compliments. The gradual establishment of correct scientific feeling on that subject and cognate ones is what we endeavour to promote, and evidence such as you supply that it is appreciated is very welcome.

First Edition.—Can any of your readers tell me where I can get a book by Robert Knox (1724), entitled "Great Artists and Great Anatomists," also a copy of "An Historical Sketch of the Edinburgh Anatomical School," by Prof. Struthers.

Meetings of the Societies, Lectures, &c.

Wednesday, April 27th.

Hunterian Society (Poplar Hospital Blackwall, E.).—4 p.m.; Clinical Meeting. Cases can be seen at 3.30 p.m.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Cantlie: Clinique. (Surgical.)

North-East London Post-Graduate College (Tottenham Hospital, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Central London Throat and Ear Hospital (Gray's Inn Road, W.C.).—5 p.m.; Demonstration: Dr. A. Wylie: Pharanx.

Thursday, April 28th.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

Friday, April 29th.

North-East London Post-Graduate College (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

Royal Devon and Exeter Hospital, Exeter. House Surgeon. Salary £120 per annum, with board, apartments, and washing. Applications to Samuel S. Cole, Acting Secretary.

Leicestershire and Rutland Asylum.—Second Assistant Medical Officer. Salary £130 per annum, with apartments, board, and washing. Applications to W. J. Freer, Esq., New Street, Leicester.

University of Birmingham.—Demonstratorship in Anatomy. Salary £150 per annum. Applications to Geo. H. Morley, Secretary.

Wolverhampton and Staffordshire General Hospital.—Senior House Surgeon. Salary £100 per annum, with board, lodging and laundry. Applications to J. Stephen Neil, House Governor and Secretary, Wolverhampton.

Cornwall County Asylum. Bodmin.—Third Assistant Medical Officer.—Salary £140 a year, with furnished rooms, rations, laundry, and attendance. Applications to Medical Superintendent.

Staffordshire County Asylum, Cheddleton, Leek.—Junior Assistant Medical Officer. Salary 150 per annum, with board, furnished quarters, and washing. Applications to the Medical Superintendant.

Leeds Public Dispensary.—Two Junior Resident Medical Officers. Salary £100 per annum, with board and lodging. Applications to the Secretary of the Faculty, Public Dispensary, Leeds.

The General Infirmary at Leeds.—Resident Casualty Officer. Salary £125 per annum, with board, lodging, and washing. Applications to the Secretary to the Faculty, General Infirmary, Leeds.

Monaghan District Lunatic Asylum.—Second Assistant Medical Officer Salary £100 per annum, with furnished apartments, etc. Applications to R. L. Donaldson, Resident Medical Officer (See advt.)

Appointments.

Bergin, Frank Gower, L.R.C.P., M.R.C.S., House Surgeon at the Bristol General Hospital.

Blacket, James Francis, M.B., B.S.Lond., Assistant House Physician at the Bristol General Hospital.

Briscoe, William Thomas, M.D., M.Ch.Dublin, Medical Officer for the Pewsey District by the Chippenham (Wilts) Board of Guardians.

Carey-Evans, T. J., M.D. Brux, M.R.C.S., L.R.C.P.Lond, House Surgeon at the Royal Southern Hospital, Liverpool.

Coulson Thomas Edmund, M.B., Ch.B.Edin., Senior House Surgeon at the Bristol General Infirmary.

Elliott, William Harold Arthur, M.B., B.S.Lond., L.S.A., Medical Officer to the Bristol Dispensary.

Hughes, Edward Blythe Hurst, L.R.C.P. and S.Edin., L.F.P.S. Resident Medical Officer at the Newport (Mon.) Workhouse.

Miller, A. H., M.B., B.C.Cantab., Resident Medical Officer to Outpatients at Queen Charlotte's Hospital.

Pinniger, Wilfrid J. H., M.B., B.S.Lond., L.R.C.P., M.R.C.S., Casualty House Surgeon to the Bristol General Hospital.

Taylor, J. Francis, M.R.C.S., D.P.H., Medical Officer at Leyton.

Thompson, Theodore, M.D.Cantab., M.R.C.P.Lond., F.R.C.S.Eng., Assistant Physician at the London Hospital.

Wade, Reginald, M.R.C.S., L.S.A., Medical Officer of Health for the Highbridge (Somerset) Urban District.

Marriage.

Waugh—Young.—On March 20th, at Sarratt, Hertfordshire, John Waugh, M.D., J.P., of Conger House, Toddington, Beds., to Alice, second daughter of the late Geo. Young, Esq.

Deaths.

Casley.—On March 23rd, at Elmroyd, Park Road, Ipswich, in his 56th year, Reginald Kennedy Casley, M.D., C.M. (Edin.)

Leach.—On March 11th on the S.Y. Argonaut, John Comyns Leach, M.D., J.P., of the Lindens, Sturminster Newton, Dorset, aged 65.

O'Connor.—On March 15th, at 40 Grove End Road, St. John's Wood, London, Ignatius Jeremiah O'Connor, third son of the late William O'Connor, M.D., aged 59.

Smith.—On March 22nd, at Kent House Nursing Home, Torquay, Clement Madely Smith, M.D., of St. Enoder, Cornwall, and Argyll Hall, Torquay, late of 1st Punjaub Cavalry, in his 80th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, APRIL 3, 1907. No. 14

NOTES AND COMMENTS.

The Reprieve of Rayner.

IN our last issue we published a letter from a correspondent on the desirability of commuting the death sentence in the case of Horace George Rayner, and we believe, though that letter was strongly worded, that in the main it represents the general feeling of the medical profession with regard to the case. The heredity of the unhappy Rayner was about as bad as it could be, and his environmental conditions since the earliest days were no better. He was born and brought up under anti-social conditions, and it is proposed to punish him for an anti-social act, committed in the depths of despair and probably in a moment of temporary insanity. The evidence of the medical witnesses at the trial, to the effect that at the time of his examination by them there was no insanity present, was doubtless correct, but it is equally certain that had he killed himself as he intended, the coroner's jury would have found him "temporarily insane." Rayner, the illegitimate outcast, and Thaw, the pampered millionaire, differ at least in this, that the former's act probably was not deliberately intentional, and certainly was utterly irrational as a method of clearing himself, while Thaw's was an act of premeditated vengeance against a man who had wounded his pride. It is difficult to see what useful social purpose the execution of Rayner would have accomplished; while the commutation of his sentence at least points to a discrimination on the part of society between the victim of circumstance, who has never had a chance, and the victim of sensualism who has thrown his chances away. The pardon granted in his case is not only the humane but the scientific course to follow.

Death Investigation.

AN influential deputation, composed of members of the London County Council and of the Medico-Legal Society, waited on the Lord Chancellor recently to point out some anomalies of the coroner's position, and of the faulty system under which deaths are registered. Sir William Collins, who has been chairman of both bodies, introduced the deputation, and with them laid before the Lord Chancellor the points in connection with death-recording and burial which medical men know well to stand in need of reform. For instance, it is preposterous that the preparation of a case for submission to a coroner's court should be in the hands of an officer who is not only uneducated, but too often venal as well; what evidence shall be sought if that laid before the Court is entirely in the hands of the coroner's officer? Then, too, money is notoriously wasted in the holding of unnecessary inquests, simply because there is so little elasticity in the law as relating to coroners. The cause of many a death could be cleared up quite satisfactorily by a medical man whose business it was to make the necessary inquiries and satisfy himself that the death was natural. And then, of course, no dead body should be buried without a certificate, even in the case of still-born children. The number of still-born murders is probably higher than is dreamed of by even well-informed people.

The Lord Chancellor and Caution.

THE Lord Chancellor gave a hearty welcome to the deputation and said he considered the matter one of real and great importance, adding that without loss of time he would personally look into the matter and take counsel as to what steps could be adopted to alter such a state of affairs as was laid before him. The decision of the Lord Chancellor is very good so far as it goes, and we hope that his characteristic energy will carry him through his task without loss of time; but at the same time we hope that in arriving at his decision he will be preserved from falling into a pitfall by the way into which, if unwary, he may be led. When we say that Mr. Troutbeck formed one of the deputation and gave forth his own views, the danger we allude to is very obvious to all medical men. Mr. Troutbeck urged the need of skilled medical advisers to supervise death registers, to make the preliminary enquiries in uncertified deaths, and to perform the necessary post-mortems. Now such an officer attached to a coroner's court would be a valuable one doubtless, provided that his duties were properly defined. It has been shown over and over again that to judge merely from a post-mortem examination as to the cause of death is to leave the whole of the most important evidence out of account, namely, the clinical history and appearances. These can only be supplied by the medical practitioner in attendance, and if any attempt is made to oust him in favour of a bureaucratic officer it will prove a fatal mistake. There is room for both family practitioner and medical investigator in their defined spheres for, in spite of the ignorant sneers of certain superior people, the medico-legal skill a busy general practitioner acquires in a lifetime is often of more practical service than the generalisations of many text-books.

Failure to Notify.

We have had occasion two or three times lately to call attention to the overbearing and stupid way in which many local authorities treat medical practitioners in their districts. In illustration of this principle we may cite a case tried in the Otley Police Court the other day, when Dr. Henry White, of Bradford, was summoned for failing to notify a case of diphtheria that he had attended in the neighbourhood. The facts, briefly stated, were that Dr. White was attending a child, and the Sanitary Authority got to know something of the nature of the case and suspected diphtheria. The clerk was instructed to write to Dr. White, and not getting an answer, another letter was sent later. To this an answer was received, Dr. White saying that he found the case was one of diphtheria after all, but that the girl was then convalescent, and he regretted not having reported it sooner. On this trumpery ground the local authority proceeded to summon Dr. White in the police court, and in spite of his defence that he had not notified the case because he was in doubt for a long time about the diagnosis, a fine of forty shillings and costs was inflicted. The chairman of the magistrates said "they were bound to support the local authority," and that presumably was the reason for giving such an unjust decision.

"In My Opinion."

Now it would be well if the local sanitary authorities would learn that they cannot have their cake and eat it too. A medical man has to certify that in his opinion a patient is suffering from diphtheria, scarlet fever, or whatever the disease may be. Till his opinion is formed, therefore, if he keeps to the strict letter of the law, he cannot certify, and every medical man knows that his opinion never is properly formed about many and many a case that passes through his hands. On the other hand, if the local authorities want the interpretation of the words varied, so as to cover all doubtful cases, as to which his mind is not made up, no medical man would object; but the number of notification fees would increase enormously and the consequent work thrown on the sanitary staff would be immense. It is only possible for the Act to work well by local authorities giving confidence to the medical practitioners, and leaving them to notify cases in which they are reasonably sure. Any other way, chaos lies.

Epidemic of Diphtheria in Lincolnshire.

Owing to an outbreak of diphtheria at Spalding, the medical officer of health has ordered the closing of the Spalding Central Schools. An emergency meeting of the managers was held on Saturday, and the closing of the schools was agreed to. The cause of the outbreak is unknown, but the sanitary arrangements of the school are in good order, and it is suggested that the disease had been introduced from outside. Up to the present there have been fifteen cases. Scarlet fever is also prevalent in the town, but the action of the medical officer in closing the schools was due to the diphtheria cases.

LEADING ARTICLE.

LONDON AND ITS MILK SUPPLY.

The scientific investigations of the Royal Commission on Tuberculosis, as all the world knows, have emphasised the absolute necessity of a rigorous control of the national milk supply. It seems probable in the light of the evidence thereby obtained that the major part of the terrible sum total of infantile tuberculosis and possibly a fair proportion of the disease in adults, arises from milk infection. The inevitable outcome of these clear-cut and incontrovertible propositions is that the State, whose duty it is to safeguard the public health, must enforce stringent sanitary control of farms, dairies, cows and byres, in short, of every detail concerned with the production and distribution of dairy produce. Clearly it is a feeble policy to attempt to cure consumptives by establishing palatial sanatoria such as those at Winsley and elsewhere, while we permit the careless or ignorant farmer to go on infecting the community with his tuberculous cows, and the dairymen to distribute tubercle bacilli systematically in his milk cans. Nor is the whole of the danger comprised in the spread of tuberculosis. There is no need to remind medical readers of the many epidemics of enteric fever, scarlet fever, diphtheria, foot and mouth disease, and other infections that have been traced to the agency of the ubiquitous and noisy milkman. It seems more than probable that he has a hand in the dissemination of that most fatal of infantile scourges, summer diarrhœa, just as he is probably implicated in epidemic disquamating dermatitis, otherwise known as "Savill's" disease. Under these circumstances all who have at heart the progress of the public health were rejoiced at the prompt and thorough nature of the control of the milk supply asked for in the General Powers Bill of the London County Council to be brought before Parliament this Session. Amongst other powers it petitioned for the following:—"To enable the Council to prohibit the sale of milk from any dairy situated within or without the county where the medical officer suspects that cases of infectious disease within the county occurring in more than one sanitary district are attributable to the milk supplied from such dairy. (Clause 32). To enable the Council to take samples of milk at railway stations and elsewhere in the county with a view to prevent the sale of milk unfit for human consumption. (Clause 33). To enable the Council's medical officer to require dairymen to furnish lists of sources of supply of milk and of their customers, with a view to prevent the spread of infectious disease. (Clause 34). To require dairymen to notify under penalty all cases of infectious disease among their servants, &c., and to prohibit any person suffering from an infectious disease from milking any animal whose milk is intended for consumption within the county. (Clauses 35 and 36). To enable sanitary authorities, with a view to prevent the spread of infectious disease, to require proprietors of dairies to furnish lists of their customers. (Clause 37)." The Bill itself stands for second reading on April 11th. It is somewhat alarming, therefore, to learn that the Parliamentary Committee of the London County Council report unfavourably to the foregoing proposals on the ground that they are highly controversial, and are opposed by a number of local authorities and other petitioners. This retrograde step in the face of a grave public health danger is the more to be regretted inasmuch as the entire change of political complexion in the recent election suggests that in this case the health of Londoners is not so much a matter of imperative and overwhelming importance as the trade and other private interests represented by various metropolitan local authorities. It is a thousand pities that matters of this importance should be imported into the domain of politics. The tubercle bacilli of the milkman's can infect conservatives and liberals alike, and the exclusion of so terrible and insidious a danger from our households should be the aim not alone of progressives or of moderates, but of the whole Council, grim, enthusiastic, and determined. The fight of the sanitarian has always been beset with difficulties. At every fresh advance he finds himself faced by vested interests prepared to defend their pockets at the cost of the health, or, if need be, the very lives of the community. We doubt whether in the history of the long struggle for the public health could be found a more typical instance of the contemptuous levity with which public bodies habitually treat measures advancing the public health when the latter threaten to clash with sordid petty interests. It is to be hoped, however, that the new London County Council will be warned in time, and will settle down into a wiser mood when the first flush of its exuberant success has somewhat passed away. At the same time, that august body may be reminded that in this particular matter it is acting as the pioneer, or the reverse, of an important movement affecting the policy and the lives of citizens throughout the length and breadth of the United Kingdom.

CURRENT TOPICS.

The Death of a Great German Surgeon.

News has come from Berlin of the death of Professor Ernst von Bergmann, the famous German surgeon. A few months ago we announced the public celebration of his seventieth birthday, and his visit to the Sultan of Turkey was quite of recent date. Von Bergmann was a Russian subject in Livonia, although of Teuton blood and education. He served on the Prussian medical staff in the wars of 1866 and of 1870-71, and afterwards as consulting surgeon on the Russian Danube force in the campaign of 1877. He was appointed Professor of Surgery in Berlin in 1882. He came into prominent European notice as surgeon to the late Emperor Frederick, upon whose illness he was the first to give a decided opinion as to its cancerous nature. He was generally understood to have inspired the attacks on Sir Morrell Mackenzie circulated in Germany after the Emperor's death. He also performed a slight operation some time ago upon the present Emperor. Of huge stature and blunt speech, he was one of the most familiar as well as the most popular figures in Berlin. His fame is founded on a sure basis as a scientific surgeon, apart from mere technical skill. For some five years past he has suffered from intermittent intestinal symptoms, which he himself recently diagnosed as malignant. A few weeks ago he was undergoing a cure for lumbago at Wiesbaden, when his old symptoms returned, and two operations were performed. On Monday, March 25th, however, the great surgeon died of shock and exhaustion.

"Carelessness" of a Royal Commission.

The coming extermination of tuberculous cattle has naturally fluttered the dovecotes of the farming and the dairy interest to a considerable extent. That fact was abundantly illustrated last week at a meeting of the Central and Associated Chambers of Agriculture held in London under the presidency of Lord Desborough. One of the speakers, Mr. H. Rider Haggard, maintained that it would be unfair to ask the farmers and dairymen to protect the public health by the huge sacrifice that would be involved in the systematic destruction of tuberculous cows. With regard to that attitude it may safely be assumed that no British Government would attempt to enforce such a measure except on the basis of compensation. Another speaker, Professor F. J. Lloyd, declared his belief in Koch's theory that tuberculosis in man and in the lower animals is not identical. He is reported to have said, further, that he was not proud of the scientific men of England because of the "carelessness" with which the Royal Commission's conclusions had been arrived at. We do not happen to know the precise faculty in which Mr. F. J. Lloyd fills the professional chair. Whatever its nature, however, he must surely know that to stigmatise the work of a Royal Commission as "careless" in a mixed public assembly where there is no chance either of maintaining or of refuting the charge, is to take upon himself a most serious responsibility. Fortunately "professors" who entertain doubts are, as a rule, more cautious in publishing their views and more precise in furnishing at the same time an adequate statement of their grounds of difference.

An International Standard Pharmacopœia.

The principle of *Tot homines tot sententiæ* applies to nations as well as to individuals. In habits, fashions, laws, religion and a thousand other ways one nation is sharply marked off from its fellows. Modern civilisation has done a great deal towards the development of a certain broad international cosmopolitanism. If there be need for a common understanding among the people, of the earth for one thing above all others it is for the acceptance of a common pharmacopœia with a standard method of estimation and universal drug formulæ. With a perfectly authorised Volapuk of the kind suggested, a traveller armed with his pet physician's prescription would feel safe whether it were compounded in the bazaars of Constantinople, of Calcutta, the Broadway of New York, St. Petersburg, or anywhere else in the civilised globe. For once in a way the Foreign Office has adopted a most sensible and advanced position in dealing with a socio-scientific matter. It has signed a convention, so we understand, together with the United States of America and the principal European countries, under the title of "A Treaty for the Unification of the Pharmacopœial Formulæ of Potent Drugs." The partial standardisation thus foreshadowed appears to be a step in the right direction, that is to say, towards the goal of an international pharmacopœia. By the way, is there any such technical vocabulary in Volapuk?

Poison in a Beer Bottle.

It would be interesting to find out, were such a thing possible, the number of persons who have died, say, within the last decade, from drinking poison retailed in beer bottles. Elsewhere in our columns will be found the facts of a case in which carbolic acid was sent out by the chemist in a pint black bottle bearing the label of a well-known firm of brewers. A baby of two and a half years took the bottle from the table and drank from it, causing death. A widow, who sold the carbolic, and was prosecuted under the 17th Section of the Pharmaceutical Act for selling a scheduled poison in a bottle not labelled with her name and address as seller. Defendant stated that she had carried on the business since the death of her husband, and had served the disinfectant on a statement that a child of the purchaser was suffering from fever. There was a narrow red label with the word "poison" on the bottle. As the magistrate, Mr. Cluer, pointed out, no matter how the bottle had been labelled, it would not have prevented a child of two and a half years from drinking from it. We cannot agree, however, with the further remark attributed to the learned magistrate that "it was no act of carelessness on her part which had contributed to the death." We should be inclined to say that to dispense carbolic acid in a beer bottle and without a proper label is a reckless proceeding deserving a heavy penalty. The accidental deaths from carbolic acid form a terrible death-roll every year, and in many cases the safeguards entailed by the law are grossly violated by the vendors.

Seasickness and Christian Science.

Of all the evils that have cursed mankind since the far-off prehistoric time when first they began to go down to the sea in ships that of seasickness is one of the most tragic, dramatic, and inevitable. Thousands of our fellow mortals have wrung their brains in the vain endeavour to circumvent this evil, but neither prevention nor cure has yet been attained. Icebags down the spine, drugs and patent medicines by the score, patent ships, patent cabins, patent berths, all are worthless in the face of a "choppy" sea and a rolling ship. The latest invention for steadying ships is the Gyroscope, which may, or may not, succeed where other devices have failed. It has occurred to us that in this unspeakably terrible malady of seasickness Christian Science might have a fine field for experiment. Let us take, say, two or three score miserable sufferers and put them in the hands of Christian Science healers, and make a minute and careful record of results. If faith healing be competent to perform half the wonders claimed for it by the Scientists, they will make short shrift of so slight a thing as a mere attack of *mal de mer*.

The Lord Lister Celebration.

The celebration of Lord Lister's eightieth birthday on April 4th will be of a somewhat novel character. Instead of the stereotyped dinners and presentations, it is proposed to form an International Committee for the publication of our distinguished countryman's scientific papers, prefaced by a short biography. Always a sparse writer, his contributions are scattered in many journals, and their collection will present an interesting survey of the development of one of the most momentous discoveries that has ever been made in the domain of medicine. One point that will be emphasised is the variety and originality of Lister's early researches in physiology, more especially perhaps in the direction of the coagulation of the blood, of non-absorbent ligatures and of the action of anæsthetics, the present scheme has been hailed with acclamation throughout the civilised world. Professor Elie Metchnikoff and Professor Championniere, who sat at the feet of Lister in the first days of the new discovery as representatives of the Pasteur Institute and of France, are on the list, together with Professor Ehrlich, the late Professor Von Bergmann, Professor Philip Welch, of the John Hopkins University, Professor Tilanus, of Amsterdam, Dr. Koch, Dr. Roux, Dr. Gaffky, Professor Fleuger, Dr. Franckl, Professor Poltauf, Professor Loeffler, Dr. Kossel, and Dr. Salamon, besides representatives from every British Colony, and a very large number of medical, surgical and bacteriological authorities in America. The Committee is now several hundreds strong. A meeting will be held shortly after Easter, and the form of the work, which will be published in two quarto volumes, will be decided on, and its editor and biographers officially chosen.

The Approaching Conquest of Seasickness.

"The long night of waiting is drawing to a close, and already over the hills appear the shafts of light which announce to the weary sufferer that dawn is at hand. Since the time that order came out of chaos the world has sat patiently waiting for a sign that it should master the deadly seasickness which holds it by the throat, chaining commerce with fetters of iron and hampering the interchange of friendly relations with nations over the sea. But the malady can no longer face the determined onslaught of science, and now we know how it may be wrapped in its own blanket and hoisted with its own petard. As we write there lies before us the account of an important meeting of the Institution of Naval Architects, at which Sir William White, K.C.B., late Chief Constructor to the Royal Navy, read a paper based on experiments conducted by Dr. Otto Schlick on the application of gyroscopic apparatus to control and limit the rolling motion of ships when exposed to the action of ocean waves. According to Sir William White, by means of a Gyroscope weighing half a ton the roll of the *See-bar*, the ship on which the experiment was conducted, was reduced from thirty degrees to one degree, without any shock or jarring of the ship. Professor Biles and other speakers pointed out that under certain circumstances the Gyroscope would increase the roll of the ship, but these criticisms are, of course, ignorant cavils. I have personally read the paper of Sir William White, and can assure my readers that they may rely on me. If sea-sickness can be conquered in Germany, why, in the name of the Eternal, not in this country, too? I have written on this subject for years, and it has not advanced the solution a scrap." This, or something like this, we may perhaps expect to read in the *Pall Mall Gazette* in the near future.

Vaccinated Veal.

Mr. Arnold Lupton has already established for himself fame in Parliament—not the fame of an orator or of a man of affairs, or for being possessed of any of the hundred-and-one qualities which are regarded with respect and esteem, but the fame of being what the French would call a *blageur*, and the English school a "rotter." For him there is felt little or no animosity, but a sort of curious interest as to what he will do next with regard to vaccination, for it is vaccination which (like King Charles' head) forms the subject matter and substratum of all his utterances. His last two attempts have been more than usually ingenious and disingenious. Of these the first was addressed in the form of a question to the President of the Local Government Board, asking him whether the "epidemic" of cerebro-spinal fever was due to blood-poisoning, and whether there was any frequently-occurring mode of introducing poison into the blood without its passing through the digestive organs other than vaccination? The suggestion that the present cases of cerebro-spinal meningitis are due to vaccination is nearly as far-fetched as the old anti-vaccination notions about vaccinated children being liable to low like cattle as the result of the bovine inoculation. The second of Mr. Lupton's efforts was made last week, and also took the form of a question, this time addressed to the Chairman of Kitchen Committee of the House, asking if any "vaccinated veal" was bought for the consumption of Members? Unhappily Mr. Jacoby was away, but the question is to be renewed after the Easter vacation. We shiver to think what the result on Mr. Lupton would be if the answer were "Yes." Perhaps it might frighten him out of the House altogether. Or is it possible that it is to his having partaken of vaccinated veal unawares that he owes the ox-like grace of his oratorical gyrations?

Eugenics in Practice.

A curious sect is said to be in existence in Chicago under the title of "The Architects," headed by an Austrian physician, Dr. Asher Gluck. The founder has laid down stringent rules for a simple life, and he declares that if followed strictly, perfect children will be born to his followers. The conditions, however, are, to say the least of it, somewhat trying. The day is divided into three periods of eight hours each, allotted to work, sleep, and study. Recreation is not provided for. Dietary excludes alcohol, tobacco, pepper, salt, tea, coffee, meat, candies or any animal product tea, coffee, meat, candies or any animal product. and women adopt men's dress. Neither shaving nor cutting the hair are permitted. They are not allowed to handle money, as they belong to a co-operative community, and any money they earn goes into a common treasury. The study is regulated by the wish of the parents for the future of their children. "If they wish him to be an artist they study art, and if a musician they must study music," and so on. Dr. Gluck is reported to claim that his new method will not only produce perfect children, but it will promote longevity, even to two or three hundred years; it will bring the human structure to a point of absolute perfection; abolish money and the competitive system in the world, and solve all social and economic problems. Curiously enough, a bride and bridegroom have been found willing to face the rigours enforced by this creed, which appears to form a strange hotch-potch of half-truths and fantasies strongly tinged with insanity.

The Polyclinic.

We are very glad to see from the report of its annual meeting that the Medical Graduates' College and Polyclinic is making such admirable progress. If it cannot be said the College fills a unique place in London medical life, it did so up to recently, but there are now two or three organised post-graduates' schools offering different advantages of one kind and another. But the Polyclinic is unique at least in that its cliniques are reserved entirely for consultation work, and patients are only received on the recommendation of their medical advisers. This is, of course, the arrangement that should be made at all medical schools, that is, if they are not to be brought into unfair competition with the practitioner outside. As it is, although the Polyclinic has no beds, it gets the pick of the clinical material of London for investigation and teaching, and this is what post-graduates want. It is sorely taxing to a man who has made great efforts, and, maybe, sacrifices, to get three months' study in London, to sit hour after hour in the out-patients' room of the hospital and see nothing but cases of anæmia in servant-girls and gastric ulcer in dressmakers, when his own practice comprises a dismally large number of similar cases. At the Polyclinic, at any rate, he will be kept constantly agog by the variety and interest of the cases. The laboratory attached to the institution is doing capital work, and the chief thing needed at present is money. No Government education grant could be given to a more directly and indirectly utilitarian object.

Sir Richard Douglas Powell has been re-elected President at an extraordinary Committee of the Royal College of Physicians of London.

Dr. H. P. Taylor, of Yell, Shetland, and his wife, have been presented with handsome testimonials by their friends and patients in the islands of Yell and Fetlar.

Dr. P. W. Kent, of Barry, was last week awarded £250 damages in an action for slander brought against Dr. Peter O'Donnell, another medical practitioner, of the same town. Dr. Kent's case was taken up by the London and Counties' Medical Protection Society.

A Clinical Lecture
ON
ARTHRITIS. (*a*)

By F. J. POYNTON, M.D., F.R.C.P.Lond.,

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Introductory.

In this short lecture I ask you to consider arthritis as a manifestation of diseased states and not as in itself a disease. The condition then becomes one of particular interest at the present time, for there are examples of its occurrence when there can be no doubt that it is by origin infective, and there are other examples which few believe can be so explained. No one, for instance, will dispute the nature of suppurative arthritis during the course of a pyæmia, when the staphylococcus aureus has been isolated from the arthritic exudation.

When, on the other hand, we are confronted with gouty arthritis, there is much doubt as to its nature, and some would have us believe that this arthritis is a mechanical result of the deposition of biurate of sodium in the articular structures. If we accept this explanation, then we must recognise, in arthritis, processes which range from the comparatively simple one of crystallisation to the formation of the most virulent toxins produced by bacterial growth in the human body.

It is to be expected that a minute and protracted study of infective arthritis of known origin will eventually throw much light upon all forms of joint disease. My belief in the truth of this has led me to maintain that the problem of the nature of *acute* gouty arthritis is at present better attacked by minute investigation of the processes of infective arthritis, than by theories based upon the far more difficult and less understood problems of the metabolic processes of the human economy.

Again, if our attention is confined to one such lesion as arthritis, we can the more easily keep in touch with some of the great difficulties which present themselves in general medicine.

Such difficulties, for example, as :—

(1) Determining what conditions are truly infective, and what are due not to infection but to disordered metabolism

(2) Again, in infective conditions, deciding which are the results of infection from without and which of infection from within ?

(3) Ascertaining, in an infective process, to what extent its peculiarities are dependent upon the infective agent, and to what extent upon the tissues of the individual infected.

(4 and lastly). Confining our attention entirely to the infective agent.

Investigating to what extent the *disease* is the result of the local lesions, viz., the arthritis—produced by that infective agent, and to what extent of the toxæmia caused by the poisons getting into the general system. These difficulties may be lost sight of in the difficult and complicated study of general medicine, but if we narrow ourselves down to one such lesion as arthritis, they can be very readily appreciated.

A considerable number of forms of arthritis depend upon infection from without, for example, among others, the tubercular, the pneumococcal, the gonorrhœal, those due to the streptococcus pyogenes, and staphylococci, and in my opinion also the rheumatic and some cases of rheumatoid arthritis. There are others which are uncertain. Such are hypertrophic pulmonary oste-arthropathy, "Charcot' joints," intermittent hydrops, and gouty arthritis, and the arthritis met with in colitis and dysentery. Among these there are some which are thought by many to be the result of an infection from within. Thus the pypertrophic pulmonary osteo-arthropathy, " Charcot's arthritis in colitis and some cases of hypertrophic pulmonary osteo-arthropathy are often looked upon as the result of an invasion by an infective agent, from an ulcerated colon or from a suppurating vomica in a lung.

It is correct nowadays also to lay stress upon auto-intoxication from the intestines as the cause of the gouty form, although the links in the chain of evidence are far from being complete, and it is still held by many that gouty arthritis represents an example of a condition not dependent upon infection from within or without but upon a disorder of the normal metabolism.

When we consider infective arthritis we cannot fail to see how prominent a part the infective agent takes in giving to it its peculiar stamp. Thus the ordinary form of tubercular arthritis is very different from the severe suppurative arthritis or the more transient rheumatic inflammation, and although there are exceptional cases in all these infections, we must judge of their usual effects from the common form.

Again, if we consider for a moment an arthritis resulting from rheumatic fever and an arthritis resulting from a virulent streptococcal infection, we see how in one case the general toxæmia, and in the other the local lesion comes into prominence.

The Synovial Membrane and Exudation.

It is very essential in a study of arthritis, to remember all the constituents of a joint; the synovial fluid, the synovial membrane, capsule, ligaments, bursæ, cartilages, bones, and muscles in the neighbourhood, for disease may attack them all. There is, as can be imagined, considerable difficulty in discovering with exactitude in which structure the process commences, but so far as the infective forms are concerned, the balance of evidence points to the *synovial membrane* as the starting-point in the majority of instances. The vascular supply is very considerable, and a synovial membrane in a condition of acute rheumatic inflammation demonstrates convincingly the great injection of the blood-vessels that occurs.

If the infective agent has invaded the system from some distant point—from the tonsil, for example—it is carried into the terminal capillaries by the blood stream, and, escaping, finds itself in the retiform tissue of the membrane. Anatomists point out that the synovial membranes have no perfect endothelial lining as have the pleura, pericardium, and other serous membranes, but it has always appeared to me that there is a superficial cellular layer under which the connective tissue is more retiform than elsewhere. These cells are phagocytic, and from the blood-vessels escape numerous polynuclear leucocytes which aid in destroying the bacteria. These facts seem to explain very reasonably the great difficulty there may be in demonstrating the bacteria in the synovial fluid. It is a difficulty which is prominent in acute rheumatism, but which was well recognised before this as occurring in gonorrhœal and tubercular arthritis. An increase in the synovial fluid is a very frequent and rapid response to many joint lesions, whether by bacterial infection or by mechanical injury; but an increase in the

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(*a*) Lecture delivered at University College Hospital, London.

synovial fluid need not by any means imply that you will find numerous bacteria in that fluid. This fluid in any acute inflammation soon contains numerous leucocytes, which continue the bacterial destruction so active in the synovial membrane, and Dr. Seligmann has also brought forward some interesting points bearing upon the inhibitory action of some synovial exudations upon bacterial life—a point to which I shall again allude later. Moreover, this difficulty in demonstrating bacteria in the synovial fluid is not peculiar to human arthritis. In experimental arthritis also, it is sometimes surprisingly difficult to demonstrate the bacteria in the acute early condition or in the chronic forms, and you may meet with repeated failures. You may also meet with an exudation in which you see a few bacteria either free or in the polynuclear leucocytes, and yet the culture may be negative. I think, then, the interpretation is that these bacteria are living, or rather dying hard in a hostile fluid, and cannot rally even if put in a suitable medium outside the body.

The bacteriological results in arthritis are then uncertain, except in those particularly virulent types in which the bacteria overcome the resisting cells, destroy them, and escape into the synovial fluid destroying in that fluid also the protective cells, see fig. 1.

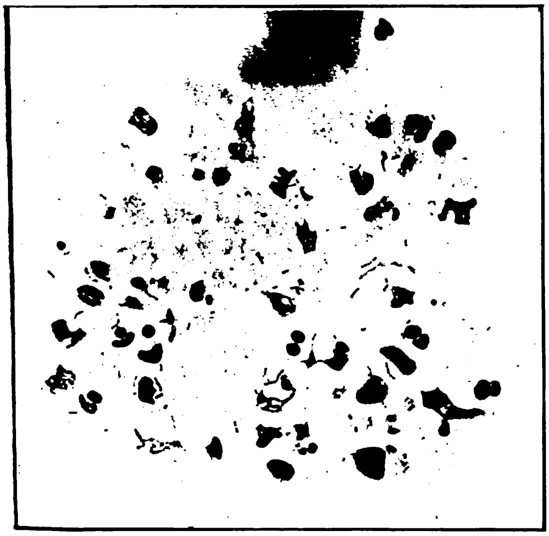


FIG. 1.

Synovial Fluid (Streptococcal Arthritis). The streptococci are present in large numbers in the exudation, and the cellular elements have been destroyed by their toxines.

When the struggle has been a severe one the condition is called suppurative arthritis, yet it must be clearly understood that this is not the most virulent toxic process. Even more virulent is that in which there is an absence of cellular reaction—dependent, as Sir A. Wright's researches tend to show, upon a deficient opsonic power in the blood—and the bacteria may then multiply in a fluid which may be almost clear. It will be readily understood from these remarks that the synovial fluid is not such a plain guide to the cause of arthritis as might at first sight be thought. It will, I think, also be clear that the correct way to study the synovial fluid in arthritis is to give as accurate an account as possible of its constituents. Such words as "septic" and "pus" are now no longer really helpful. It is not the dead cells in the pus that are harmful, but the victorious bacteria and their poisons, and as I have already mentioned, a clear fluid may mean exceeding virulence. The study of rheumatism has, in fact, been made more difficult by the rigid statement that suppuration does not occur in that disease. This gives the impression that some particular specific process, viz., suppuration, does not occur. Yet suppuration is not a rigid entity. It is on the contrary a phase of reaction to many different infections, and there are all sorts of kinds and degrees of suppuration. Among these I recognise a rheumatic suppuration, but quite admit that in rheumatic fever you do not see a staphylococcus or pneumococcus suppuration because the disease is a special disease and not the result of either of these infections.

Another cardinal point in the study of arthritis is a recognition of the fact that the great infective diseases, such as tuberculosis rheumatism, pyæmic infections and gonorrhœal infections, each and all run through various stages, one stage is more usual in one, another in another, but occasions arise in which you can trace all the stages in each disease. Take tuberculosis, for instance. Chronic tubercular disease of a joint is among the best known of tubercular lesions, but there also occur acute transitory forms of tubercular arthritis. These, so well studied by Poncet, of Lyons, have been most unfortunately named tubercular rheumatism. Yet they are not rheumatic at all but acute tubercular arthritis, and are only called rheumatic under the mistaken impression that rheumatic inflammations are always transitory.

Take rheumatism next. The most usual form of rheumatic arthritis is an acute transient process, but it would be a great mistake to think this was invariable, the contrary, indeed, is sometimes most convincingly illustrated in an acute attack. In such an attack one joint may remain most obstinately inflamed, and both bone and cartilage may be damaged, and yet the process be undoubtedly rheumatic. The ankle joint is in my experience the one most liable to differ in this way.

As a third example instance pyæmic arthritis. The characteristic condition is a suppurative one, but often one joint or possibly more will be found to contain a clear fluid. In other words the usual course of the infection is a more virulent one than that of rheumatism, and yet a transient arthritis may occur in one or other joint simultaneously with the usual suppurative arthritis.

Are we to consider the various stages in these various infections, the stage of clear effusion, for example, to mean that these fluids in the different diseases identical in nature? It would surely be a great mistake to adopt that view, and yet it is often done. The clear stage is called rheumatic, and the purulent is called septic, as if all the clear and all the suppurative processes were identical in the different diseases.

There are other conditions of the synovial exudation in arthritis which are not so well understood in part because they are not so often seen. One of these is a thick glairy exudation, which resembles unboiled white of egg. This may give rise to a very deceitful sense of fluctuation, and yet if the joint is aspirated this fluid is so thick that none of it can be got away. Such a condition is met with in the severer forms of arthritis of the rheumatoid type—as in gonorrhœal arthritis—and it may be associated with a gelatinous periarticular swelling—such cases are very troublesome and chronic.

In Charcot's disease of the joints, a condition of great scientific importance, an immense quantity of viscid fluid may be obtained from the joint. These fluids have been in my experience always sterile.

Dr. Seligmann has recently made some interesting investigations upon this curious viscid exudation obtained from tabetic joints.

He has found that it has a remarkable inhibitory effect upon bacterial growth, which he attributes to the viscid nature of the fluid rather than to any particular chemical property. In hæmophilia there may be a hæmorrhage into the joint cavity, and although one might think the sinious fluid would not do harm, it does, nevertheless, sometimes give rise to severe destructive lesions in the joint, of the type of a rheumatoid arthritis.

Gouty arthritis is characterised in some instances by an exudation which is opaque with enormous numbers of acicular crystals of biurate of soda. It is very tempting to ascribe the severe pain of gouty arthritis to the deposition of these crystals, but I think this is unlikely, for these crystals are deposited in such minute atoms that even with an object lens of $^1/_{12}$ Leiss and an high eye piece, the magnification is not sufficient for seeing the commencement of their formation. The minute size of these crystals makes me think that the pain in gouty arthritis is more probably to be explained by the sharp reaction in the gouty inflammatory processes than by the mechanical deposition of the crystals.

Joint Capsule and Ligaments.

Leaving now the subject of the synovial exudations, the next structures are the capsules and ligaments.

In acute arthritis, when the attack is a severe one, these become infiltrated with cellular and serous exudation, and their tissues thus become softened. There is considerable importance to be attached to the diagnosis, between periarticular and intra-articular swelling. The distinction is generally simple, for fluctuation is more perfect in intra-articular swelling and the outlines of the joint are more clearly mapped out. Periarticular swelling, on the other hand, is a more inveterate process. Slower in subsiding, and, therefore, more damaging to the stability of the joint.

Deformities of the most remarkable kind may, as you are aware, result from subacute and severe arthritis, and one factor in these deformities is this damage to the ligaments, for when softened they allow the powerful muscles to pull the articulating surfaces out of place and this danger becomes the more probable because the joints are often habitually flexed or extended by the patient on account of the pain.

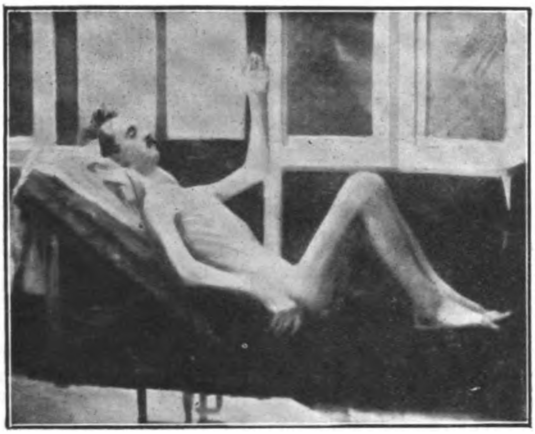


Fig. 2.

Severe Rheumatoid Arthritis, illustrating fixation of the joints in faulty positions.

The condition of the blood vessels in the capsule and the synovial membrane is also of interest. In these protracted cases there is a perivascular cellular exudation and later a perivascular fibrosis which interferes with the circulation in these structures and thus impairs the recuperative power.

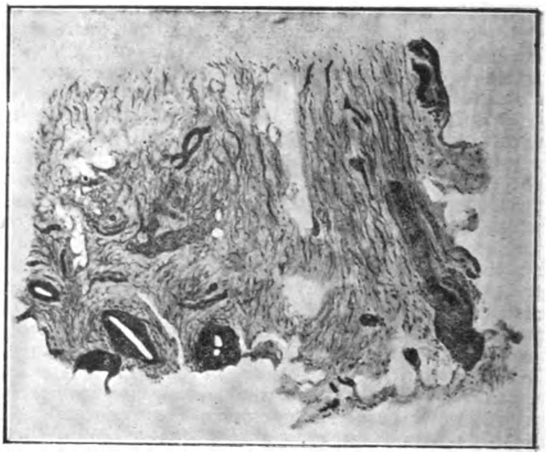
The process of damage does not even end here, for though the softened ligaments may heal, in healing they become scarred and shortened.

At all risks then, in spite of causing pain and suffering to the patient, every effort must be made to prevent this process of contraction in its early stages. Yet how difficult it may sometimes be to do this those who have to deal with them can only realise.

Much in the practical treatment of arthritis turns upon a thorough knowledge of the changes that occur in the ligaments, and serious results may occur from an imperfect acquaintance with these changes.

If, for instance, the weight of the body is thrown upon the feet when the tarsal and metatarsal ligaments are still softened by inflammation, painful flat foot may occur, or the joints may be so strained as to remain for a long time and perhaps permanently insecure.

When these structures have been much swollen and softened there will frequently be a history of much pain and stiffness in joints, lasting for a long time after the acute illness is over, and much of the success obtained at hydropathic centres depends upon the vigorous, methodical, and industrious stimulation of these structures during their convalescence.



F

A section through a part of the synovial membrane from a case of chronic rheumatoid arthritis, showing perivascular phrosis and consequent ischœmia.

The internal ligaments of the joints should be remembered, for they suffer in the same manner as do the external. An example of this would be the crucial ligaments of the knee-joint upon whose integrity depends so greatly the prevention of that backward displacement of the tibia which is so serious an occurrence.

The Cartilages.

The cartilages next require consideration. They have much wear and tear and on this account illustrate excellently the necessity there is for taking a broad view of our subject. There can be no doubt that this wear and tear tells upon even healthy cartilage when its possessor has passed many years in laborious employment, and so an arthritis in the elderly is much more liable to be accompanied by some damage to the cartilage than

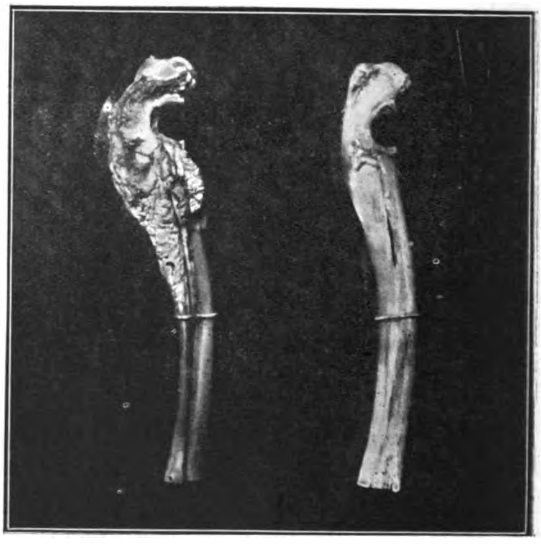


Fig. 4.

"Guttering" of bone produced by a chronic arthritis, the result of intravenous inoculation into a rabbit of the diplococcus rheumaticus.

it is in early life. The old joint throws off arthritis with more difficulty than the young joint does, and without claiming any specific process this very chronicity encourages damage to the cartilage.

Osteo-arthritis is a form in which changes in the cartilage are particularly liable to occur, and it has been thought that the process actually commences in these structures. The truth of this, however, is doubtful, yet it has a decided bearing upon the pathology of the process. If the cartilage is really damaged, the first of all the structures, it hardly looks as if these osteo-arthritic changes could be the result of an infection, for then the synovial membrane would be the first seat of damage. If on the other hand it is a disease of disturbed metabolism, it might well be that the cartilages were the first structures to degenerate. I would add that it is possible to produce changes in cartilage and a condition of joints resembling osteo-arthritis by experimental inoculations of the diplococcus rheumaticus into the veins of rabbits. Whether these changes are comparable to human osteo-arthritis it is, of course, most difficult to say, but they have also been produced by a micrococcus isolated by Dr. Paine from the knee-joint of a case of osteo-arthritis, which is an exceedingly interesting fact. Such results as these naturally incline one to think that although the first visible changes may occur in the cartilages the real commencement of the process in rheumatoid arthritis is in the synovial membrane, and lead us to believe that such rheumatoid arthritis is infective. Sometimes in chronic severe arthritis, small pieces of cartilage are separated and lie in the joint as foreign bodies. Here doubtless the difficult and laborious movements that are results of severe arthritis introduce a traumatic element which must be taken into account with the disease itself.

The presence of biurate of sodium in the cartilage of gouty arthritis is one of the landmarks in the study of arthritis. The drift of the disputes that rage around it can be easily explained.

Are these crystals the cause or the effect of the inflammation? Sir Alfred Garrod aud many authorities maintain they are the cause. There are others who think they are the effect. It has seemed to me that they are the effect and not the cause.

The biurate of sodium is located in and not on the cartilage, and I think there must first of all be change in the cartilage as Ebstein and others have maintained. In this change, delicate though it must be, it seems very possible that biurate of sodium is formed, and that it is not deposited from the fluid in the joint.

It has been noticed in gout that where the vascular synovial membrane is attached to the larger cartilages as in the knee joint, these are blood vessels which pass into the cartilage for a short distance, and in these positions biurate of soda is often present only in minute quantities. Many years ago Dr. W. Budd spoke of the urate avoiding this part of the cartilage, but recent investigations seem to me to point to another explanation. If biurate of soda is placed under the skin of animals crystals are found in the leucocytes in the neighbourhood, crystals that have been taken up as are other foreign bodies by these cells. Very possibly then the same process takes place round the margin of the cartilage in gout, and hence this relative freedom of that part of it from the crystals, depends on the blood vessels in the synovial fringe providing leucocytes which take up the crystals.

There does not seem to be anything about this presence of biurate of soda in the cartilages which negatives the possibility of some infective process starting the arthritis, and the gouty nature of the patient determining the formation of the crystals. Yet I think that if we accepted that infective processes may produce gouty arthritis and other gouty phenomena, we still do not explain in any way the *gouty disposition*, which is the chief feature of that remarkable disease.

THE BONES.

Taking the bones next. The changes differ in nature in different types of arthritis. The severe streptococcus and pyæmic infections destroy the cartilages and continue the eroding process in the bones. The severe and subacute processes, those that is to say of the rheumatoid type, also soften the bone with the result that it becomes eroded, and in addition they may induce formative processes where there is no pressure which give rise to bony outgrowths or osteophytes. Mechanical movement takes a part in causing further changes, for it is the duty of the cartilages to cope with the wear and tear of friction, but when they are destroyed the bony surfaces coming in contact are in course of time worn smooth, and the opposing surfaces become later eburnated.

When, however, the patient is bed-ridden for many years, and the arthritis exceedingly chronic, the bones atrophy from disuse and their ends become softened by the continual disease and rendered porous, so that a slight injury will produce a fracture, and if the fracture is into the joint much oily material may escape into the articulation.

A good deal of attention has been directed lately to the rarefying osteitis which occurs in rheumatoid arthritis, for even in an early stage it can be detected by the X-Rays. Nevertheless I should not lay too much stress upon these appearances as pathognomonic of a disease rheumatoid arthritis, but rather look upon them as indications of a rheumatoid type of arthritis, which may be produced by various causes, some unknown, others well known—as the gonorrhœal and some tubercular forms of arthritis.

The X-Rays again are very valuable in giving help in those cases in which a joint is stiff, and there is a doubt as to the exact explanation of the stiffness. It is essential to know whether it is due to periarticular change and muscular spasm or to fibrous ankylosis, or again to synostosis, for these questions must be answered before attempting any drastic measures for rendering a joint mobile. Recently a woman came in with her left elbow quite stiff. She had been a terrible sufferer from rheumatoid arthritis, and the X-Rays showed complete synostosis.

On the other hand a little girl came to me at the children's hospital with her right wrist joint immovable, and the photograph showed that this was the result of muscular spasm and periarticular fibrosis. In her case careful massage was indicated.

In "Charcot's joint" the destruction of bone is a very remarkable feature, and clearly points to a great lack of resistance. In spite of the failure to find any micro-organism and of the interesting observations of Dr. Seligmann, I incline to the belief that there must be some infective agent at work at some time or another in this affection, for it is just sufficiently rare an occurrence in tabes to make one think there must be some factor superadded to the primary nervous degeneration.

In gout the bony changes are not usually so extensive as in the rheumatoid conditions. Yet in chronic gout synostosis has been noted in some of the joints that have suffered very severely from the gouty inflammation—as, for example, in the metatarso-phalangeal joint of the great toe.

The bursae in the neighbourhood of gouty joints are sometimes much enlarged, the olecranon bursa is the most commonly affected, and may reach a large size and become distended with a white fluid containing innumerable crystals of biurate of soda.

BURSAE.

Passing notice must be given to Morrant Baker's cysts, which are herniæ of the synovial membrane of joints, particularly of the knee joint.

Chronic arthritis, due to tuberculosis or the rheumatoid form, may by causing chronic overdistension of the synovial cavity, thus produce these cysts.

MUSCULAR ATROPHY.

Muscular atrophy and spasm are results of severe arthritis. It is in rheumatoid arthritis that this muscular wasting is most pronounced. This wasting is not a slow process, as is the atrophy of disease, but a rapid one, and sometimes a fibrillary twitching is noticeable in the atrophied muscles. Again the atrophy is not localised to that part of the muscle near the inflamed articulation, but affects the entire muscle.

This wasting is usually associated with great myotetic irritability, and sometimes with fibrillary tremor. Triboulet has demonstrated changes in the anterior cervical cells of the cord in one such case. In some cases there is much muscular spasm, which may be so extreme as to cause the greatest suffering on any attempt at movement.

This concludes my lecture, and I hope that I have made it clear to you that there is an immense amount to be learnt and studied, with regard to arthritis, even putting aside the most important of all points, that of treatment, with which time precludes my dealing.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Arthur J. Whiting, M.D., M.R.C.P.Lond., Dean of the North-East London Post-Graduate College, Physician to the Tottenham Hospital, and to the Mount Vernon Hospital for Consumption and Diseases of the Chest, on "Acroparaæsthesia."*

CLINICAL LECTURES.

The following Lectures recently delivered are in hand, and will appear in these columns in due course. Those received from the Lecturers are hereby acknowledged with thanks. The others have been specially reported for this journal:—

Carter, Wm., M.D., F.R.C.P., LL.D.Lond., Senior Physician to the Liverpool Royal Southern Hospital, Professor of Therapeutics in the University of Liverpool. Subject: "Some Cases of Nervous Disease."

Giles, Arthur E., M.D., B.Sc.Lond., F.R.C.S.E., Surgeon to the Chelsea Hospital for Women, Gynæcologist to the Tottenham Hospital. Subject: "Developments and Dangers of Extra-Uterine Pregnancy," with illustrations.

Ormsby, Sir Lambert H., M.D., F.R.C.S., Senior Surgeon to the Meath Hospital, and to the National Children's Hospital, Dublin. Subject: "The Study of Diseases Peculiar to Children."

Palmer, Fred. S., M.D., M.R.C.P.Lond., Physician to the West End Hospital for Diseases of the Nervous System. Subject: "Friedreich's Ataxia."

Paton, E. Percy, M.S., F.R.C.S., Surgeon-in-Charge of Out-patients, Westminster Hospital, and Dean of the Medical School. Subject: "Some Observations on Intra-Abdominal Adhesions," with illustrative cases.

John Poland, F.R.C.S., Surgeon to the City Orthopædic and the Miller Hospitals. Subject: "The Use and Abuse of Skiagraphy in Fractures and Dislocations."

Raymond, F., Professor to the Faculty of Medicine, Physician to the Salpêtrière Hospital, Paris. Subject: "Abortive Forms of Tabes."

Savage, Geo. H., M.D., F.R.C.P.Lond., Consulting Physician to, and Lecturer on Mental Diseases at Guy's Hospital, Examiner in Mental Pathology, University of London. Subject: "The More Recent Treatment of the Insane."

Smith, Alfred J., M.D., M.Ch., F.R.C.S.I., Professor of Midwifery and Diseases of Women, Examiner in Midwifery, Royal University, Ireland, Gynæcologist to St. Vincent's Hospital. Subject: "Climateric Floodings," with illustrations.

Stewart, Purves, M.D., F.R.C.P.Lond., Physician to the Westminster Hospital and to the Royal National Orthopædic Hospital. Subject: "Disorders of Sleep."

Williams, Leonard B., M.D., M.R.C.P.Lond., Physician to the French Hospital, London, Assistant Physician to the Metropolitan Hospital. Subject: "Some of the Organic Consequences of High Blood Pressure."

Whiting, Arthur J., M.D., M.R.C.P.Lond., Physician to the Tottenham Hospital and to the Mount Vernon Hospital for Diseases of the Chest. Subject: "Acroparæsthesia."

ORIGINAL PAPERS.

THE REARING OF CHILDREN. (*a*)

By GEORGE CARPENTER, M.D.Lond., M.R.C.P.,
Physician to the North-East London Hospital for Children; Membre Correspondant de la Société de Pédiatrie de Paris, &c., &c.

The lecturer, in his introductory remarks, said that although four words were ample for the title of the subject, yet an hour was not sufficient time to do it justice, because it comprised the whole life history of the child, and was a vastly important one, not only to the individual, but to the nation.

He emphasized the advantages to the infant in the possession of a good heritage, physical as well as mental, on which to erect the superstructure—body. He thought it was a subject for discussion whether certain individuals—the tuberculous, the syphilitic, the alcoholic, and the degenerate—should procreate. The importance of safeguarding the material health during the pregnancy was insisted upon. He looked upon breast-feeding as the dietetic foundation-stone, and he advocated the popularizing of this function. The causes which tended to prevent this should be studied, and he looked upon the provision of food and funds to needy mothers to enable them to carry out these duties as all-important. He strongly urged mothers not to use proprietary foods for rearing infants. Failing breast-feeding, he advocated unboiled, clean, unadulterated, and tuberculous-free cow's milk, suitably diluted with water. The failure of the Legislature to assist the Public Health Authorities by the enactment of fresh laws controlling the supply to the public of a pure, unadulterated, tuberculous-free article was explained to the audience. The present unsatisfactory state of the milk trade as a public necessity, and the wholly unsatisfactory way in which milch cows are kept and milked, were also described. The Walker-Gordon Dairy Farm at Sudbury was an admirable institution, and should be imitated throughout the kingdom. Untold infant lives were, he said, sacrificed to the Demon Dirt, and the health and physique of innumerable others seriously undermined.

The diet of children at the first, second, and third years of life was gone into at length. The lecturer explained that cow's milk was still to be the standby. It was by degrees to be taken less and less diluted until it could be digested whole. During this period the motions are to be watched, and if there be curds in them further dilution is necessary.

He advocated a varied diet and the avoidance of sameness in meals. Oatmeal he considered an excellent food, which is well borne by most children. Children should be allowed water to drink between meals, but should not be given milk to quench their thirst.

Meals should be served punctually. A poor breakfast was not to be followed by an enormous lunch, and children must not be allowed to be capricious. All overloading of the stomach was to be avoided, as that was a sure way to produce chronic indigestion and its attendant evils.

Children's meals must be presided over. Some children are inveterate food bolters, while others contract the habit of dawdling; both tricks are bad, the former especially so. Dawdling over meals is not to be confounded with loss of appetite. Children must not be allowed to become fanciful; they must be made to eat what is placed before them without a murmur. Many a fight has to be fought out to a finish at the nursery table, and parents are not to be alarmed if a bad-tempered child holds its breath with rage and goes blue in the face. The child must not have its way because the mother or nurse imagines it is going to have a fit; nothing of the sort will happen. But if they be frightened by such appearances, and if they relent, worse unpleasantnesses are

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(*a*) Abstract of Lecture delivered at the Incorporated Institute of Hygiene, Devonshire Street, W., on Wednesday, Feb. 20th, 1907.

in store for them; the child has gained a great moral victory. Mothers are advised to gain the mastery at the outset. Nor is a mother to be alarmed if a child becomes periodically sick after certain articles of diet which do not happen to please its palate. This is another childish trick which has to be nipped in the bud.

Fads and freaks about food are not to be encouraged. Little pitchers have long ears, and often remarks on the subject of diet are overheard by, though not intended for, baby brains, but which, nevertheless, make a strong impression upon them. These little eavesdroppers then become "picksome" and troublesome about their meals. A healthy child has no business to take a dislike to any wholesome article of diet; if it does, that is the fault of the mother or the nurse. A child that cannot take milk according to its mother is frequently found to digest it well enough in the hospital or private nursing-home. Children must not be encouraged to over-eat. The craving for the repetition of a helping because it is appetising must be discouraged, though hunger must be appeased. The enforcement of discipline at the nursery table is not only of educational value to the stomach, but is a very fine moral and social training for the child.

Simple sweets may be allowed in small quantities, and as a reward for good conduct; but they should never be offered as bribes. Children who are perpetually stuffing sweets, who are fed to repletion on a variety of good things at all times and at all seasons, are a horrid exhibition of parental incapacity and folly. This is a sure way to bring about disease. Bowel troubles with an enlarged abdomen, foul-smelling motions, nervous instability, and all those objectionable mental and bodily characteristics which denote the spoilt child arise from such indulgences.

To rear children properly the lecturer insisted upon the necessity for fresh air and plenty of it. Simple instructions were given for ventilating and furnishing the nurseries.

Children require at least 1,500 cubic feet of air per hour, and they are better with 3,000 cubic feet.

Carpets in the nursery are most objectionable. Skirting boards and picture rails act as dust-traps. Gas should never be used in the nursery, and burning a light at night is unnecessary and harmful. Adults and children should not occupy the same bedrooms; exhalations from the lungs of adults poisoned the atmosphere, and made the children anæmic and inert. It is necessary to have ventilation both day and night, and he advocated the top sashes of windows being opened to ensure this.

A suitable temperature at which to maintain the day nursery is 60° F., and the night nursery, 55° F.

All sanitary conveniences are best on the same floor as the nurseries, but separated from them by either a room or a passage. The sanitary fittings should be of a high order, and they require periodical inspection to ensure efficiency. He drew attention to the want of care exercised in regard to the traps, even in cases where the closet-pans are kept scrupulously clean. He objected to the bath-room and the closet being contained in one compartment. Details were given in regard to the fitting out of both closets and bathrooms, and he advocated the bath being placed in the centre of the room, or, at least, away from the wall, so that it could be readily kept clean, and, at the same time, be more get-atable for bathing purposes. He drew attention to the importance of having closet seats of the right size and of the right height from the floor. Allowing a child's legs to dangle when at stool is a sure way to produce constipation; the feet should always rest on the floor during the act.

Evacuations and soiled diapers are not to be kept in the nursery. They should be removed at once to the closet and be dealt with there.

Sleep, the lecturer said, is the most important feature of a child's life. Training to sleep should commence at birth and the infant should be placed in its cot immediately after feeding without rocking. It must not be allowed to sleep at the breast or with the teat in its mouth. He said that if an infant does not sleep naturally either its napkins are wet and require to be changed, or its clothing is moist with perspiration, and it is uncomfortable. If artificially fed the infant possibly has stomach ache, and if it be breast-fed it is very possibly hungry.

The long sleep of infants should take place between 11 p.m. and 5 a.m., so as to give the mother or nurse a good night's rest, and at the fifth month the time can be extended from 10 p.m. to 7 a.m.

Regularity of sleep for the young is as important as regularity of meals. Children require twelve hours' sleep at night and an hour or two in the middle of the day in addition. The child who is allowed to sit up night after night until 9 and 10 o'clock or longer, fails in health, becomes irritable, peevish, and bloodless, and a nuisance to himself and to others. When asleep, change of position is desirable, and children are to be accustomed to sleeping on their backs and on either side alternately.

Exercise is all important for the enjoyment of a healthy and vigorous childhood, and be it wet or fine, the daily walk must not be omitted.

East winds and north-easterly winds brace the vigorous child, though for the weakly they are not beneficial. In their cases it is necessary to temper the wind to the shorn lamb, and not to be too Spartan in one's methods. But while keeping this latter in view, mothers must beware of the opposite extreme—that of coddling.

Infants in arms should in summer be taken out of doors in the nurse's arms a few days after birth, though in winter time it is advisable not to be in too great a hurry to face the elements.

Infants require daily exercise for their limbs and bodies to keep them in good health. They should be placed on the bed in a loose garment and be encouraged to kick their legs and throw their arms about and wriggle their bodies. Even crying has its uses as an exercise for the heart, the lungs, and the chest muscles. It is not wise to try to make an infant walk because its mother thinks the right time has arrived for it to acquire that accomplishment.

If it is late in learning to walk, or, if having attempted to walk, it abandons the attempt, there is probably some physical cause underlying this inability in the shape of commencing rickets. He advocated the prevention of assuming faulty positions either at play or at their exercises.

Girls, if learning to ride side-saddle are to be placed first on one side of the pony then on the other. He was in favour of teaching children to be both-handed; there are many reasons why they should be taught to be ambidexterous.

The lecturer said the object of clothing was to protect the child from the inclemencies of the weather, and to keep the skin at an equable temperature, so that the internal organs are not flooded with blood. Clothing should be loose so as not to constrict the limbs, and restrain the free use of the muscles or hinder the passage of blood to and from the limbs. So, too, the chest and the abdomen require free play, otherwise the heart and lungs are hampered in their working. There must be no girdles; petticoats should be slung from the shoulders, and stockings should be supported by suspenders. Woollen garments should be worn next to the skin except by those who suffer from skin irritation. These children should be given silk or linen or Anglo-Indian gauze underwear and be clothed in woollen overalls.

Bare legs and knees and bare arms and bare chests are hurtful to the young.

Children are to be clad according to the state of the weather and not according to the time of the year. Fashion should not be allowed to dictate the choice of clothing; health should be the sole consideration.

Children must not be overloaded with clothes at nighttime; restless nights ensue.

Footwear was the next consideration. He advocated shoes for children—the shape of the child's foot. Boots are only to be worn under medical advice for flat feet and weak ankles. He explained to the audience the importance of not allowing the toes to be cramped together by the use of pointed shoes. Not only do such deformities arise but hammer-toes are thus made, and the big toes are thrown out of the straight and bunions form on them later on in life. He advised mothers to accustom themselves to periodically pinch the toes of their children's shoes to see that they are not being worn too short. He told them that heels and soles worn down to one side denoted weak ankles, and the doctor should be consulted. The toenails also require special attention; the nails are to be cut square, and not rounded.

Bathing is very important. There are some children who cannot tolerate cold sponging — sometimes even tub-bathing. There is no reaction; their faces become pale and their extremities cold and they are miserable and wretched for a long time after. The skin to act well must be kept in good order. There are certain cutaneous areas that require special attention, such as the prepuce. The indications for circumcision and the necessity for cleanliness of this part were clearly laid down. Not only is it necessary to keep the skin clean, but the teeth must not be neglected. Regular use of the toothbrush and periodical visits to the dentist are necessary for health's sake. Carious temporary teeth often infect the oncoming permanent set, and they must be stopped or removed. Not only are carious teeth injurious for this reason, but they lay the seeds of dyspeptic troubles, and they cause a good deal of suffering.

In regard to amusements, the lecturer said the golden rule is, never to select an indoor game if it be possible to obtain an outdoor one. He warned parents to be careful in their selection of toys and not to provide those which are likely to damage the children or their playmates. But although the number and variety of toys at the disposal of the well-to-do modern child is legion, the lecturer doubted whether the pampered minority are happier than the rustic infant making mud-pies and playing with a bundle of sticks in the precincts of the parental cottage.

No distinction should be made between the amusements provided for girls and boys. Children's lungs and limbs require exercise and those games of skill which train the hand and eye to work in unison are admirable for them. Skipping is splendid exercise for both sexes. Children at play are not to be worried about their clothes; a cotton smock-frock or overall will protect these, and make their wearers feel that they are armour-plated against a scolding.

"Nagging" is calculated to spoil a child's temper, and is a thing to be avoided. The lecturer considered the selection of a nurse a most important event in the training of children. While the mother ought herself to be the head nurse, there are numerous occasions on which the nurse must take the sole command. Mothers who devoted their lives to their social engagements instead of looking after their offspring, are not doing their duty to their children or their country.

He pointed out the attributes of a good nurse both in regard to her physical health and her moral attributes. Children are born imitators; they quickly learn both good and bad habits—the latter especially—and it is therefore very important for a mother to select the right woman. A nurse's duties are not confined to keeping her charges clean and taking them out for a walk, but she has to train them also and in addition look after their health and their happiness. The acquirement of nice habits and manners, of self-control and of many other attributes of polite society, should be learned in the nursery. To be always with children is very trying to the nervous system, and to get the full value out of a good nurse it is necessary for her to have regular off-duty periods.

Education, the lecturer reminded his audience, is not the least important feature of the rearing of children. The infant, he said, is born with certain characteristics, viz., those which he inherits from our common ancestry through remote ages and those which he has acquired from his parents and forefathers. When born into the world, other forces come into play, chief among them being the *personalities* of the mother and the nurse and training. By training it is possible to curb and eradicate the inherited bad traits and to foster and accentuate the good. It is by training that early control over the evacuations is acquired, regularity in meals and in sleep are learned, and subjugation of the desires by the will and the habits of self-control are mastered. An uninterested mother and a slovenly and irresponsible nurse cannot be expected to rear healthy children. Nor will foolish and over-indulgent parents who wait on their offspring hand and foot, produce satisfactory specimens of humanity. That is the way to grow neurotic boys and girls without a particle of self-control.

For normal healthy development of the higher nerve centres there must be quiet and an absence of all excitement and undue stimulation. It should be brought home to the masses that the early training of the child is all-important, that the child's nervous system is as clay in the hands of the potter. The production depends very much on the individual skill of the artificer.

Many of life's failures owe their want of success not so much to themselves or to their heredity as to their unfortunate early environment and to the failure of their parents and their trainers to do their duty by them.

On the other hand, many of life's successes are fashioned in the nursery owing to maternal strivings faithfully and well performed.

REMARKS ON THE POLICY WITH REGARD TO
TUBERCULOSIS,
OUTLINED IN THE REPORT OF THE VICE-REGAL POOR-LAW COMMISSION. (a)

By E. J. McWEENEY, M.A., M.D., [R.U.I.]; D.P.H. [Irel. Conj.], F.R.C.P.I.

Were my audience what is known as a "popular" one, my task to-night would be simple indeed. But such is not the case. I am addressing an assemblage of experts who are familiar with the reasons that have guided the Commissioners in framing their recommendations regarding tuberculosis, and there is accordingly no need for explanation or defence. There is left to me either criticism or what I may term "completion." For the former there is little occasion. The recommendations of the Commission are moderate, well grounded and carefully thought-out. By way of completion, I may be permitted to refer to some general aspects of the tuberculosis question, and to some of the consequences which the introduction o rate-aided sanatoria would entail.

First of all, I would like to say a word about the prevalence of tuberculosis in Ireland. In par. 102 of the Report the decrease of tuberculosis in England and its increase in Ireland are mentioned. Whilst in no wise desirous of minimising the urgency of the question, I think that the use of the word "increase" may be deprecated. The last year for which statistics are available, 1905, shows a drop of 2 (per 10,000 living) and the variation during the past forty-one years lies within the narrow limit of 5. The tuberculosis mortality in 1867 was only 1 less than it was in 1905, and that of 1880 was equal to that of 1904—the highest recorded.

What really does seem to be happening is that in the Sister Isle, the mortality from this cause is coming down by leaps and bounds, whereas in Ireland no such diminution is perceptible.

As regards the cause of this difference in the behaviour of the disease in two countries, the Commissioners are no doubt right when they say that *on our side* it is due to our not doing anything, whilst on the English side it is due to a number of changes, among which may be cited improved housing of the working class, an increasingly high standard of food and general comfort among them, and the State-regulation of dust-producing industries. Moreover they have whole-time County Medical Health-Officers who, supported as they are by public opinion, can afford to act independently of individual interests, and can accomplish much more than even the most energetic Dispensary Medical Officer in Ireland, confronted as he is with the risk of losing his popularity or imperilling his very livelihood, in the exercise of the powers with which he is invested. Whilst in no way depreciating the value of the improvements just mentioned, it is only fair to draw attention to the surprising conclusion lately arrived at by that eminent statistician, Dr. Newsholme, of Brighton, and communicated by him to the Epidemiological Society a few months ago. After an elaborate survey of all the facts and figures obtainable Dr. Newsholme concludes that the really operative factor in the decrease of the tuberculosis mortality in England is—not the several above-mentioned or any cognate improvements, but the *increased institutional segregation* of consumptives. If this be so, then a new and most powerful argument is furnished for putting into force the Commission's recommendations.

(a) Paper read before the State Medicine Section of the Royal Academy of Medicine, in Ireland on Friday, February 8th, 1907.

Turning now to the oft-debated question, "Is the sanatorium worth while?"—a question to which just now it is very important to know the correct answer, in view of the fact that here in Dublin this very week an inquiry is being held by the Local Government Board to determine whether the Local Sanitary Authorities are justified in co-operating in the establishment of a rate-aided sanatorium—I have no hesitation in declaring my belief in the efficiency of these institutions for the real as well as the economic cure of suitable cases. Let me give a few figures. From Dr. Noel Bardswell's interesting little book entitled "The Consumptive Working-Man—What can Sanatoria do for him?" (*a*) I find that 42 per cent. of all cases recover and keep their full working power for several years after discharge. The figures relating to the consumptive employés of St. James's Gate Brewery, who have been treated at the Newcastle Sanatorium, Co. Wicklow, show that about 41 per cent. are still able to work three or four years after discharge. They are classified into "early" and "advanced." and I am inclined to suppose that a somewhat large proportion of these cases were fairly advanced before entering the sanatorium.

I am under the impression, indeed, that in this country the treatment is not begun early enough to yield the best results. With increased sanatorium accommodation, and increased attention on the part of clinicians to diagnose before the bacilli appear in the sputum, I have no doubt whatever that British all-case statistics might be brought up to the highly satisfactory level attained in Germany. As an instance of what is being accomplished there, let me quote the results set forth in my recent Tuberculosis Report to the Local Government Board, as having been achieved at the Sanatoria maintained by the Hanse-Towns Workmen's Insurance Society:—

Year.	Number treated	Percentage capable of full amount of work at commencement of 1904.
1895	56	45.5
1896	146	61.2
1897	208	59.2
1898	251	53.7
1899	306	55.7
1900	296	61.0
1901	215	57.6
1902	175	65.5

These figures refer to both sexes. Those for women are more, for men less satisfactory—the universal experience.

The recommendation of the Commission that the converted workhouse sanatoria should receive not only curable but also advanced and infective cases, seems to be an excellent one. There is a most urgent need for isolation hospitals or refuges for advanced cases, whither they may be removed from their small houses or tenement rooms, and kept from infecting their families. This need is no less urgent than that of a curative sanatorium. Now, in a country where people are so much swayed by sentiment as they are in Ireland, a hospital altogether reserved for advanced and hopeless cases would, no matter how named, become a sort of byword in a locality, and the patients, even if willing for the sake of their families, to go there, would not be allowed by their relatives to enter such an institution, stamped as it would be with the brand of hopelessness. They might go, no doubt, towards the end, when the burden of looking after them would have become too heavy to bear. But the mischief would then have been done—at any rate to a large extent.

Nor do I see any grave drawback to the admission of both classes to the one institution. The most infective cases would probably be in bed, owing to temperature and weakness. It would be easy to keep them separate in an isolated ward. The advanced "ambulatory" cases could be kept at first in the same division till they had become thoroughly "broken in" to the rules for the collection and disinfection of sputum, and the prevention of air-infection from projected sputum-droplets. Their compliance with the regulations once assured, I really can see at present no valid reason why they should be kept strictly apart from the curable cases. These latter are actually destroying the bacilli already implanted within them and might fairly be expected to oppose an obstinate resistance to fresh infection. But with proper observance of the rules, there is really no reason why they should run any danger.

There is one class of patient from whom observance of rules cannot be expected—the insane consumptive. Tuberculosis is already very prevalent in our enormous, overcrowded asylums and must add considerably to the difficulties and anxieties of administration. The Commissioners suggest that all insane consumptives in the advanced stage should—in so far as their mental condition permitted—be removed from the various asylums and segregated in one or more disused workhouse sanatoria that had been specially modified for their accommodation. The recommendation seems an admirable one and I hope it will be carried into effect. Many of these patients recover, so far as concerns their mental condition, sufficiently to return home, and the experience of cleanliness, sputum disposal and fresh air which they have had in the Asylum-Sanatorium cannot but cause them to exercise a beneficial influence on their home conditions.

The proposal of the Commissioners is that the expense of converting the disused workhouses into sanatoria, and their maintenance as such, be defrayed out of special county-at-large rate. Under the existing law sanitary authorities can form joint hospital boards for the erection of infectious disease hospitals and levy a 1d. in the £ rate to support them. In view of the magnitude of the evil to be grappled with I would suggest that under the new fiscal arrangements contemplated by the Commission, the limit of 1d. would need to be considerably increased. Is a superior limit necessary at all? The natural tendency of popular bodies towards economy does not need curtailment. If the clause were made to read "not less than 1d. in in the £," it would be all the better.

If I do not altogether mis-read the "signs of the times," the rate-aided sanatorium will become a centre of popular endeavour. Among ancillary measures, more or less necessary for the successful working of these Sanatoria, may be mentioned.

(1). The Consumption Dispensary, the objects and institution of which will be found set forth in my Report to the Local Government Board above referred to.

(2). A local committee for supporting those dependent for their existence on wage-earners who are undergoing treatment in the sanatorium.

(*a*) London: The Scientific Press, 1906.

(3). A local committee for the purpose of finding suitable employment for those discharged from the sanatorium. Unless healthy out-of-door occupations can be found for such "cured" or "improved" cases, the "cure" will too often be found to be a misnomer, and the "improvement" evanescent.

The stimulus to the formation of such local Committees, or of a voluntary organisation which would take on all three functions just named, might fittingly be afforded by the only central Governmental body competent to do so, namely, by the Local Government Board, either through its medical inspectors or by lecturers specially appointed for the purpose. This is admittedly a poor country, and financial experts and a Royal Commission have stated that it is over-taxed. Poverty is probably the chief ultimate cause of tuberculosis, which is in reality nature's punishment for bad economic conditions. Could not the Treasury be induced to unloose the national purse-strings and "lend a hand" with money, co-ordination and expert advice and assistance—the essentials to successful action, and the very things in which purely local action is apt to be lacking?

Whatever be the issue of this Commission—whether its proposals are to be pigeon-holed amid the dust that covers the Reports of so many of its predecessors, and the country is to keep on sinking deeper into the slough of preventible but not prevented disease—or whether the recommendations will be put in force and form the nucleus for successful onslaught on tuberculosis—time alone can tell. Meanwhile, the Commissioners have deserved the gratitude of the country for the bold and statesmanlike attitude they have taken up in regard to this crying evil.

PUBIOTOMY: WITH NOTES OF THREE CASES. (a)

M. J. GIBSON, M.D., B.Ch.

Assistant Master of the Coombe Hospital, Dublin.

THE idea of improving the prognosis for the mother and child in cases of contracted pelvis, and of lessening the number of Cæsarian sections, inductions of premature labour and perforations of the living child, by an artificial enlargement of the pelvis, is a very old one. Symphysiotomy, first demonstrated by Courvée in 1655, was first performed on the living by Sigault one hundred years later. It was not and is not a very satisfactory operation. To Gigli belongs the honour of being the first to propose as a substitute for it an incision through the os pubis. The great danger in his operation lies in the large easily-infected incision which he employs, and this was overcome by Döderlein's subcutaneous pubiotomy, which is really a new operation. It is so simple and the results are so good that it may be regarded as one of the greatest discoveries in modern obstetrics. It is indicated in cases of narrow pelvis when the cervix is fully dilated, and when, in spite of good contractions, the head moves freely about the brim. Good contractions are a power which must always be considered because, by preparation of the maternal soft parts, and especially by good moulding of the fœtal head, many a head is driven through a narrow pelvis when we could hardly believe that such a thing could occur. The operation may be performed in cases of flat pelvis with a conjugata vera up to 6.75 cm., and in generally contracted pelvis up to 7 cm., but for these very low conjugates the head must not be larger nor harder than normal. I have adopted Döderlein's method in three cases. Its technique is as follows:—A small incision, sufficient to admit a finger, is made over the bone, usually at the left side between the symphysis, and the pubic tubercle. Döderlein's needle is passed down behind the bone and its point brought out in the greater labium. Gigli's saw is attached and the bone divided. The hæmorrhage is as a rule, easily stopped by compression. The patient should not be delivered unless delivery is absolutely indicated, but should be allowed to deliver herself. After labour is completed a few strips of adhesive plaster are put around the pelvis, a binder is applied, and the patient is kept lying on her back for twelve days. She may get up on the fourteenth or sixteenth day.

The advantages of pubiotomy over symphysiotomy are that the pelvis is prevented by the undivided soft parts from springing suddenly apart. The bladder and urethra are not so liable to injury during the operation. The operation is very much more easily and more rapidly performed. I performed my first operation on August 16th, 1906, on a 9-para, æt 34 years, who had no living child. She had had premature labour induced twice, and the pelvis generally was contracted with a true conjugate of 8 cm. A child weighing twelve pounds was delivered without difficulty. The patient was walking about on the twenty-first day. Mother and child left hospital two days afterwards in perfect health. The second case was also a 9-para, æt 32 years. Her second child had been delivered with forceps and is still alive. She had had labour induced three times. The patient came into hospital after being in labour for fourteen hours. The cervix was fully dilated, the membranes ruptured, small head free above the brim. The pelvis generally contracted, and flat with a true conjugate of 7.5 cm. The fœtal heart was 160, and very irregular, meconium coming away in large quantities. The patient had lobar pneumonia and was in a very bad condition. Pubiotomy was performed, and a six-pound child extracted with forceps, The mother had her crisis on the ninth day. Both she and her child left hospital on the twenty-fourth day in good condition. The third case was a 3-para, æt. 29 years. Her second child had been delivered alive with forceps. It weighed five-and-three-quarter pounds, and is still alive. The pelvis was a rachitic flat, with a conjugata vera of 7 cm., The child, which lay transversely was easily delivered by podalic version after pubiotomy had been performed. It weighed seven and a half pounds. All three babies were subsequently breast-fed. None of the women complained of pain or showed any difference from a normal confinement, except, of course, the second case, who was suffering from pneumonia. These three women dreaded a Cæsarean section, and absolutely refused such an operation, yet they had no fear of pubiotomy. The maternal mortality in these cases so far is about 3 per cent. In my opinion there is a great future for this operation, and it will never share the fate of symphysiotomy, but will remain for us, both in hospital practice and in private practice, a means of overcoming the difficulties connected with the lesser degrees of contraction of the pelvis without injury to the mother or child.

(a) Abstract of Paper read before the Royal Academy of Medicine, Dublin, March 8th, 1907.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

A case of Dentigerous Cyst.

By Joseph Cunning, M.B., B.S., F.R.C.S.

Amongst the out-patients was a boy, æt. 9, who came complaining of swelling of the left cheek. The history of the affection was that four months before he had received a blow; swelling was noticed immediately and it had gone on increasing since. There was neither pain nor tenderness.

On examination, the skin of the cheek appeared normal over the lump and not adherent to it. The enlargement was about the size of a tangerine orange, confined to the outer aspect of the superior maxilla, definitely circumscribed and immovably fixed to it. The lump, though hard, fluctuated like a very tense cyst. On lifting the cheek there could be seen projecting above the alveolus a bluish white swelling which was the lowest part of the enlargement seen in the face. Mr. Cunning remarked that no doubt this was a tumour of the upper jaw, and he pointed out that such tumours had to be divided into those that were innocent and those that were malignant. The malignant tumour which began in the jaw itself (except in the alveolar margin) infiltrated the jaw in all directions so that enlargement could be observed in all its aspects—not only pushing out the cheek, but pushing downwards the roof of the mouth, pushing inwards the outer wall of the nose and pushing upwards the floor of the orbit. In this case, he pointed out that the only projection was on the facial aspect. The nose, orbit and roof of the mouth were unaltered.

Again, there was no trace of infiltration of the soft tissues of the cheek, the absence of which would be very unusual in a malignant tumour of this size.

The cystic character was a strong point also in favour of innocence.

The age of the patient was an unusual one for a malignant growth, but it had to be recognised that sarcomata of the upper jaw were not so very rare in children.

Then taking it that this was an innocent cyst, it had to be considered what kind it could be. The most likely was one connected with the teeth. On examination the teeth were found to be erupting in an irregular fashion—one tooth was being shed sideways, another was coming through the alveolus above a temporary one, which still remained fast. So Mr. Cunning thought this was suggestive of a dentigerous cyst (follicular odontoma). He explained that now and then a tooth was so placed that it could not erupt properly and its follicle continued secreting till quite a large sac was formed. As the follicle expanded, so the plates of the alveolus became more and more atrophied till at last no bone remained covering it. The outer wall of the antrum got pushed inwards till the cavity almost disappeared. There were other cystic swellings of the upper jaw beginning in the mucous membrane of the antrum, but these he said need not be considered in a patient of this age.

The history of this condition following a blow, he remarked, was interesting only from the fact that this probably first called attention to a swelling which, though smaller, had been present beforehand. The treatment advised was incision in the neighbourhood of the canine fossa from the mouth and removal of the lining membrane of the cyst and, of course, of the tooth if one were found in it.

The patient was subsequently taken to the theatre, the cyst opened and sponged out. A canine tooth was then found with its base attached to the top of the cyst, close to the orbital margin. The tooth and cyst wall were easily peeled out and the cavity was packed with gauze.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

Exploratory Laparotomy: Anastomosis Between the Upper Part of the Sigmoid Flexure and the Rectum.—Mr. A. Carless operated on a woman, æt. 60, who had been admitted to the hospital complaining of abdominal pain and diarrhœa. She had been under the observation of Dr. Tunnicliffe in the Out-Patient Department for some time, and he had come to the conclusion that an intestinal growth was present. On admission, she presented the aspect of a somewhat feeble old woman, and she stated that she had lost weight. The temperature was normal; her appetite was not good, but there was no vomiting; the bowels were opened three or four times a day, and the motions were greyish, fluid offensive and contained some mucus, but no blood. There was no discharge from the rectum or vagina. On examination of the abdomen, the patient located her pain mainly to the lower half, but there was some slight rigidity of the abdominal wall in the right upper quadrant, and a feeling of increased resistance low down on the left side. Examination per vaginam revealed an atrophic os of senile type, but the uterus appeared to be fixed. There was nothing abnormal in the rectum. On combined rectal and vaginal examination, a mass was discovered, lying between the fingers, moving with the uterus, and extending upwards, so that it could be felt bimanually. Although there was no vaginal discharge, it seemed probable that the uterus was the cause of the trouble, and it seemed possible that there was a carcinoma of the body of the uterus with secondary deposits in the iliac glands; at the same time the earlier history of the case suggested the existence of an intestinal growth, and exploration was proposed and agreed to. The abdomen was opened in the middle line below the umbilicus, and the cause of the resistance in the iliac fossa was at once determined to be the presence of scybalous masses in the sigmoid. On tracing the colon back, fæcal masses were found occupying the bowel as far up as the hepatic flexure. On passing the hand into the pelvis, a tumour about the size of a small cocoanut was found, which at first was thought to be of uterine origin. On careful investigation, however, it was discovered that the tumour had grown from the sigmoid flexure, and had dropped into the pelvis, where it had become closely adherent to the posterior uterine wall; in fact, the lowest part of the intestine was shaped like an S, with very sharp turns. The convexity of the first curve was occupied by the tumour, and from it the bowel passed upwards and took a sharp turn down into the pelvis to become the rectum, which was pushed over to the right of the middle line. An attempt was made with the patient in the Trendelenburg position to detach the tumour from the back of the uterus, but the hæmorrhage was so great that this could not be managed. It was found possible, however, to approximate the upper end of the sigmoid flexure to the top of the pelvic portion of the rectum, and it was therefore decided to short circuit the tumour by performing an anastomosis between these two portions of bowel. Mayo Robson's clamps, as used for gastro-enterostomy were applied, the portions of intestine thus guarded were brought side by side, a longitudinal incision two and a half inches in length was made through the longitudinal muscular fibres; a small strip of redundant mucous membrane removed from each viscus, and the anastomosis effected by the employment of two rows of sulpho-chromic catgut treated with iodine. The clamps were then removed, and the abdomen closed, except at the extreme lower end, where a strip of packing had to be passed down between the uterus and the growth to control the hæmorrhage which had been lighted up by the attempt to separate the two. Mr. Carless stated that the growth was probably a carcinoma of the hypertrophic variety, and the physical conditions demonstrated by the operation were quite sufficient to explain the difficulty which had been experienced in diagnosis. The displacement of the growth downwards into the pelvis and its adhesion to the posterior uterine wall were, he thought, most unusual developments, and could not be anticipated prior to operation. It was unfortunate, he said, that the growth could not be separated from the uterus, as its complete removal in this case would have been practicable owing to the laxity of the intestine above and below; it would easily have been possible to perform an anastomosis. As it was, all that could be done was to make a free passage for the intestinal contents from the lower end of the descending colon into the rectum. The actual performance of this was easy in this particular instance, he pointed out, and was carried out exactly in the same way as a gastro-enterostomy. It was probable, he thought, that the patient's pain and discomfort would be much relieved by this procedure.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Obstetrics.

Meeting held Friday, March 8th, 1907.

The President, Dr. R. D. **Purefoy**, in the Chair.

UTERUS SHOWING A FIBRO-MYOMA IN FUNDUS AND CANCER IN CERVIX.

Dr. **Alfred Smith** exhibited a specimen of above from a lady, æt. 40. He had diagnosed and discovered polypus of the uterus, and had made up his mind to remove it as the cause of the hæmorrhage from which the lady suffered. During removal he found an ulcerated spot in the cervix which proved to be an adeno-carcinoma under the microscope.

Sir A. V. **Macan** said the specimen was very interesting as showing two things which were extremely rare in combination, though neither was rare by itself.

CARCINOMA OF BODY OF UTERUS; SARCOMA OF BODY OF UTERUS.

Sir A. V. **Macan** exhibited specimens of the above. One case was that of a woman, æt. 60, who had had ten children, the last being eighteen years old. She had had two miscarriages. For two years, up to October, 1905, she had not menstruated. She then had a heavy period lasting for three weeks, after which she saw nothing until October last, when she commenced a period which continued until operation on February 14th. The other case was æt. 50, and was operated upon on January 17th.

Dr. M. J. **Gibson** read a short paper on

PUBIOTOMY,

with notes of three cases, which will be found in another column under the heading of "Original Papers."

DELIVERY BY PUBIOTOMY.

Dr. **Hastings Tweedy**, Master of the Rotunda Hospital, read a paper dealing with a case in which he had delivered a primaparous woman of a living child through an internal conjugate of 6.5 cms., at full term, by the performance of a left-sided hebotomy. Hæmorrhage had been very severe, and had resulted in a considerable degree of collapse. Delivery had to be hastened because of prolapse of the cord, which took place before the operation was undertaken. Deep lacerations of the cervix, of the soft parts lying between the severed bone, and of the perinæum, required catgut sutures. The patient's recovery was uneventful, and she left the hospital in perfect health on the ninth week with a living child.

In discussing the two papers conjointly,

Sir A. V. **Macan** said the ease with which he had seen the operation done by an operator who had never done it before, had convinced him that pubiotomy was certainly the operation in such cases as had been described by Dr. Gibson. There was nothing in it which could not be done by a man who had been through the Dublin school; and he considered it of the utmost importance that they should be able to put before the practitioner in the country the possibility of saving the life of both mother and child in cases where he had put on the forceps, but had failed, and was face to face with perforation.

Dr. **Neil** considered the operation of great importance since the risk of sepsis would be less than in the induction of premature labour.

Dr. **Alfred Smith** believed the operation had come to stay.

Dr. **Jellett** asked the communicators whether they would agree in dividing the operation into two classes: First, as the operation of election which they would select in preference to other procedures in any case in which they had reason to believe that the patient could not be delivered by forceps or her own efforts; secondly, as the operation of compulsion, where the forceps had been tried and failed. Looking at the operation from an unprejudiced standpoint, it seemed to him that in doing Cæsarean section on a perfectly healthy patient, unweakened by the long continuance of labour, they were more certain of the after results. On the other hand, he certainly agreed that, in the second class, pubiotomy had got its place and would keep it. The ease with which it was performed, the small amount of assistance required, the small extent of the wound, and the short time in performance, would be important factors in producing a small mortality.

The **President** said he could not see how pubiotomy could take the place of Cæsarean section in certain cases. He thought that its danger had perhaps been passed over too lightly. The danger of injury to the bladder had been amply demonstrated by recorded cases. The danger of hæmorrhage must, he thought, be considerable, since a fatal case had been reported from Vienna. He could not help wondering whether the locomotive powers of the patients had been satisfactory afterwards in all cases, or whether sufficient time had elapsed to enable them to judge on the point. He agreed, however, as to the value of the procedure.

Dr. **Tweedy**, in reply, said that while both symphysiotomy and hebotomy had come to stay he did not think that either would prove a perfect panacea. He had performed both operations with equal ease.

Dr. **Gibson**, in reply, said that as regards the chance of injuring the bladder, they must remember that in pubiotomy they had a great protection of the pelvis by the undivided soft parts. The bladder was never so intimately connected with the pubic bone that any tearing could result from the small amount of stretching undergone, except when owing to a previous puerperal sepsis there were adhesions between the bladder and the bone. This occurred very rarely. A French author had stated that the ends of the bone could separate up to 8 cm. without injury to the bladder or articulations. If bleeding could not be stopped by compression they could open the wound and find where the bleeding was coming from. Pubiotomy was, he believed, a safer operation than Cæsarean section up to a certain point—*i.e.*, a pelvis with a conj. vera above 6.75 c.m. The latter was better done at the beginning of labour, therefore we had no chance of seeing what the contractions would do for us, and no matter how well it was done there were cases on record where the cicatrix gave way afterwards. Both operations would unite equally well if performed aseptically, but the danger to the bladder and urethra was much greater in symphysiotomy than in pubiotomy, and the former was also a more difficult operation and therefore not so well suited for the country practitioner.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, March 21st, 1907.

The President, **Frank T. Paul**, F.R.C.S., in the Chair.

Exhibition of Clinical Cases.

A large number of cases of interest were shown. Medical cases by Dr. A. G. Gullan, Dr. A. E. Ford, and Drs. Nathan Raw and R. G. Wills; surgical cases by the President, Mr. David Morgan, and Mr. K. W. Monsarrat; skin cases by Drs. H. Leslie Roberts, F. H. Barendt, G. G. S. Taylor, MacKenna, W. C. Oram, and E. L. Anderson; eye cases by Drs. K. Grossman, R. G. Hamilton, W. E. Livsey, and A. M. Walker; ear cases by Mr. E. M. Stockdale.

The **President** showed the following cases:—

1. A boy, æt. 11, who had been scalded when two years old on the side of the chest. Subsequently the mother noticed a swelling in the region of the left pestoral muscle. This had gradually grown until it was now the size of a hen's egg. It had been examined and found to consist entirely of muscle.

2. Case of immense hypertrophy of the gums of both jaws—shown previously before the society, and now cured. The gums were removed by four operations two years ago, without extracting the teeth, and recurrence had taken place. A second series of four operations was undertaken with removal of the entire alveolar processes resulting in complete cure. Models of the original condition were shown by Mr. Phillips, dental surgeon to the Royal Infirmary.

3. A woman, æt. 53, who had received an injury to the fifth and sixth cervical nerves from a fall on the shoulder, causing paralysis of the muscles supplied by those nerves.

THE TREATMENT OF THE ACUTE PATHOGENIC INFECTIONS WITH VACCINES AND SERA.

Dr. **Nathan Raw** read a paper on the above subject. He particularly mentioned the great value of antidiphtheritic serum if given early in pure cases of diphtheria, but said that in mixed infections it did not seem to exert the same beneficial influence. He had treated 212 cases of erysipelas, puerpural fever, and other septic infections with anti-streptococcic serum, and was convinced that in streptococcal infections the serum, if given early, had a marked curative effect. The use of a polyvalent serum had immensely improved the results of treatment. In the treatment of a large number of cases of tuberculosis he had come to the conclusion that tuberculin R. had not much curative value in phthisis pulmonalis even in the early stages of the disease, but in the so-called surgical forms of tuberculosis, such as lupus, tubercular glands, joints, and peritonitis, tuberculin R. had a most marked curative effect and his results of treatment of numerous such cases was astonishingly good. He was not favourably impressed with the value of anti-tetanic serum.

Dr. W. B. **Warrington** considered anti-streptococcic serum to be of little utility in medicine, and pointed out that it was the recognition of this that lead Sir A. E. Wright to introduce the method of vaccines. He alluded to the value of endoneural injection of the anti-toxin in tetanus.

Dr. **Ernest E. Glynn**, commenting upon the very favourable results obtained by Dr. Raw with anti-streptococcic serum in puerpural septicæmia, asked what evidence there was that the cases were true septicæmia and also due to streptococci as cultures were not made in the majority of instances. Might not many have been cases of intoxication, and recovery been the result of local treatment of the uterus? Dr. Raw's success in treating lupus with tuberculin uncontrolled by the opsonic index and unassisted by light treatment was not in accord with the experience of many, for lupus was very refractory. He was also surprised that Dr. Raw had cured three cases of tubercular meningitis with tuberculin, especially as the opsonic index had not been taken.

Dr. A. S. **Parkinson** said that the earlier tuberculin was given in phthisis the greater the probability there was of a good result. He thought that the failure in advanced cases was sometimes due to secondary infection of the lungs by pyogenic organisms, and that the immunity of such patients against secondary infections should be raised as well as the treatment by tuberculin injections carried out.

The following gentlemen also took part in the discussion:—Dr. G. G. Stopford Taylor, Dr. J. Hill Abram, Dr. B. Sumner, Dr. N. E. Roberts, Dr. R. J. M. Buchanan, Dr. W. C. Oram.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting held at Sheffield, March 15th, 1907.

Dr. **Croft** (Sheffield), President, in the Chair.

Card Specimens.

Dr. J. W. **Martin** (Sheffield) showed the uterus removed from a woman, æt. 60, on account of adenocarcinoma of the cervix. Microscopically, the columnar cells were undergoing metaplasia.

Dr. **Stookes** (Liverpool) exhibited (*a*) a large multilocular ovarian cyst, weighing 10 lbs., in which suppuration had occurred; (*b*) an ovary with the adherent appendix vermiformis.

Specimens.

Mr. **Cuff** (Sheffield) showed bilateral ovarian cysts with intracystic growths, removed from an unmarried woman, æt. 39. Abdominal swelling had been noticed for nine months.

Dr. **Lloyd-Roberts** (Manchester) exhibited an abdominal tumour of pelvic origin occurring in a woman, æt. 43, 22 years married, sterile. There had been eight months amenorrhœa and abdominal enlargement had been noticed for five months, latterly increasing rapidly. The tumour extended as high as the ensiform cartilage and bimanually could not be moved independently of the uterus. Abdominal section revealed a cystic tumour intimately connected with the uterus. The tumour was enucleated prior to the removal of the uterus at the level of the internal os. On section, it consisted of one large and innumerable small cysts microscopically lined by columnar epithelium.

Cases.

Mr. **Cuff** (Sheffield) communicated a case of ruptured isthmial ectopic gestation. The patient, æt. 34, four-para, had two miscarriages, each at about the fifth month. Menstruation was regular up to the last period, which was a week late. After an interval of thirty days she was suddenly seized with intense pain in the lower abdomen. This rapidly became worse. There was considerable collapse, pulse 120, temperature subnormal, respiration sighing. Abdominal section was performed within six hours of the onset of the first symptom. The abdomen contained free blood and the isthmus of right Fallopian tube was found to be the seat of an early gestation which had ruptured.

Mr. **Cuff** also related a case of uterine fibroid in a woman, æt. 35, one-para, four months pregnant, who suffered from abdominal pain and constant vomiting. The temperature was 101°, and the pulse 120, and she looked very ill. The size of the abdominal swelling exceeded a four months' pregnancy, and on the left side a hard, excessively tender swelling could be felt. It could be moved independently of the uterus, and this, together with the fact that it had increased in size, rapidly pointed to its being a solid ovarian tumour with twisted pedicle. Abdominal section revealed a uterine fibroid of the size of a fœtal head springing posteriorly from the left cornu of the uterus. Enucleation was performed and a second and smaller fibroid also removed. Superficial and deep sutures closed the uterine incision, and the abdominal wall was sutured in three layers. There was no interference with the progress of the pregnancy.

Mr. CUFF also related a case of hydrocele of the canal of Nuck.

Dr. GEMMELL (Liverpool) read notes of a case of "Early Carcinoma of the Cervix Uteri Treated by Abdominal Hysterectomy and Pelvic Dissection." Five years previously he had removed a left adenomatous ovarian cyst and right hydro-salpinx. She remained in good health until the summer of 1906, when she began to have pain in the left leg and thigh. On admission to hospital, in January, 1907, there was marked œdema of the left leg. *Per vaginam*, the uterus was the size of a three months' pregnancy, of soft, solid consistence and fixed, the cervix hard, irregular, bleeding easily. Early epithelioma of the cervix was diagnosed with fibroid of the uterus. Abdominal hysterectomy was rendered difficult by short broad ligaments resulting from the previous operation, and the presence of enlarged pelvic glands only recognised on opening the abdomen. The pelvic glands were removed, those in the obturator canal forming a mass 2 ins. long and ½ in. broad. Sections of the cervix showed early adeno-carcinoma, some of the acini being free from infiltration, definite carcinoma in the obturator and pelvic glands. The uterus contained pus and sections of its wall showed round-celled infiltration with destruction of the endometrium. The patient made a good recovery. The case demonstrated how extensive an infiltration might take place in the pelvic glands with very early disease of the cervix.

Dr. STOOKES mentioned a case of single condyloma of the cervix in a patient five months pregnant. There was no other evidence of syphilis except pigmentation of the thighs.

Dr. WALLACE (Liverpool) made a short communication, on "A Modification in the Technique of Ventrofixation of the Uterus." The subsequent occurrence of intestinal obstruction in a patient on whom he had performed ventrifixation as well as recorded cases of a similar accident in the practice of some other operators, led him to modify his procedure in the technique of the operation. He had noticed that when occasion arose for opening the abdomen in patients who had previously been subjected to this operation, a window existed in the utero-vesical pouch below the suspended uterine body. This space will sometimes admit four fingers, and through it a loop of bowel could readily pass. To obviate this, a complete peritoneal diaphragm is formed from the vesical and utero-vesical peritoneum, before suspending the body of the uterus.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, March 31st, 1907.

AT the Medizinische Gesellschaft, Hr. Waldeyar spoke on behalf of a Committee that had been formed for the purpose of erecting a monument to

THEODOR SCHWANN, ANATOMIST AND PHYSIOLOGIST, in his native city of Neuss in 1910.

Schwann was the son of a bookseller, and was born on December 7th, 1810. He studied in Würzburg and Berlin, and in 1834 went to Berlin. Here his chief works were composed. In 1839, he went to Louvain, was called thence to Lüttich as anatomist in 1848, where ten years later he became professor of physiology. In 1878, he celebrated his forty years' jubilee as teacher, and it was on this occasion that Professor Waldeyar made his acquaintance. He described the impression that his acquaintance with such a spiritual and equally modest man made on him. An account of his life was given by Henle in the *Archiv. für Anatomie und Drickios*, from which one speaker quoted. He mentioned the chief work of Schwann, which began even with his dissertation; this took up the subject as to whether the embryo, more especially that of the chick, required oxygen before the development of its blood vessels. Later he busied himself with the chemistry of the stomach, and discovered pepsin, which he was the first to prepare and name. Then he turned to decompositions and fermentations, and showed that they were associated with living organisms—studies which might be considered important precursors of those of Pasteur. Then he studied the contractile power of muscles. Then came his numerous investigations into the unity of structure of animals and plants. Here he recognised that the cells that Malphigi had seen 200 years before without recognizing their importance in life was the real elementary organism, and the egg also was nothing but a cell.

Accident would have it that in the same year, 1839, Rudolf Virchow matriculated in Berlin, whose revolutionary teaching as to the importance of the cell in pathology was built up on the discoveries of Schwann.

In conclusion, he sketched roughly the development of the doctrine of cells; how at first the cell was taken for a drop of fluid surrounded by a membrane; how Schleiden then discovered the mucous substance and the nucleus, how Schwann recognised how important the nucleus was; how he assumed for the nucleus a sort of primal progenitorship which he now disputed in the case of the infusoria, and imagined that a deposit took place around it. How then Leybig and Max Schulze recognised that the cell membrane was not an integrating constituent of the cell, and that the nucleolus was just as little an essential part; but that on the other hand the centrosoma was of importance for cell division and how the whole doctrine of generated deguidea lost ground more and more until Virchow was able to put forth his formula, "Omnis cellula e cellula," and how then the knowledge of the more delicate processes in nuclear and cell division advanced further. All this was delivered with the speaker's usual clearness and conciseness. He concluded by expressing the hope that the erection of the monument would be happily carried out.

At the Otologische Gesellschaft, Hr. Levy spoke on THE MORTALITY OF DISEASES OF THE EAR AND THEIR IMPORTANCE AS REGARDED LIFE INSURANCE.

The refusal to accept proposals for life insurance from people suffering from ear diseases was not a justifiable one. In 46,480 deaths, among 150,594 of persons whose lives were insured the mortality was only 58, or 0.04 per cent of the total of insured cases, and 0.12 per cent of the total mortality.

In 9,000 post-mortems performed during the preoperative era, there were 57 deaths from suppuration of the middle ear. The speaker had gone through the statistics of the Charitée from 1881 to 1890, and found a mortality of 0.4 per cent. from 1891 to 1905 the mortality was 0.7 per cent. Of cases of chronic suppuration, at most 2.6 per cent. died from the disease. Under these circumstances, the cases with large, non-marginated borders, with free mucoid non-smelling discharge, and showing permanently no traces of retention, should be considered as free from danger, and such should be accepted by the life insurance companies at an advanced rate. The decision as to the character of the case should be left to the expert in ear diseases.

Hr. Brühl said the question was not so much how many of the insured died, but how many were placed in danger by these ear discharges. Two years recovery after radical operation did not show definite cure as was shown by a recurrence of a cholesteatoma.

Hr. Sountog said that in Brühl's Klinik, amongst 7,794 patients, there were 632 chronic suppurations, and among these 387 were dangerous; 100 of them had been operated on. Complications occurred 23 times, 10 times intercranially. That gave a percentage of 3.7 as opposed to Hr. Levy's 2.6 per cent.

Hr. Passow agreed in the main with Hr. Levy, but his statistics proved nothing.

Hr. Lucae said the danger was increased by subjective symptoms such as giddiness, disturbances of equilibrium and pain.

Death of Exc. von Bergmann.

The death of the celebrated surgeon, as announced in the daily papers, took place in Wiesbaden on the 25th ult. No death, since that of Langenbech, has made such a break here in the surgical department of medicine, but, unlike Von Langenbech, Von Bergmann worked to the last. Only on February 27th, at the Medizinische Gesellschaft, he showed a case of sarcoma of the skull in a young woman, as reported in these columns. It was little thought then that the end was so near. The deceased was born in Dorpal in 1836, and was translated from the professorship of surgery in his native city to that in Berlin in 1882.

AUSTRIA.

Vienna, March 31st, 1907.

Post Typhoid Cholecystitis.

Reitter and Exner exhibited a patient to the members of the "Gesellschaft," on whom they had operated for a tumour in the right epigastric region, which was discovered after the patient was narcotised, the reflex action being so resistent before that time that no tumour was observed, although the patient was so emaciated and the pain so great in the left side that death appeared to be a relief. The diagnosis before this time was obscure, but gall stones were suspected. After this discovery the presumption rested on a malignant condition of the pancreas, or in the retroperitoneal gland, or, finally, a simple compression of the ductus choledochus.

Whichever it might be it was ultimately resolved to operate, and prepare for draining off the bile after opening the ductus choledochus or gall bladder. Happily nothing but an inflammatory condition of gall bladder was met with. After this the incisions were all closed and the patient recovered rapidly. and is now apparently in good health ; nothing to be found in the abdomen, while the patient is gaining health rapidly.

This morbid condition commenced after an attack of typhoid, and was probably the result of the ravages of the Eberth bacillus. Dörr, who devoted so much time to this subject found the Eberth bacillus in the gall, even in the gallstones when cut, which he cultivated and subsequently injected with the same result. In this case the bacillus was present and seems to have been the exciting cause for the cholo cystitis.

Politzer related the history of another case where cholecystitis followed typhoid, which was undoubtedly caused by the Eberth bacillus as subsequently proved. Kolisch went further, and held that cholecystitis was present at the beginning of the typhoid attack, in every case, more or less ; indeed, he considered this one of the initial symptoms in typhoid. Teleky remarked that diabetic icterus often caused a chronic inflammation in that portion of the choledochus where bile and pancreatic secretions met. Is it not possible that this change of tissues blocked the passage and subsequently produced the inflammation in the gall bladder and in this way had no causal connection with typhoid beyond the accident of time? Although the typhoid bacillus may be found in the bladder it does not follow that inflammation results from it. The bacillus is often found in other organs after typhoid, where no inflammation result. Reitter replied to the latter by saying that happily for this objection the urine was carefully examined several times for three days before the operation and no sugar or trace of diabetes to be found. As to the presence of the bacillus typhoidus and no inflammation, Teleky may be right, but when we have great enlargement of the liver, during the typhoid attack with a prior three years' history of chololitrasis it is reasonable to suspect an easy entrance by a morbid surface after a year's rest subsequent to the typhoid attack. With the changes present in the pancreas and the closure of the duct it is more than possible that the bacillus was the real cause.

Sarcoma and Morbus Basedowii.

Haim showed a case of Basedowii where he had removed a sarcoma from the upper jaw and cured the Basedowii. The patient was a lad, æt. 14, who had suffered for years with morbus Basedowii associated with a sarcoma on the right upper jaw, which had increased to such dimensions in July, 1906, that it was deemed necessary to operate. Kocker's incisions were made, the caratoid externa tied and right jaw totally resected. The symptoms of morbus Basedowii, which had existed five years, did not go down immediately, but gradually declined to the present time when no trace now remains. Under these circumstances it would be dangerous to speculate on the real cause of the recession, but it is probable that the tying of the external caratoid and the cutting off of the blood supply to the thyroid were instrumental in bringing about the change.

Sarcoma removed by Torsion.

Boese related a case of alveolar sarcoma in the scrotum that he removed by twisting the pedicle 180° and allowing it to degenerate. This method of twisting and returning the torsion was described as easy and simple.

Gangrene from Ice Bag.

Haim shewed photos of a case of abdomenal gangrene caused by applying ice to the abdomen for parametritis suppurativa. Three days after the application of the ice the gangrene commenced and ended fatally.

HUNGARY.

Budapest, March 31st, 1907.

At the last meeting of the Nagyvarad Medical Association, Dr. Adolf Erdös read a paper on

The Early Diagnosis of Pulmonary Tuberculosis.

He said that little evidence is attainable by percussion and palpation in the early stages of tuberculosis. Auscultatory phenomena while delicate, are audible to the careful examiner. An interrupted rhythm, a weakened and rough inspiration, are suggestive if found to persist over any definite area. General symptoms, even though slight, should be given careful attention. A slight hack, a constant desire to clear the throat, slight dyspnœa, a localised pleuritic stitch, an indefinite neuralgic ache in the sternal or clavicular regions, accelerated pulse-rate, capricious appetite, restlessness, night sweats, disinclination to exertion, an afternoon rise of temperature, all should be regarded with suspicion. The tuberculin test should be used in all doubtful cases in the following way (Stubb's method) :—A two-hour chart should be kept for three days before the injection. A one-half of a one per cent. solution of crude tuberculin is made in distilled water, and 2½–5 milligrams of tuberculin injected into a fleshy part of the body. A positive reaction is indicated by a rise of temperature of the previous day, headache, backache, general malaise and nausea. The local signs in the chest are exaggerated at this time. If the test is negative the injection should be repeated after a two weeks' interval, using a larger amount of tuberculin.

Dr. Revesz Vilmos read a paper on

The Treatment of Trigeminal Neuralgia.

During the acute attack it is often the best policy to resort at once to the hypodermic use of morphine, which will not only still the pain and bring the patient quick relief, but as some authors claim, it may even have a curative effect. The danger of establishing the morphine habit renders a trial of other analgesics preferable in all but the most severe attacks. Quinine in thirty to fifty centigramme doses, repeated once or twice, should be given when there is the least suspicion that malaria may be the underlying cause. Salicylate of soda stands only second to quinine, with which it may be given, and by continuing with them one of the coal tar derivatives a most effective anti-neuralgic preparation is obtained. The dangers attending the administration of the last mentioned class of remedies should never escape the physician's memory. Some doctors have confidence in gelsemium, too. Arsenic in the form of Fowler's solution is one of the most reliable remedies. Counter irritation of any kind may bring relief. An elegant preparation will be obtained by mixing in equal parts chloral hydrate, camphor and menthol. On sensitive faces this may cause blisters. Heat or electricity may also be useful. In selecting the effectual treatment for each patient there is opportunity for the exercise of much skill on the part of the physician in testing the several lines of treatment in rapid succession. Should all fail the intervention of surgery must be sought.

Dr. Ràcz delivered a lecture on

THE MORPHINE-SCOPOLAMINE NARCOSIS.

He holds the opinion that morphine and scopolamine alone are narcotic, and hardly ever safe since the dose of the former drug is too high. Small doses are, however, highly to be recommended if followed by one of the usual anæsthetics (morphine hydrochlorate 0.01 to 0.02 gm. scopolamine, hydrobromate half to one milligramme in fresh solution). Either chloroform or ether may be used, with ether the advantages are perhaps more marked. The excitation stage is shorter, less anæsthetic is necessary, salivation is never troublesome, and the danger of postoperative pneumonia is considerably diminished. Some 150 cases have been reported with a mortality of one per cent., but many of the patients were already in a moribund condition when operated on. It may also be advisable to resort to the two drugs in smaller doses in Schleich's infiltration anæsthesia.

OBITUARY.

SIR JOHN H. KER INNES, K.C.B., F.R.C.S.

We regret to record the death of Surgeon-General Sir John Harry Ker Innes, K.C.B., senior honorary surgeon to the King, at his residence in Florence, on March 12th. Born in 1820, Sir John Innes was educated at University College, London, where he qualified M.R.C.S. in 1841. He entered the medical department of the Army, and in 1854, his regiment being in India, he went to the Crimea as a Volunteer. During the Sepoy revolt in India he served with great distinction; he was wounded, and had his horse shot in the action on the Hindun, and he was present at the battle of Budli ke Serai, at the storming of the heights before Delhi, and the siege, assault, and capture of that city. In recognition of his services during the Mutiny he received the C.B., and was promoted a deputy-surgeon-general in 1858. Two years later he took the F.R.C.S. of England. Further distinction followed in 1871, when Surgeon-General Ker Innes was selected to act as British Medical Commissioner on the staff of the Crown Prince of Prussia during the Franco-German war. At the close of this campaign he received from the Emperor the Steel war medal and the Iron Cross. From 1876 to 1880 he held the appointment of P.M.O. in India, and in 1878 was appointed an honorary surgeon to Queen Victoria, retiring in 1880. He was given a K.C.B. in 1887, and on the death of the Queen was gazetted to the appointment he held at his death.

SPECIAL ARTICLE

THE PLEA OF INSANITY IN THE SCOTCH POISONING CASE.

A trial for murder, which has excited considerable interest by reason of the unusual issues raised, was concluded in the Court at Edinburgh last week. The facts are as follows: Last November, a Miss MrKerson, housekeeper to a Mr. Lennox, partook of a cake of shortbread which had come by post to her master, and immediately thereafter manifested symptoms of strychnine poisoning and died in the course of a few hours. Suspicion fell on a retired colliery manager, Brown, as the sender of this cake, and he was duly arrested and brought before the Sheriff. The fact of strychnine poisoning, and the fact that the drug was contained in the icing of the cake, which had obviously been put on by an unskilled hand, was not in dispute; the only question was whether Brown was the perpetrator of the crime. On the prisoner's appearance before the Sheriff, the Procurator Fiscal produced certificates from Brown's own medical adviser and from Dr. Carswell, Glasgow, to the effect that he was a subject of chronic epileptic insanity, and in respect of this the Sheriff did not ask him to plead, but reserved the matter for trial at the adjournment. Accordingly, when Brown was brought before the Court of Justiciary, a curious state of matters arose. As a preliminary, it had to be settled whether he should be allowed to plead, or whether he was to be regarded as insane. The Solicitor-General, prosecuting, asked the Court of five judges to find the prisoner insane—which would, of course, have put an end to the whole matter, and prevented the case from coming before a jury at all; while the prisoner, through his counsel, appealed for trial on the ground that he was sane and competent to plead. The Lord Justice General decided that the case should proceed. He pointed out that where insanity is established and it would therefore be useless to allow the prisoner to plead, the Court has been accustomed to ensure the public safety by relegating the prisoner to confinement until further orders, while under the Lunacy Act of 1857 there is a provision that where any person charged with crime is found insane he shall be kept in custody during his Majesty's pleasure.

The case thus came before the Lord Justice General and a jury, and the evidence was entirely circumstantial. The facts of poisoning were not in dispute, and the Crown was able to trace all Brown's movements on the day of posting, and to show that he could have procured and dispatched the shortbread on the day in question. The main piece of evidence, on which the whole guilt practically hinged, was the question of whether the address was in the prisoner's handwriting. So far, then, the case of the Crown was rather thin. They produced, however, undoubted evidence of the prisoner's insanity: he had had to give up his business as colliery manager because he became unfit for it; neighbours regarded him as peculiar; he had grandiose and other delusions and he was notoriously an epileptic. Dr. Carswell swore that he was suffering from chronic epileptic insanity, and his own medical attendant averred that he would have been prepared to certify him as a lunatic at any time within the past year or two. The defence was limited to pointing out the incompleteness of the circumstantial evidence, and no medical testimony to the prisoner's soundness of mind was forthcoming. Lord Dunedin, besides being the head of the Scottish bench, is universally recognized as one of the ablest lawyers in the kingdom, and his charge to the jury is full of interest. After pointing out the unusual nature of the case, his lordship went on to say that the 87th section of the Lunacy Act of 1857, under which the case proceeded, used the word "insane." In one sense, no one could say what insanity is. He did not think that any doctor learned on the subject, would agree to a definition. What might be called scientific opinion upon insanity had greatly altered in the course of years, and the courts of law were bound to follow so far as they could the discoveries of science, and alter their definitions and rules along with the experts. His lordship then went on to explain that minor epilepsy robbed the patient of the full control of his faculties yet left him free to act, not, as he (his Lordship) thought, automatically, but free to act, it might be, of set purpose, but yet a purpose which was not controlled by a rational and sane will. He then referred to the absence of medical evidence for the defence, and spoke in high terms of the testimony of Dr. Herbertson, the prisoner's medical man, who seemed to him a very eminent example of that typ of country practitioner of whom they might well be proud. His evidence apparently impressed the judge greatly, as also did that of the other Crown experts. His Lordship then charged the jury *first* that they must consider the prisoner's present mental state, and, if they came to the conclusion that the ravages of disease were such that the prisoner was not in the same condition that a sane man would be, and that he was not able to tell about his actions, then they were bound to state he was insane, and not to proceed further. If they did proceed, the next point in order was whether the prisoner sent the poisoned cake. The one direct point in evidence was the address label, but he did not say it was impossible for the jury to be very sure in their own minds. Thirdly, if they answered the question affirmatively they had again to consider whether the prisoner was at that time sane or insane. The jury returned a verdict, by a majority, that the prisoner was now insane, and his lordship subsequently told them they had arrived at a perfectly right one in the circumstances.

The case seems noteworthy on two points—first, the peculiar procedure which involved the prosecution trying to prove insanity; and, second, the extremely lucid summing up by the judge of a very difficult question of responsibility. He definitely lays down what medical men are thoroughly familiar with—that an epileptic may under an insane or epileptic impulse perform purposive acts, and yet that he may in all good faith entirely forget all that has happened. Lord Dunedin thus shows himself much more willing to take up an advanced view of insanity, corresponding with what modern science teaches, than many of his other brethren on the bench.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

County Down Infirmary.—The annual report of this hospital for last year has just been issued, and shows that 539 patients were treated in the wards during the year. The average number of beds daily occupied was 47, and the average cost was 2s. 5¾d. per day per patient. Dr. T. M. Tate makes special reference to the treatment of tuberculosis. The number of patients admitted to hospital who were suffering from tubercular affections was 16.6 of the total admissions, and though, as he says, anything they can do will only deal with a fractional part of the great problem the prevention of tuberculosis, he believes it is their duty to do what they can to treat these cases in the best way known to modern science. To this end he urges the further provision of outdoor shelters, a small number of which have already been provided for men, on most suitable ground generously given at a nominal rent by Lord Dunleath. He looks forward to the county authorities taking up this matter at no distant date, and providing proper sanatoria.

Royal Victoria Hospital.—The annual meeting of this hospital was held last week, the Lord Mayor, the Earl of Shaftesbury, K.C.V.O., in the chair. The report showed that the number of patients treated in the wards during the year was 3,280, and in the extern department 27,626. The daily average of beds occupied was 218.2, but there are still 64 beds not in use owing to lack of funds. There were 1,384 surgical operations, with 44 deaths after them, giving a mortality of 3.17 per cent. Excluding the cases moribund on admission, the mortality in the medical wards was 4.26 per cent., and in the surgical wards 4.54 per cent., the average mortality in all wards being 4.42 per cent. One sentence in the report of the Committee (not the Medical staff) will be noted with pleasure by the general practitioners of Belfast:—"The subject of hospital abuse, and the ever-increasing numbers to be attended to in the extern departments of hospitals has been prominently before the public of late, and must undoubtedly be tackled in the near future if patients seriously ill are to have the time and care given to them that the nature of their illness renders imperative." Dr. H. L. McKisack, the honorary secretary of the medical staff, in moving the staff report, referred specially to the medical school, and the benefit which the hospital derived from its association with it.

Cerebro-Spinal Meningitis.—Each day during the week a few new cases have been sent to the Purdysburn Fever Hospital, but on the whole the numbers are less than before, and there is some reason to hope that the epidemic is abating. A good deal of dissatisfaction and criticism have been aroused in medical circles by the neglect of the authorities, and specially the Medical Officer of Health, to report on the various sorts of serum which have been tried in the treatment of these cases. It is known that a quantity of serum was obtained from Berne, and it is believed that another lot was got from one of the London hospitals, and a third variety, which is said to have been the only one found of any use in Glasgow, from a large firm of manufacturing chemists in England. It does not seem to be much to ask of the Public Health authorities, in view of the importance of the matter and the amount of public anxiety aroused, that they should report at the earliest possible moment as to results, whether positive or negative, obtained by the use of these medicines.

LETTERS TO THE EDITOR.

THE RIDEAL-WALKER COEFFICIENT.

To the Editor of the Medical Press and Circular.

Sir,—We ask a few lines of your space to state that it has been found necessary to substitute the term "Rideal-Walker Coefficient" for that originally introduced by us, viz., "Carbolic Acid Coefficient," owing to the abuse of the latter on the part of unscrupulous manufacturers and vendors.

The necessity for adhering strictly to the *modus operandi* prescribed in our test has been strongly emphasised in the last two or three years since we published our method, and that this caution is necessary is shown by the fact that many disinfectants are advertised as having a certain "carbolic acid coefficient" when the figure given has obviously been obtained by methods having little or nothing in common with the test as described in the *Journal of the Royal Sanitary Institute*,* thus introducing confusion and robbing the term of the value it originally possessed.

Much of the success of our method is due to the fact that we provide for the postulant and control being tested not only *in* the same time but *at* the same time. As the resistance of the test organism, even when sub-cultured from the same stock, varies from day to day, it is unfair and misleading to offer a "coefficient" obtained by testing the postulant on one occasion and the phenol control on another.

Similarly, when the "Thread," "Garnet," or any modification of the Rideal-Walker test has been employed, information that such a method has been used should accompany the "coefficient," and the latter should certainly never be advertised without this information.

It is therefore most desirable that bacteriologists when reporting on the germicidal value of a disinfectant should specify *precisely* the method employed. Great discredit has been thrown on the Rideal-Walker test by the publication of results obtained by the worker modifying the technique—sometimes to a very large extent—without notifying the modification, and many of the discrepancies referred to by critics are directly attributable to this fact.

We are, Sir, yours truly,

Samuel Rideal.
J. T. Ainslie-Walker.

The President of the Local Government Board has appointed Mr. J. M. Hamill, M.A., M.B., B.Sc., Assistant Inspector of Foods in the Medical Department of the Board.

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* Vol. xxiv. Part III., 1903.

REVIEWS OF BOOKS.

COLLECTED PAPERS BY SIR LAUDER BRUNTON. (*a*)

DEDICATED to Ferrier and prefaced by an interesting introduction telling of the author's early struggles in connection with his researches, this volume will be welcomed by everyone interested in the scientific aspects of practical medicine. No one, perhaps, has done more to advance our knowledge of remedies than Sir Thomas Lauder Brunton. His name will always be associated with amyl nitrate and its great service in cases of cardiac angina. The publication of this series of papers, some of them dating back to the sixties, affords a record of work of which anyone might be justly proud. Most, if not all, of the papers are familiar to everyone who makes a specialty of materia medica and therapeutics, and therefore in re-reading them in this collected form one feels that he is merely renewing his acquaintance with old friends in new guise.

Such a collection possesses a special value for the general reader, because the papers are arranged in definite sequence, which is, of course, impossible when they are read individually, scattered as they are throughout a wide range of scientific literature. No one appreciates more the usefulness of the collected writings of such an eminent scientist as Sir Lauder Brunton than original workers who must frequently refer to the teaching and experience of others. They have, however, a wider sphere, for they appeal to every up-to-date practitioner who is bound to realise that the true basis of all practice must rest upon scientific investigations, such as are described in the work under review. Empiricism in medicine would soon be abolished entirely if more real work were done on the lines laid down by the author of these valuable papers. No worker has excelled him in diligence and care, and few have equalled him. His painstaking efforts are marked on almost every page, so that the reader is enabled to rely absolutely on every statement made, knowing that it has been given as the result of the most elaborate and thorough research and observation.

We shall await with much interest and expectation the publication of the subsequent series of papers, and meantime we commend the present collection as a valuable addition to the scientific practitioner's library, not merely as a reference volume, but as a stimulus to original observation and study in the practical and scientific aspects of this work.

THE PRACTICAL MEDICINE SERIES. (*b*)

IT is often, no doubt, a distinct advantage to the busy practitioner to have an epitome of the year's work in every department of medicine prepared ready to his hand. Such an epitome, however, to be of any real service must be well made. We fear we are unable to say this of any of the volumes before us. The summarising appears to us to have been made on no very definite plan, much that is quite of passing interest being included, and many facts of importance entirely passed over. We regret that we have been unable to find much to commend in these volumes. In fact, the editors have attempted a highly delicate task, and the result, we fear, from the practitioner's point of view must be regarded as leaving much to be desired. Such a series could never fully replace the reading of medical journals, or the excellent abstracts given in many of these from week to week.

Should this series be continued we would strongly urge the editor to enforce upon his collaborators the necessity for more judicious selection of their material and for very thorough pruning and condensation before it is put in print. Such books as these might possibly serve a useful purpose were they worked out on a definite system, and were they to contain the essence and the cream, so to speak, of the year's literature on any single subject. As they stand, their usefulness to British medical men will be found to lie chiefly in the fact that they give the experience of their American colleagues practising in the various specialities. So that if the series were made thoroughly representative of all that is best in American medicine for each year, it might be of real help and value. The idea is good, but its execution might be considerably improved. We think the success of the "Practical Medicine Series" lies rather in its promise than in its performance. The binding and get-up of the volumes is not very elegant.

SWANZY ON THE EYE. (*a*)

THIS excellent handbook has reached its ninth edition and has been very largely re-written. It now appears under the joint authorship of Mr. Swanzy and Mr. Louis Werner. The work is brought well up to date, and there are a good many changes to be noted. Perhaps the first is the large number of new illustrations which have been added, and very good ones they are. These account, according to the preface, for the increased size of the book by about 60 pages; but on the other hand we note that the references to literature (formerly given at the end of each chapter) have been left out, though a few are given in footnotes. This is hardly an advantage. The theory of the ophthalmoscope, the optical structure of the eye, refraction and accommodation are more fully treated than in previous editions, and a chapter on elementary optics has been again inserted. A new section has been added on the bacteriology of the conjunctiva, and Parinaud's conjunctivitis is well described, but no hint of its rarity is given. In the chapter on the uveal tract a radical departure from generally received views may be found in the statement that, excluding syphilis, "tubercle is probably the most common cause of iritis" (p. 353). Most ophthalmic surgeons, in this country at all events, would, we think, demur to this statement, unsubstantiated as it is by any statistics in the work before us. Another new feature is a much needed description of heterophoria and the various tests, &c., for it.

Misprints are few and far between, though the dual authorship is perhaps shown by the varying spelling of hypopyon, which occasionally appears as hypopion. For a book of its present size, "Swanzy on the Eye" can hardly be surpassed, but the pages in each edition are becoming more numerous, and, we may presume, the students' task more onerous.

TREVES' "OTHER SIDE OF THE LANTERN." (*b*)

A FINE popular edition of Sir Frederick Treves' book of travel has been issued by Messrs. Cassell and Co. "The Other Side of the Lantern" professes to be an account of a "commonplace tour" round the world. Certainly the book itself is not commonplace, for it is crammed from cover to cover with sharp, incisive observation and no small amount of literary power.

(*a*) "Collected Papers on Circulation and Respiration." First Series, chiefly containing Laboratory Researches. By Sir Lauder Brunton, M.D., D.Sc., LL.D., F.R.S., F.R.C.P., Consulting Physician and Late Lectures on Pharmacology and Therapeutics to St. Bartholomew's Hospital, &c., &c., London: Macmillan and Co., Ltd.

(*b*) "The Practical Medicine Series for 1906," in nine volumes:—Vol. III., The Eye, Ear, Nose and Throat, edited by C. A. Wood, M.D., A. H. Andrews, M.D., and G. P. Head, M.D.; Vol. IV., Gynæcology, edited by E. C. Dudley, M.D., and C. von Bachelle, M.D.; Vol. V., Obstetrics, edited by J. B. De Lee, M.D., D. Rochler, M.D., and H. M. Stowe, M.D.; Vol. VII., Pediatrics, edited by Isaac A. Abt. M.D.; Orthopædic Surgery, John Ridlon, A.M., M.D., and Gilbert L. Bailey, M.D.; Vol. VIII., Materia Medica and Therapeutics Preventive Medicine, Climatology, Forensic Medicine, edited by George F. Butler, Ph G., M D., Henry B. Favill, A.B., M.D., Norman Bridge, A.M., M.D., Daniel R. Brower, A.M., M.D., LL.D., and Harold N. Moyer, M.D.; Vol. IX., Anatomy, Physiology, Pathology Dictionary, edited by D. A. Evans, M.S., M.D., Adolph Gehrmann, M.D., and William Healy, A.B., M.D. Chicago: The Year Book Publishers, 40, Dearborn Street. Agents for the United Kingdom, Messrs. Gillies and Co., Glasgow.

(*a*) "Diseases of the Eye and their Treatment." By H. R. Swanzy, A.M., M.D., (Causa hon.) Univ. Dublin, President of the Royal College of Surgeons in Ireland, Surgeon to the Royal Victoria Eye and Ear Hospital, etc., etc., and Louis Werner, M.B., F.R.C.S.I., Ophthalmic Surgeon to the Maternity Hospital, Assistant Surgeon to the Royal Victoria Eye and Ear Hospital, etc., etc. Ninth Edition. Pp. xx. and 744. 12s. 6d.

(*b*) "The Other Side of the Lantern." By Sir Frederick Treves, Bart., G.C.V.O., C.B., LL.D. Popular Edition. London and New York: Cassell and Co., Limited. 1906. Price 6s.

From the technical point of view of the author's craftsmanship, we should say that the book would have gained by the omission of part one, consisting of twenty-eight pages of a kind of prologue, in the course of which the reader is conveyed from Tilbury to Aden. The descriptive style of the writer is terse and graphic. It would be difficult to compress more substance into a few words than in the following picture of the famous Kashmir Gate at Delhi :—" The parapet of the gate," it runs, " has been much battered by shell, and its outer walls are pitted in a hundred places by shot from English guns. The place is haggard with grim memories. The ditch is spanned by just such a bridge as spanned it in '57, but the depth of the fosse is diminished, while its sides are less rugged than they were." The gem of the whole book, to our mind, is Chapter XVII., which describes " The Garden of the Unforgotten." Indeed, one lays down this book with the conviction that Sir Frederick Treves would as a writer have made a name no less distinguished than that he has attained as a surgeon. The book contains forty illustrations from photographs made by the author. These illustrations many of them display fine artistic insight in their selection, and some of them—notably that of the " Garden of the Unforgotten," are pictures of unrivalled excellence and beauty. All medical men should possess this book.

SAINSBURY ON THERAPEUTIC PRINCIPLES. (*a*)

A TRUE conception of science is one of the greatest needs in the quest for clear thought at the present day. An inventory of facts, however carefully set in order, is not itself science, any more than a dictionary is literature, or a table of dates history. They are useful in their proper places, but they must not be taken for what they are not. Accuracy is a prime virtue, it is true, in science as in history, but mere accuracy of statement does not constitute either science or history. For science there must be, if the facts permit it, the broad sweep and the full survey, the general, and not merely the mass of particulars. The wood must be obvious, and not merely the trees. The parts must stand to each other and to the whole in proper harmony, and the whole be in harmony with its neighbours. In a word, only when the standpoint becomes philosophical does a group of facts become science.

In this sense, Dr. Sainsbury's book is one of the most scientific which has come under our notice for a long time. To the medical reader, jaded with indiscriminate facts from the perusal of the books which form the bulk of medical publications, the present volume is like the shadow of a rock in a weary land. There is no hurry here ; there is no attempt to impress the reader with the multiplicity of the author's knowledge, but there is meditative disquisition, calm, careful reasoning, and lucid, even distinguished manner of expression.

Dr. Sainsbury discusses the first principles of therapeutics, and he applies them to the facts of health and disease. He will be a dullard who comes away without many new ideas in his mind, and without many new points of view open to him. It must not be supposed, however, that the book is unpractical. Many details are discussed, but they are discussed relatively, and not absolutely. Thus, not only diet, atmosphere, surroundings, the nurse, the attitude of the patient, offer food for reflection, but the uses of the various classes of drugs in the *materia medica* are explained, rather, it is true, by suggestion and illustration than discursively. There are doubtless individual points of view in Dr. Sainsbury's book with which various readers may quarrel. For ourselves, we feel grateful for much pleasant and leisurely reading, and we commend a book which is at once literature and science.

(*a*) " Principia Therapeutica." By Harrington Sainsbury, M.D., F.R.C.P. London: Methuen and Co. 1906. Pp. xi. and 244. Price 7s. 6d. net.

LACK ON DISEASES OF THE NOSE. (*a*)

THIS book is somewhat unevenly written, parts of it are extremely good, while others are rather the reverse. The chapter on nasal obstruction will well repay perusal. The relation of nasal to oral pathology and the way in which affections of one cavity act and react on another have only within recent years received attention. The effect of dental disease on the nose has been fairly well investigated and is fairly generally known, but the effect of nasal obstruction on the growth and health of the teeth is still very imperfectly appreciated, and this most important relation is well expounded in Mr. Lack's book. The treatment of chronic sinus suppuration is discussed on rather antiquated lines ; one would expect less stress to be laid on drainage as the ultimate aim in the performance of radical sinus operations. We cannot agree with the statement that it is useless to try examination of the antrum by direct illumination during the radical operation ; in our judgment the only way of securing accuracy in such operations is by inspection during the operation with the forehead lamp.

Numerous operations for the treatment of deflected septum are given, most of these are entirely out-of-date, their place having been taken by the sub-mucous resection. The author's criticism of this elegant operation is, in our opinion, unjust. With an experience of more than a hundred such cases we have never seen subsequent sloughing, and inconvenient hæmorrhage during operation is very rare. It is never necessary to use a general anæsthetic. That there is a certain amount of difficulty in its performance is, of course, true ; but no one with any pretensions to being a rhinologist would have such difficulty in carrying it out as Mr. Lack states. The book is well, if not profusely, illustrated, and is, on the whole, a useful addition to the literature of the nose.

THE ELIMINATION OF THE UNFIT (*b*).

THE poor, in mind and body as well as purse, are ever with us. Would-be reformers talk glibly regarding " degenerates " and " defectives," but we are still far from understanding the ætiology of these " regrettables," and while many advocates are loud in their advertisement of preventive and curative measures, the rational medico-sociologist hesitates until the day dawn of scientific truth shall have afforded sufficient light to indicate the right path which should be travelled.

But Dr. Reid Rentoul is not among these halting and hesitant ones. He is a bold thinker and a brave writer, and lacks not either in the courage of his convictions or in a pungent power of expression which is often more forcible than scientific. It is interesting, but not surprising, to learn that " no less than eleven—apparently respectable—publishing firms could not see their way to publish the first edition." In these pages there is a ghastly catalogue of the physical deterioration, mental degeneracy and general decadence of our people. Truly, the list is a terrible one, but statistics on which Dr. Rentoul depends for most of his contentions require much more careful handling than they receive in these impetuous pages if their full truth and complete meaning are to be revealed. With much of the author's denunciations and demands we have considerable sympathy, and can only regret that he has weakened his case both by extravagances of expression, and an, at times, most offensive lapse into vulgarisms and an employment of inexcusable expletives. The work is one which must be studied with much discrimination, and for many of the so-called facts here presented we would like more precise and authoritative evidence. It is evidently written for the the ordinary layman as much as, or perhaps more, than

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(*a*) " Diseases of the Nose and its Accessory Sinuses." By H Lambert Lack, M.D.Lond., F.R.C.S., Surgeon to the Throat Department of the London Hospital, Surgeon to the Throat Hospital, Golden Square, etc. Pp. 399 and xv. With 124 illustrations. London: Longmans, Green and Co.

(*b*) " Race Culture, or Race Suicide ? " (A Plea for the Unborn). By Robert Reid Rentoul, M.D. Pp. 182. London and Felling-on-Tyne: The Walter Scott Publishing Co., Ltd. 1906. Price 7s. 6d. net for the medico-sociological student. Dr. Rentoul's specific for the ills that afflict us from the presence of "mental degenerates and physical deteriorants," as he terms them, as either voluntary or compulsory sterilization: "The operation consists in excising and ligaturing the divided ends of, in the male, the vasa deferentia, or spermatic cords, and with female, the fallopian tubes." Some interesting points are discussed as to the effects of sterilization upon the sexual characteristics and general health upon "the patients." Really Dr. Rentoul's proposal is under present conditions of civilized life in a Christian country so impossible, and from some standpoints, so risky, that it is hardly likely to receive that consideration which he considers it to merit. The book in spite of its egotism, its many objectionable features of style and diction, its looseness of argument and lack of logical arrangement, is nevertheless full of speculative interest, and is not deficient in suggestiveness, and the subject dealt with is clearly one of such pressing racial importance that no rational proposal should be neglected. We cannot but think that the very title of this book is indicative of its unsatisfactory inconclusiveness.

AN EGYPTIAN HEALTH RESORT. (*a*)

Egypt is for many reasons a peculiarly attractive land for the tourist and health seeker. During recent years, means of transit, hotel accommodation, and all the many needs and necessities of the invalid and traveller have been improved, so that the Land of the Pharaohs is now one where medical men may send patients with a guarantee that adequate provision will be available. Dr. Hobson's manual is an admirable guide which may be consulted with profit by both physician and patient. It describes the manner of access to Helonan, the special features of the place, its baths and mineral waters, and deals with many other matters, such as amusements, places of note in the neighbourhood, the flora of the district, and much general information likely to be of real service. The illustrations are excellent. No one should set out for Egypt without this guide-book in his hold-all.

THE RIVIERA OF PORTUGAL (*b*).

Portugal is but little known to most English medical practitioners. Dr. Dalgado's *brochure* is intended to quicken interest in the Portugese Riviera, and to show that Mont' Estoril is a desirable winter station, and Ciutra a charming summer resort. Much valuable meteorological and climatic data are here collected, and numerous particulars likely to be of service to the tourist and health seeker. There is no map, which is a regrettable deficiency to such a monograph as this.

PHILLIPS ON GYNÆCOLOGY.

This work on gynæcology was published first in 1893, and since then has passed through three editions. The present, the fourth, edition is said in the preface to be "revised." In addition, a more detailed account has been given of Chorion-Epithelioma, and the operation of Ventro-Suspension. The literature appended to many of the chapters has been carefully altered and kept up to date.

Discussing the treatment of myomata, the author tells us that removal of the ovaries "is indicated in young women with slowly growing hæmorrhagic fibroids, interstitial or sessile subserous in variety, and where the level of the tumour does not reach above the level of the umbilicus." Hysterectomy "is the last resource for the patient." "There is a growing feeling in favour of it" (intra-peritoneal hysterectomy) "as compared with the extra-peritoneal operation." "The relative value of supra-vaginal amputation and total extirpation" (in malignant disease of the cervix) "is at present not decided." Such statements scarcely prove that a careful "revision" took place.

The revised references to literature at the end of a chapter on "Affections of the Uterus" respectively refer to communications published in the years 1898, 1886–7, 1897, 1885, 1898, 1885–6, 1885–6, 1888, and 1885. The author apparently does not think that here at least there is any scope for the "advances of gynæcology" to which he refers in his preface. The fact is the book is incapable of revision, and for this reason we regret to see a new edition of it.

DORLAND ON WORDS. (*a*)

This very excellent dictionary of medical and scientific terms has been thoroughly revised and brought up to date. Over 2,000 new words have been added, and numerous improvements have been made throughout the text. Six new coloured plates have also been added illustrating appendicitis, diphtheria, gall-stones, Leishman-Donovan bodies, measles and nephritis. The dictionary is a most complete one, and at the same time it is handy in size, whilst its appearance is all that could be desired.

MEDICAL NEWS IN BRIEF.

Medical Graduates' College and Polyclinic.

The annual general meeting of the Medical Graduates' College and Polyclinic was held on March 22nd at Chenies Street. Dr. C. Theodore Williams presided. Captain Hayward Pinch, the medical superintendent, read the annual report, which stated that there were now 149 members and 563 subscribers. During the year 1,164 cases of disease, many of them being of extreme rarity, were shown at the clinics. The four sessions of practical classes were attended by 198 practitioners. In the laboratory 512 clinical investigations were carried out. The chairman, in proposing the adoption of the report, said that it clearly showed that there was plenty of energy in the college and that excellent work had been done, but they wanted more members and subscribers. Fleet-Surgeon A. W. French proposed, and Dr. J. Fletcher Little seconded, a vote of thanks to five retiring members of the council, which was carried, and they were re-elected, together with Dr. F. M. Sandwith. The chairman and the medical superintendent were thanked for their active interest in the work of the college.

Inquests.

At Greenwich, on March 22nd, Mr. H. R. Oswald held an inquest on the body of Dr. Henry William Payne Makeham, aged 54 years, of 330, New Cross Road. Mrs. Makeham, the widow, stated that her husband had recently suffered from erysipelas, but had nearly recovered. On Tuesday evening she returned home and found him very drowsy. As she knew that he had been in the habit of taking morphia to relieve abdominal pains, she asked him if he had taken morphia, but he appeared too insensible to answer her. Later she found in a pocket of the coat he was wearing a paper which she suspected had contained morphia. He was not depressed, and had never threatened to take his life. Dr. Kenneth Brewer having stated that the cause of death, which took place on Wednesday morning, was asphyxia following morphine-poisoning, the jury returned a verdict of "Death by misadventure."

The Sale of Poisons.

Mrs. Simpson, a widow, carrying on business as a chemist at Hoxton, was summoned at Old Street, London, under the 17th section of the Pharmaceutical Act for selling a scheduled poison in a bottle not

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(*a*) "Helonan: An Egyptian Health Resort, and How to Reach It." By H. Overton Hobson, M.D. Pp. 88, with 35 illustrations and 2 Maps. London: Longmans, Green and Co. 1906. Price 2s. 6d. net.

(*b*) "The Climate of Lisbon and of the Two Health Resorts in its Immediate Neighbourhood, Mont' Estoril, on the Riviera of Portugal and Ciutra." By Dr. D. G. Dalgado. Pp. 52. London: H. K. Lewis. 1906. Price 2s. 6d.

(*a*) "The Illustrated Medical Dictionary." A new and complete dictionary of the terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, and the Kindred Branches, with their pronunciation, derivation, and definition. By W. A. Newman Dorland, A.M., M.D., Assistant Obstetrician to the University of Pennsylvania Hospital, &c., &c. Fourth edition, revised and enlarged. London: Saunders and Co. 1906. Pp. 836.

labelled with her name and address as seller. The opening statement showed that the child of people named Wheatley had died from drinking carbolic acid, counsel saying that the child was only two and a half years old, and yet had taken up a bottle from the table and drank from it. Mr. Cluer (astonished): At that age? The bottle was produced, and proved to be a pint black bottle bearing the label of a well-known firm of brewers. On one side, but not across the label, the bottle bore a narrow label in red letters with the word "Poison." The prosecution added that the Act required that the name and address of the seller should be added. For the defence, Mr. Margetts said that Mrs. Simpson had been carrying on the business since the death of her husband, and had served the man Wheatley with the disinfectant in question on a statement by him that a child of his had been removed suffering from fever. She had acted from oversight, and had taken the unfortunate result very much to heart. Mr. Cluer: The best defence is that, however the bottle might have been labelled, it would not have prevented a baby of two and a half years from drinking from it. Mrs. Simpson need not allow the death of this child to worry her mind. It was no act of carelessness on her part which had contributed to it. For the breach of the Act he fined her 20s. and 2s. costs.

Infant Mortality at Barrhead.

SOME time ago the Town Council of Barrhead appointed a nurse to give her services in cases of birth in the poorer classes of the community, the object being to reduce the death-rate among infants, which is abnormally high in the borough. Recently it became apparent that the relations between the nurse and the local medical men were not of the most harmonious character, and a special meeting of the Town Council was called for the consideration of the matter. The meeting was held in private, but a minute has now been issued from which it appears that the points of difference were fully discussed, it being agreed, the doctors present cordially concurring, "that the nurse should continue her work on existing lines, and that the doctors would support and utilise the services of the nurse in attaining the objects aimed at."

Medical Education of Women.

THE Scottish Association for the Medical Education of Women held their annual meeting in the College, Chambers Street, Edinburgh, yesterday afternoon. Sir Alexander Christison, Bart., who presided, said the College had been very prosperous. It had started on a small scale, but was now flourishing. Miss Fairgeld, in submitting a motion "that every effort be made to obtain entrance to the University for first-year medical subjects," said that her reason was that they knew the matter had been brought up by other channels to the notice of the University Court. The matter had been treated from the standpoint of scientific students. They must regard the classes as not being purely medical classes at all but as science classes, and as such there were some prospects that they might be excluded altogether from the medical curriculum. Miss Lowe moved the previous question. She maintained it was by far too great a question to decide in an afternoon. It touched upon a big area of University reform. If the women went to University classes, the school would be affected to a great extent. Dr. A. Goodall seconded, and after discussion the motion was withdrawn for the present.

Flowers as Ozone Producers.

THE medical officer of health to the Tunbridge Wells Corporation reports, for the past year, the lowest death rate on record, viz., 11.35 per 1,000 of the inhabitants. The Town Council makes a novel recommendation to householders to ensure even healthier surroundings. It urges that, instead of keeping fowls and domestic animals in small gardens, sweet smelling flowers, such as mignonette, lavender, and mint should be planted, as these produce ozone in large quantities, and are most useful in purifying and disinfecting the air.

The Spread of Anthrax.

A QUESTION was asked in the House of Commons a few days ago of the President of the Board of Agriculture whether he was aware there were twenty-eight outbreaks of anthrax and thirty-six animals attacked by the disease in seventeen different counties in England, Wales and Scotland in a week; and whether in consequence of the spread of anthrax throughout the country, which is not only financially disastrous but dangerous to human beings who have to deal with it, the Board of Agriculture would institute an inquiry as to the origin of the disease and as to what steps should be taken to stamp it out. In reply thereto Sir E. Strachey regretted that the reported increase was but too true, and that the first part of his hon. friend's question was in the affirmative, but was happy to say that the disease is not increasing throughout the country, the number of cases this year being slightly less. Investigations are proceeding both as regards the nature of the disease and the means by which it is spread, and any amendments in the existing order on the subject which may appear to be necessary will at once be made.

Sale of a Celebrated Medical Residence.

THE sale of 123 Harley Street, Cavendish Square, which has been in the occupation of well-known medical men for nearly a century, is announced for sale by auction on the 12th inst. Competition for houses by medical men in this centre of activity is at all times keen, and doubtless the present occasion will prove no exception.

British Medical Association Meeting at Exeter.

IT is proposed on the occasion of the visit of the British Medical Association to Exeter this year to amplify, if possible, the handbook of the locality issued to members attending the meeting into a handsome volume, with special articles, historical, descriptive climatological, etc., profusely illustrated with photographs of Devon and Cornwall scenery, and portraits of worthies of the two counties, so that instead of finding its way into the waste-paper basket this book shall be given a permanent place on the bookshelf or table as a necessary work of reference. If this can be accomplished, the claims of the health resorts and residential neighbourhoods of Devon and Cornwall will be placed permanently before the medical profession. About 1,000 medical men from all parts of the kingdom, including many of the leading authorities on medicine and surgery, and possibly not a few from the Colonies and foreign countries, are expected to attend the meeting. Further, it is intended, if sufficient money can be raised to carry out this scheme, that many extra copies shall be taken over by the United Devon Association for distribution in this country and abroad. This book of the south-west will be compiled and published by the South-Western Branch of the British Medical Association, and a copy will be presented to each member attending the annual meeting of the British Medical Association.

Trinity College, Dublin—Hilary, 1907.

Licence in Dental Science.—Charles E. Moore.

Intermediate Medical Examination (Part II.).—Thomas A. Hughes and Adams A. M'Connell, passed on High Marks; Robert E. T. Tatlow, George E. Craig, William R. Watson, Albert E. Wynne, Ralph T. St. J. Brooks, Eric J. Powell, Charles G. S. Baronsfeather, Desmond Drew, Victor B. Kyle, Wellesley R. Allen, Charles B. Jones, James D. Murphy.

Final Medical Examination (Part II.).—*Midwifery:* Julian B. Jones, passed on High Marks; Duncan F. Hunter, Charles H. O'Rorke, Oliver St. J. Gogarty, Edmund H. Sheehan, Bethel A. H. Solomons, George H. Stack, Allman J. Powell, James D. K. Roche, James G. M. Moloney, Thomas P. S. Eves.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

The Radical Cure of Trigeminal Neuralgia by Means of Peripheral Operations.—Moschcowitz (*Med. Record*, February 16th, 1907) states that all recurrences in trigeminal neuralgia have been found to be due to regeneration and re-union of the divided nerve tissue. The desideratum at present, therefore, is to prevent this occurring. Most of the terminal endings of the trigeminal nerve make their exit from the skull through bony foramina. This suggests the possibility of dividing the nerve in the canal, and preventing the re-union by permanently plugging up the foramen of exit. The author accomplished this by means of silver buttons, each consisting of a flat top not more than one-sixty-fourth of an inch in thickness, and of a diameter of about one-quarter of an inch. It is sufficiently firm to retain its shape, and yet sufficiently malleable, so that it will give if lightly hammered on. In the centre there is annealed a silver rivet, ranging in thickness from one thirty-second of an inch to one-eight of an inch, and about three-eights of an inch in length. The operation in appropriate cases consists in the following steps:—Through an incision of suitable length, half to one inch, the foramen in question is exposed. The nerve is then carefully isolated from accompanying vessels; a short length is drawn out from the foramen, in order to secure that the nerve will detract sufficiently from the surface, and it is divided. The accompanying vessels are treated in a similar manner after double ligature. A button of suitable diameter is selected and driven into the foramen, so as to fill it completely. As some foramen are not absolutely round, the overhanging flat top is now moulded to the underlying cone, so as to make the closure absolutely tight. The small cutaneous skin incision is closed. If necessary the entire operation can be done in local anæsthesia. The author records some cases. Case I. Lady, æt. 58, had suffered for several years from left-sided trigeminal neuralgia involving the three divisions of the nerve. Local and internal treatment, and removal of teeth had not improved the condition. The pain was very frequent and severe. The patient was operated upon the 17th September. The mental infraorbital and supraorbital foramina were exposed in the order named by small transverse incisions; the nerves divided and the foramina plugged by means of silver buttons, the pain completely disappeared, and has not returned since. The buried metal causes no discomfort whatever. The other cases recorded were of a similar nature. S.

A Report on Clinical Experiences with Spinal Analgesia.—Barker (*Brit. Med. Journ.*, March 23rd, 1907) reports a series of one hundred cases in which the procedure was employed tentatively during the last year in the ordinary course of hospital study. In all the cases stovaine only has been employed in order to gain some adequate idea of its behaviour from a fair number of observations. The patients' ages varied from fifteen to seventy-one years. The amount of stovaine injected was from three to six centigrammes, in most cases about five. In only three, among the first fifty cases was two centigrammes extra required to produce the desired affect. The duration of analgesia varied between twenty-three minutes and a couple of hours. Adrenalin compounds were added in these cases. Adrenalin derivatives undoubtedly prolong the analgesia, but the author cannot help thinking that some of the few undesirable sequelæ recorded have been due to them. Among the operations performed during spinal analgesia are—strangulated hernia, resection of gut, appendictomy, piles, wiring patella, amputation through the thigh, &c. The author has performed no operation above the umbilicus yet. In from five to ten minutes after the injection the patient was not only completely anæsthetised, but also relaxed in all the parts supplied below the parts reached to. In rectal operations—piles, for instance—the sphincters relaxed completely, and the piles presented themselves without any dilatation with the fingers, and with the straining and movement sometimes seen under general anæsthesia. That the specific influence of stovaine is limited almost exclusively to the locality into which it is injected in moderate doses seems highly probable from experience of it as a local and spinal anæsthetic. Its effect, if any, on the pulse is to reduce its frequency, and increase its volume, and a patient after injection usually feels and looks warmer than before. The injection can be made in the second or third interspace of the lumbar vertabræ, thus avoiding the cord. Puncture in the middle line is easiest, safest, and best. Here the puncture is least painful, and there is less danger of wounding any nerve structures, as on either side there is a possibility of touching the spands of the cauda equina. The puncture is easiest with the patient sitting on the edge of a table with his back rounded to its maximum. The author employs a modification of Bier's needle. The needle pierces the dura mater, and a cannula through which the fluid is injected projects just beyond this into the subdural space. S.

A Case of Gastro-Enterostomy Combined with Gastrostomy, for Ulceration of the Stomach.—Moynihan (*Brit. Med. Journ.*, March 23rd, 1907) reports his treatment of a patient who accidentally swallowed a few mouthfuls of hydrochloric acid, which caused extensive ulceration of the stomach with consequent stenosis of the pylorus. There was no obstruction of the œsophagus. A few days after the accident the lips, mouth and throat became very sore, and any food was followed by severe pain and vomiting. Seven weeks after accident the abdomen was opened. The stomach was small. The pyloric antrum was solid and hard, and it seemed quite impossible that any fluid could find its way through so dense a tumour. Posterior gastro-enterostomy was performed. The gastric mucosa was a deep plum colour and very attenuated. When the stomach was replaced a small opening was made on its anterior surface, through which an indiarubber drainage tube was passed. With the fingers of the right hand placed below the stomach this tube was guided through the gastro-enterostomy opening into the distal limb of the tube for about five inches. This being done, the right hand was removed, and the omentum replaced. At the point of entrance of the tube into the stomach on its anterior wall a gastrostomy was now performed after "Senn method." A single cat-gut stitch fixed the tube to the end of the opening, and a series of circular purse string sutures were applied round the tube in tiers, so that a cone of stomach was enfolded. A couple of sutures then fixed the anterior wall of the stomach to the panital peritoneum of the anterior abdominal wall, and the wound was closed. For the first two and a half weeks the patient was fed every four hours directly into the jejunum. On the eighteenth day food was again given by the mouth. The tube was removed in the fourth week, and the little wound left in the abdominal wall speedily granulated up; there was never any leakage from it. The operation practiced in this case effects two purposes: it enables the patient to be fed while healing of the ulcerated surfaces is in progress, and by means of the gastro-enterostomy it establishes an alternate route from the stomach when the pylorus is closed by the contractions of the cicatricial tissue deposited in the ulcers. S.

Chorioidal Hæmorrhage after Cataract Extraction.—McNabb (*Ophthal. Review*, November, 1906) records a case of this unusual complication. In the records of the Manchester Eye Hospital for the past twenty years he finds mention of two other cases out of a total of 4,422 extractions. From the cases reported in literature we learn that the hæmorrhage may occur immediately after the corneal section, later before the completion of the operation, or still later, some few hours or a day after the operation. In the case under notice NcNabb attempted a confined operation, but fluid vitreous escaped after the iridectomy and the lens had to be spooned out. About two hours afterwards the dressings became soaked with blood. The eye was removed two weeks later. McNabb had removed a cataract from the other eye with excellent result. A pathological examination showed the vessels to be undergoing slight fatty degeneration. No amyloid degeneration could be found. McNabb says that the most frequent cause of these hæmorrhages is probably atheromatous or fatty degeneration of the vessels which give on the sudden reduction of tension following the incision in the cornea. In cases of increased tension, in the decrepit, or when marked general vascular changes are evident the author advises a preliminary iridectomy to be performed.

M.

Extraction of the Lens in High Myopia.—De Font Reaulx (*Annals d'Oculistique*, Feb., 1906) after following cases for five years or more declares himself rather in favour of this procedure, although he thinks there is no operation in ophthalmic surgery where the surgeon's responsibilities are so great or in which one is confronted with so many risks and pit falls. All this is due to the remote disappointing results which are met with from time to time, the repeated operations which are necessary, and the long time that the patient must give to the course of treatment. He warns us not to be carried away by the gratifying and immediate results that operation has on distant vision, but to remember that in a very large proportion of cases the patient comes complaining of this near vision. Unless we select those cases which will leave the eye myopic after the lens has been removed we will be disappointed to find the patient using the unoperated eye for near work. Before operation the patient's position, occupation etc., should be carefully considered and weighed with, the optical results expected to be obtained. M.

Exophthalmic Goitre.—P. Horowitz (*Post-Graduate*, March, 1907) thinks it is most probable that exophthalmic goitre is caused by some form of toxæmia, it is a disease, however, in which we have no definite predisposing cause. The pathological findings in the gland are those which may occur in a simple parenchymatous goitre, and in the so-called cases of primary exophthalmic goitre, a hypertrophy of the epithelial cell, but no apparent increase of the secretion, or of the colloid material. In the rest of the body there is practically no change, except for an enlargement of the thymus gland occasionally, and possibly some fatty degeneration of the muscles. The disease is more frequent in women than in men. There may be acute exacerbations with symptoms simulating acute septic poisoning or malignant endocarditis. The diagnosis can as a rule be made from the general symptom complex, the exophthalmus, and the enlarged gland, but we must not forget that there are cases that do not have either the exophthalmus or the enlarged gland, but which may develop later. The prognosis in acute cases is not good, but chronic cases go on and may recover with a fair amount of health, and retain it for a long period. The different therapeutic agents advanced for the relief and cure do not always accomplish the same results in different cases, probably the Roger-Beebe serum, and the surgical treatment may take the place of the numerous other forms of treating the disease, which have been advocated, so far, however, not enough results have been obtained to warrant our recommending one mode of treatment as being better than another. G.

Pyrexia in Hodgkin's Disease.—F. Taylor reports (*Med. Review*, March, 1907) two cases of chronic relapsing pyrexia associated with Hodgkin's disease. Although it has been known for a long time that pyrexial attacks separated by long periods of apyrexia are not uncommon in the course of this disease, yet the profession is not familiar with this relapsing fever much less with its extraordinary duration. The writer then describes fully two such cases, and mentions seven others. From these nine he draws the following conclusions:—(1) In Hodgkin's disease a varying temperature is common; (2) in some cases there are relapses with periods of apyrexia; (3) the temperature may be continuously high for long periods, the periods of high fever may alternate with periods of lower fever; (4) the relapsing pyrexia may be of assistance in diagnosing doubtful cases of Hodgkin's disease. G.

The Early Diagnosis of Cancer of the Rectum.—D. Drew calls attention (*Clinical Journal*, Dec., 1906) to the description usually given in the text books of cancer of the rectum, as an irregular nodular mass narrowing the lumen of the bowel, with a surface which is often ulcerated and bleeds on examination. If these signs are relied on for making the diagnosis, it is no wonder that the results of operation for cancer of the rectum are disappointing, for these signs will only occur late in the course of this disease. Here as in most other localities, cancer is at the start quite painless, and for a long time the only sensation the patient may feel is one as if the bowel had not been completely emptied after defæcation has taken place. Later on piles may make their appearance. The importance of a thorough examination of the rectum in all such cases cannot be over-estimated. In the large majority of cases cancer of the rectum commences within easy reach of the finger, and the finger is the best instrument to examine the bowel with. If any small ulcer or hard nodule is felt, a very complete examination of the lower bowel should at once be made, if necessary, under an anæsthetic; this is not as a rule necessary unless the growth is very high up in the rectum. If nothing definite can be felt by the examining finger, and symptoms continue of some irritation in the bowel, then a proctoscope should be used and the upper part of the rectum examined in this way. The chances of success after removal of such a growth are enormously increased if the diagnosis is made early. G.

Jaundice.—A. Pisani (*Post-Graduate*) March, 1907, in a paper dealing with numerous cases of jaundice, their clinical symptoms, and the pathology of the affection, believes that the natural deductions to be drawn from this disease are:—(1) That all forms of jaundice are either intra-lobular, or extra hepatic; (2) that all forms of jaundice are due to obstruction of the biliary passages; (3) that the severity of the jaundice in the inter and intra-lobular forms varies, all depending on the amount of biliary radicles occluded; (4) that the differential diagnosis between the intra-lobular and the inter-lobular forms of jaundice is generally reached after considering the history of the case, and the result obtained in the treatment of the same; (5) that in the extra-hepatic form of jaundice where the obstruction is due to biliary calculi, it is always advisable to submit the patient to a thorough medical treatment before advising him to submit to operative interference; (6) if the obstruction does not yield promptly to medical treatment, surgical interference should at once be instituted. G.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

M. A. B. (Liverpool).—The society referred to is called the "Association Medicale Internationale pour aider la suppression de la guerre." The president is Dr. Riviere, 25, Rue des Mathurins, Paris, to whom you should apply for the desired information.

Dr. S. M. T.—The powers can be obtained by adopting the Defectives and Epileptics Act, 1899, which is an optional measure, and allows (inter alia) for the provision of special schools, classes, etc., for defective children. Write to the Secretary, Board of Education, Whitehall, S.W.

R. S. Foster.—The summer opening of the medical schools varies somewhat, but the majority recommence on the 22nd inst. You will see the date of many announced in our advertisement columns.

One Interested.—Thanks for the compliment, but the communication is scarcely suitable for our columns.

"PARTING IS SUCH SWEET SORROW."

The women part with ovaries,
The men with prostate gland;
But why relinquish any more
They fail to understand.

The list of human giblets now
Is mounting up each year—
Tonsils, appendix, thyroid glands,
Are given without a tear.

But when at length you've nearly lost
The most of your inside,
You very naturally conclude
'Twas time you should have died.

A. D.

Historicus.—(1) It is a mistake to think that Keats was an inefficient student of medicine, even if he did not care for its study. Although he broke his articles with Dr. Hammond, of Edmonton, to whom he was apprenticed, it was by mutual consent, and during his career at Guy's he was diligent, as his notebooks sufficiently testify. Indeed, he seems to have been genuinely attached to Sir Astley Cooper, who was then at his zenith. (2) He did perform one, but only one, operation—viz., opening the temporal artery. V. Letters. (3) He qualified L.S.A. on July 26th, 1816, but never practised.

Meetings of the Societies, Lectures, &c.

Wednesday, April 3rd.

Obstetrical Society of London (20, Hanover Square, W.).—8 p.m.: Special General Meeting to receive the Report of the Council. Specimens will be shown by Dr. H. R. Andrews, Dr. Lewers, and Mr. J. H. Dauber. Paper:—Mr. J. D. Malcolm: On the Advisability of Removing the Cervix in Performing Hysterectomy.

North-East London Post-Graduate College (Tottenham Hospital, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-Patient (Dr. Whipham).

Central London Throat and Ear Hospital (Gray's Inn Road, W.C.).—5 p.m.: Demonstration:—Mr. Stuart-Low: Middle Ear and Labyrinth.

Thursday, April 4th.

North-East London Clinical Society (Tottenham Hospital, N.).—4 p.m.: Clinical Cases.

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Demonstration on Fevers (Dr. F. Thomson at the North-Eastern Fever Hospital, St. Ann's Road, N.), Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-Patient (Dr. Whiting), Surgical Out-Patient (Mr. Carson). 3 p.m.: Medical In-Patient (Dr. Chappel).

Friday, April 5th.

West London Medico-Chirurgical Society.—8 p.m.: Clinical Evening.

Laryngological Society of London (20, Hanover Square, W.).—5 p.m.—Exhibition of Cases and Specimens.

West Kent Medico-Chirurgical Society.—Discussion on the Necessity for Organisation in the Medical Profession (opened by Dr. F. S. Toogood).

North-East London Post-Graduate College (Tottenham Hospital, N.).—9.30 a.m.. Clinique:—Surgical Out-Patient (Mr. H. Evans). 2,30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-Patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-Patient (Dr. Leslie).

Vacancies.

Royal Devon and Exeter Hospital.—House Surgeon. Salary £120 per annum, with board, apartments, and washing. Applications to Samuel S. Cole, Acting Secretary.

Wolverhampton and Staffordshire General Hospital.—Senior House Surgeon. Salary £100 per annum, with board, lodging, and laundry. Applications to J. Stephen Neil, House Governor and Secretary, Wolverhampton.

Parish of Birmingham Workhouse Infirmary.—Assistant Resident Surgical Officer. Salary £104 per annum, with furnished apartments, rations, coal, gas, laundry, and attendance. Applications to Charles Fletcher, Clerk to the Guardians, Parish Offices, Edmund Street.

Killarney Union.—Medical Officer. Salary £150 per annum, with £25 per annum as Medical Officer of Health, and heusual Vaccination and Registration Fees. Immediate application to P. Carey, Clerk of Union.

West Sussex County Asylum and Graylingwell Mental Hospital, Chichester.—Junior Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, attendance, etc. Applications to the Medical Superintendent.

Leicestershire and Rutland Asylum, Leicester.—Second Assistant Medical Officer. Salary £130 per annum, with apartments, board, and washing. Applications to W. J. Freer, Esq., New Street, Leicester.

University of Birmingham.—Demonstratorship in Anatomy. Salary £150 per annum. Applications to Geo. H. Morley, Secretary.

Cornwall County Asylum, Bodmin.—Third Assistant Medical Officer. Salary £140 a year, with furnished rooms, rations, laundry, and attendance. Applications to Medical Superintendent.

Bury Infirmary.—A Senior House Surgeon. Salary £110, with board, residence, and attendance. Applications to the Honorary Secretary, Dispensary, Knowsley Street, Bury, Lancashire.

Lancashire County Asylum, Winwick, Warrington.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Birkenhead Union.—Resident Assistant Medical Officer. Salary £120 per annum, with board, washing, and apartments. Applications to John Carter, Clerk to the Guardians, Poor-Law Offices, Birkenhead.

Birmingham, the Queen's Hospital.—Second Physician for Out-Patients and Pathologist. Salary £100 per annum. Applications to Arthur Hulme, Secretary.

Appointments.

Cooke, Thomas Alfred Burnard, L.R.C.P. Lond., M.R.C.S., District Medical Officer by the Pembroke Board of Guardians.

Johnson, James Bovell, M.D., C.M. Montreal, L.S.A. Lond., District Medical Officer by the Sturminster (Dorset) Board of Guardians.

King, William Wilfrid, L.R.C.P., M.R.C.S., Resident Obstetric Officer at the Bristol Royal Infirmary.

Smith, Lionel Shingleton, L.R.C.P. Lond., M.R.C.S., House Surgeon at the South Devon and East Cornwall Hospital, Plymouth.

Taylor, Frank E., M.D., B.S. Lond., F.R.C.S. Eng., M.R.C.P. Lond., D.P.H. Cantab., Physician for Diseases of Women to the North-West London Hospital and to the St. Marylebone General Dispensary.

Turner, Arthur John, M.B., B.S. Durh., Junior House Surgeon at the Bristol Royal Infirmary.

Walters, Charles Ferrier, F.R.C.S. Eng., L.R.C.P. Lond., Surgical Registrar to the Bristol Royal Infirmary.

Births.

Horner.—On March 28th, at 77 Church Hill, Walthamstow, the wife of C. J. Horner, M.R.C.S., L.R.C.P., of a daughter.

Hanna.—On March 23rd, at Alma House, Exmouth, the wife of G. H. Hanna, M.B., Ch.B., of a daughter.

Hardenberg.—On March 25th, at Duffield House, Watford, the wife of E. F. H. Hardenberg, M.B., M.R.C.S., L.R.C.P., of a son.

Parker.—On March 23rd, at Clovelly, Kilmacolm, Renfrewshire, the wife of James Parker, M.B., C.M., of a son.

Scott.—On March 25th, at Hampton-in-Arden, the wife of W. Sibbald Scott, M.B., of a daughter.

Underhill.—On March 27th, at San Remo, Herne Hill, London, the wife of Thomas Hill Underhill, M.B., M.Ch., of a daughter.

Marriages.

Campbell—Mactaggart.—On March 21st, at St. Mary's, Thetford, Robert Campbell, F.R.C.S.Eng., of Belfast, to Amy Isabella, daughter of the late William Mactaggart and Mrs. Mactaggart, of Thetford, Norfolk.

Weekes—Murdoch.—On March 30th, at Parish Church, Lenzie, N.B., Charles Peterson Weekes, F.R.C.S.Ed., only son of William Tucker Weekes, of Elmwood, Sutton, Surrey, to Margaret, fourth daughter of William Murdoch, of Leebank, Lenzie, N.B.

Deaths.

Myrtle.—On March 29th, at 10 Park Parade, Harrogate, Andrew Scott Myrtle, M.D., J.P., in his 82nd year.

Waller.—On March 29th, at Peterborough, Edmund Waller, M.D., R.N., in his 75th year.

MOTOR: Electric Krieger Car to be Sold,

A Bargain, to cover advances, suitable for a Medical Gentleman, being easy riding and silent, front wheel driven, two motors, 12 h.p. tonneau, body green, upholstered red morocco, hold 4 or 5 persons, been but little used and in perfect running order; immediate sale required, arrangement for payment can be made by instalments—Apply to "Armitage," 6, Hamilton Street, Strand, London, W.C.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, APRIL 10, 1907. No. 15

NOTES AND COMMENTS.

Croaking at Epsom.

Epsom seems the withered branch which Lord Rosebery finds the most congenial, or, perhaps we should say, the latest croaking place, for everybody who has a grievance tries to prevail on the ex-Premier to come to his district and do his croaking for him. A little while ago it was the old Brig of Ayr, then came the momentous question of cavalry in Scotland; quite recently his old colleagues were found to be in need of admonishment, and now the issue is the lunatic-containing properties of Epsom. It certainly is a little odd that the London County Council should have pitched on the *locus classicus* of salts and race meetings as a site for two lunatic asylums and an epileptic colony, to say nothing of the third asylum now in contemplation. But after all some spot has to be chosen, and one would think that once the step has been taken, an odd asylum or two would not make much difference. The escaped lunatic danger in these days of good asylum administration is somewhat of a bogie. People's ideas of escaped lunatics are generally derived from novels and sensational train stories which bear a very remote relation to life. The lunatic who escapes is generally a harmless person whose disposition is so benign that he is not watched with the same eagle-eye as his companions; the dangerous cases are not likely to have much chance of regaining their liberty. Still Epsonians may feel an unmerited stigma is being cast on their pretty town, and if the County Council can select some other spot for their purpose it may be as well.

Transfusion and Confusion.

Here it is again! The chronic transfusion canard to wit. Perhaps it would be more accurate to say the recurring canard, for it generally enjoys a latent period of six months before cropping up again. The trouble having died a natural death in England, and having been introduced with wearisome iteration from various continental countries, has at last found a sure and abiding resting-place in America, whence we see it pays biennial visits to this country. This time it comes from Philadelphia and *dramatis personæ* are a husband and wife. The latter has been slowly dying of anæmia, and after despairing efforts of the doctors to wrestle with the insidious malady, as a last resource transfusion of human blood was decided on. Enter the husband. His arm is bared and the physician "pumps" blood from his veins to his wife's. The wife rapidly recovers, and the husband after lying at death's door for a suitable period, does likewise. Altogether a very pretty situation and one capable of giving points to the old one of sucking the tracheotomy tube. It is touching to note that though a good operation for appendicitis nowadays can barely stir the pulse, the public will not consent to part from its old and tried horrors, among which the transfusion business is one of the most cherished.

Wimborne Fight.

We are sorry to read that through the action of Dr. F. T. Charlton, of Blandford, the fight for an increased salary for the medical officer of the Wimborne Workhouse has been rendered nugatory. The gentleman named is reported to have accepted the post when his colleagues were standing out together for what was considered a proper salary for the appointment. The medical men of the district have written a letter saying that they refuse absolutely to recognise Dr. Charlton professionally, and that they will not aid him in any way in his practice in connection with the guardian's work. This is the natural and logical outcome of the step taken by Dr. Charlton, and it is a thousand pities that it should have been evoked.

Vaccination "At Home."

The recent scare of "black" smallpox in France caused a very wide recourse to vaccination, all classes of society flocking to their medical advisers for the protective operation. The French, whatever their failings may be, are a logical people, and they understand that when recently-vaccinated people do not catch smallpox and unvaccinated ones do, there is some efficacy in the process—an inference which our fellow-countrymen are in many instances less apt to draw. But lest they should be suspected of taking their pleasures gloomily the inhabitants of Paris made their vaccinations the occasion of a little social enjoyment, and from the groups who were inoculated direct from the calf in the courtyard to the grand dames in the salons, merriment and chaff prevailed. Indeed one leader of society made the scare a source of new form of social entertainment, and to the joy of her friends gave an "At Home," the cards for which bore "Vaccination" as the attraction in the corner. On assembling, the party were regaled with a lecture by a fluent young doctor who illustrated his remarks with photographs and pictures of smallpox and vaccine-vesicles, and when refreshments were served, the lancet and lymph were produced, and inoculations became the order of the day. Sympathetic eyes were directed to the wounds inflicted on each patient and after the operation restoratives were administered in the shape of ices and champagne. Vaccination would seem to rank with one of the (few) things that they do better in France.

The Recreation of a Novelist.

Mrs. Stannard ("John Strange Winter") is well known as a writer of bland and easily-digested, if not over-nutritious, fiction. She is also, like some other equally great and famous writers, a manufacturer of, and trader in, toilet preparations. Somebody has been so wicked as to suggest, however, that Mrs. Stannard does not herself control the business, but that she merely sells her valuable name to some chemist, and she writes, therefore, a letter to our contemporary, the *Chemist and Druggist*, asking angrily, "Are Chemist's Prejudiced ?" (*sic.*) In this letter she justifies the choice of her hobby, in that she finds it "delicious and revitalising," "to turn from particularly ageing labour to a quiet laboratory." Moreover, "if you have brains enough to write novels, you gain more practical knowledge than any professional training will bring you." This is a delightfully simple doctrine. The person with "brains enough to write novels" is qualified to adopt any professional career he or she chooses, and, as Mrs. Stannard elegantly puts it, "to get there." We stand amazed at the lady's moderation! Why did she choose the quiet laboratory, when she might have been, let us say, a consulting surgeon, or a leader of the bar, or Archbishop of Canterbury ? We wonder if other people "with brains enough to write novels," know all that is open to them ? Mr. Bernard Shaw, who once wrote a novel, might be President of the College of Surgeons; Mr. George Moore would make an edifying Bishop; Mr. Hall Caine would doubtless be Prime Minister, unless indeed, Miss Corelli "got there" first; but Mrs. Stannard and Mr. Sims would still be selling their hair-washes. By the way, Mrs. Stannard does not lack business ability, as she does not miss the opportunity of her letter of referring incidentally to her successful treatment of a lady "after ten years of suffering and constant medical treatment."

LEADING ARTICLE.

THE USE OF ALCOHOL.

For a considerable number of years the medical world may be said to have made its mind up on the use and value of alcohol to mankind. Needless to say, there are two important and entirely distinct issues involved in the primary discussion of alcohol according to its medicinal and its dietetic administration. So far as its therapeutic properties are concerned few experienced medical men would care to eliminate alcohol from their armamentarium when called upon to deal with acute conditions, such as heart failure, shock, and various rapidly progressive infections. In the treatment of many tropical maladies to deprive the physician of alcohol would be to take away a valuable adjunct. In our own temperate climes, again, the value of alcohol in dealing with the progressive infection and results of a debilitating disease, such as osteitis deformans, is too well established to need more than a passing reference. For all that, there can be little doubt that patients suffering from many severe diseases recover just as well without as with the aid of alcohol. That fact was shown years ago in the case of pneumonia, an affection in which large quantities of spirits were regarded as absolutely essential. The demonstration that the percentage of deaths was not increased by withholding whiskey and brandy came like a revelation to a former generation. Since that time the pendulum has swung always in the direction of increasing moderation. Pushed to an extreme in the case of the London Temperance Hospital the treatment of all medical and surgical conditions is undertaken practically without the prescribing of alcohol. As a general statement of ordinary medical practice it might fairly be said that while for the most part alcohol is unnecessary in the treatment of disease, on the other hand it is most valuable and, indeed, indispensable in certain emergencies, and in some acute, as well as in some debilitating chronic maladies, it is often most beneficial. Lastly, its moderate use by a multitude of patients is followed by no harmful results. That, or something like that, would describe the attitude of the average medical practitioner, who is not a fanatic one way or the other as regards alcohol. The medical point of view has been dealt with at some length, because it so nearly coincides with that of the average layman. Alcohol is not a necessity for any human being; some people may consume it in moderate doses and suffer neither mental, moral nor bodily harm during a long lifetime; others, however, are so constituted that alcohol to them spells disaster to mind and body. On the whole the cause of temperance is that of progress in thrift; comfort, morality, physique, education, in a word, of all that is of chief import to the nation in its slow and painful struggle to reach the ideals of social evolution. During the past century a vast change has come over the drinking habits of our country, but a great deal remains to be done before we can rid ourselves of one of the most potent sources of disease, misery, crime and insanity at work in our midst. Under these circumstances the recent announcement in a medical contemporary by a small knot of eminent medical men of their general approval of the use of alcoholic beverages came somewhat as a surprise to the general community. It has raised a hurricane of more or less heated discussion in the lay newspapers, a fact that may be interpreted as a gratifying proof of the wholesome temperance leaven that has permeated modern society. The interesting point in connection with the manifesto is its apparent spontaneity. Why we wonder should these gentlemen suddenly have been moved to protest against the general feeling with regard to the use of alcohol that is growing up in the profession? No one denies the weight that such a protest receives from the status of the physicians and surgeons who signed it, but were these gentlemen suddenly and at the same moment moved by a spirit of indignation against immoderate temperance? Or did some artful agent "nobble" them? The manifesto contains no explanation of its *raison d'etre*, it springs on to the stage from some unexpected trap-door and disappears in a cloud of great names. In a word, did the signatories know what they were signing, or for what purpose they were signing it, or what use was going to be made of their names? We cannot forget that the Government have announced their intention of introducing a new Licensing Bill soon after Easter, and that the brewers believe, and tremble.

THE FRAUDULENT DRUG TRADE.

A letter from a leading practical chemist appears to-day in our correspondence columns under the signature of "Analyst." Unfortunately in dealing with numerous communications of the kind that reach our office we are, for various reasons, unable to publish much information that would be useful to the general public. The writers ask indignantly whether nothing can be done to put a stop to such practices, and whether The Medical Press will not expose the individuals guilty of such deception. The case exposed by "Analyst" is that of a drug widely advertised and sold as a disinfectant of the utmost value and efficiency, whereas it is in reality practically worthless as an antiseptic. Its virtues are lauded to the skies with the exuberant art invariably at the command of the quack advertiser, and a bogus chemical test is suggested to prove to a technically ignorant public the value of the bogus disinfectant. Much as we should wish to expose and punish this particular form of trickery we nevertheless feel that the task is too great for any journal to undertake single-handed. However sustained, fearless and overwhelming our attack on quacks and quackery, general and particular, may be, we nevertheless find ourselves crying in the wilderness to a congregation of medical men, while the great outer world hears nothing of our gospel. The reason is simple, namely, that the lay newspapers dare not hint at the evil by quoting the criticisms of a medical contemporary. As everyone knows, the whole newspaper press, including the "religious" journals, draws a large percentage of its profits from quack advertisements.

It is certain many of the proprietors of these papers are not aware of the nature of the traffic they are abetting; but they are certainly to blame for not enquiring into it. With some of the proprietors it is eminently a case of *noblesse oblige*. The *Morning Post*, the *Daily Telegraph*, the *Daily Mail* are all owned by peers of the realm. These noblemen have all gained their wealth and their positions by means of their papers. Up to lately, the *Times* stood alone in refusing admission to certain classes of quack advertisements; it has lately taken to publication of puffs of even a lower type. The result of this degradation of the leading journal has been the still greater demoralisation of inferior papers. These now all print in form of editorial matter any misleading puff that the advertiser is willing to pay for. No medical paper is in a position to enter upon a campaign of exposure that could only be carried out by constant appeals to the Law Courts. The needed exposure, as we are constantly urging, can only be effectually made by means of a Royal Commission. The story that could be unfolded would touch the consciences of the educated public and of politicians and statesmen and would bring shame upon newspaper proprietors. It would be shown that the fraudulent drug concoction might easily be made amenable for obtaining money under false pretences; and it can hardly be doubted that the necessary new legislation would be without delay constructed. The movement towards promotion of a Royal Commission to enquire into the whole question of medical law, including the subordinate and inseparable question of traffic in fraudulent drugs and nostrums, could be helped on by the chemists if not by their representative corporations such as the Pharmaceutical Society. We commend this suggestion of our correspondent to members of the profession who have addressed us on the subject about which he writes so forcibly to-day.

CURRENT TOPICS.

Lord Lister's Birthday Celebration.

The eightieth birthday of Lord Lister, on April 5th, was marked by many telegrams, addresses, messages of congratulation, and presentations from all parts of the world. The day was spent at his residence in receiving and acknowledging these various tokens of admiration and respect. and a few colleagues presented his lordship with a letter formally recording the decision to signalize the anniversary by republishing all his works. Mr. Jonathan Hutchinson, Sen., headed a deputation from the Royal College of Surgeons, Professor Tilanus, of Amsterdam, presented an address from the physicians and surgeons of that city, and another, presented by Dr. Thorvald Madsen, of Copenhagen, bore the signatures of 1,000 medical men. Lord Lister made a brief reply to these congratulations and presentations. In order to commemorate Lord Lister's thirty years' connection with King's College Hospital, London, a congratulatory address was presented by the members of the medical society and students of the hospital. In view of his early connection with the City as a professor and as a surgeon in the Royal Infirmary, the

Senate of Glasgow University sent an address which recalls that Lord Lister began his great work in Glasgow, and congratulates him upon the many honours which have been deservedly conferred upon him. The Lord Provost of Edinburgh sent a telegram on behalf of the citizens of Edinburgh.

The Growth of Insanity.

The discussion that has been carried on for many months in the correspondence columns of the *Times* on the "Growth of Insanity," shows signs of coming to an end. Judging from the length and vigour of the letters, there is still abundance of material for argument and illustration at the command of the contributors. In what appears to be a parting shot, the "Original Correspondent" remarks that the dispute whether the increase of insanity is "real" or "apparent" seems to him to be relatively trivial, and he is quite willing to abandon the word "increase" and substitute "prevalence." In this view he will find many medical men ready to support him, for it is, of course, a commonplace among the profession that the official returns of insanity are open to serious fallacies. Far more to the point is the question of what real scientific progress has been made in the pathology or prevention of insanity. Apart from Dr. Ford Robertson's recent researches into the microbial causation of general paralysis, "Original Correspondent" asks what is known about the real pathology of insanity that was not known fifty years ago. We agree with his general contention that "identification" and "description" of morbid conditions do not necessarily prove of any practical use to the physician. On the other hand, it would be idle to deny their potential value as stepping-stones to higher things. What is true of insanity to-day has been always more or less true of disease generally. Nevertheless, every now and then, out of the apparently hopeless chaos of pathology emerges the generalisation of a great truth that lays the foundation, or part of the foundation, of future prevention or cure. In so obscure and difficult a subject as insanity, we may yet have to wander in the wilderness for many years—or we may not.

The Coventry Dispute.

The present position at Coventry is worthy of the close attention of the medical profession throughout the Kingdom. As a protest against the terms imposed by the local Provident Dispensary, five out of the seven medical officers have sent in their resignations. The facts of the case have been made widely known, both in the medical and the lay press. If there be any instance in which it would be undesirable for medical men to apply for the vacant posts and thereby handicap the action of their brother practitioners, who are making so supreme a sacrifice on the altar of principle, such a necessity is to be found this day at Coventry. In spite of the wide publication of the circumstances attending the resignations, it is understood that there are several applicants in the field. If that report be true, it points to a lack of honourable feeling in the profession that is most deplorable. The unwisdom of such conduct, again, is conspicuous, as it is only by unity of action that medical practitioners can ever hope to secure a more adequate general standard of emolument for their services. The future career of any who accept the Coventry posts will be anything but enviable, for they must be regarded with contempt by all fair-minded and honourable medical men.

Medical Alliance Meeting.

The representatives of the Friendly Societies' Medical Associations assembled last week at Exeter for their twenty-seventh annual conference, and after being welcomed by the Mayor, they proceeded to take counsel together. The President, in his opening address, referred to the growth of the Alliance, showing that whereas when they met together at Exeter twenty-five years previously there were delegates from only nine associations, at that conference three hundred thousand members and seventy towns were represented. After eulogising the Alliance as "the best system ever adopted to help themselves," he proceeded to deal with the differences between them and the medical profession. These differences are sufficiently well known, and it would serve no good purpose to conceal the fact that medical men regard the Alliance as very far from being the best system conceivable. Any system of medical aid which is not based on sound principles of remuneration is of the nature of charity, and as such must be treated on different lines from a purely business undertaking. Self-help is an excellent thing so long as it does not help people to do injustice to others, and it is a scandalous injustice that well-to-do people can take advantage of the privileges of the Alliance and obtain their medical attendance at starvation rates. However, the President's address, on the whole, was fair in tone, and he suggested a round table conference with the representatives of the medical profession—a proposition which we imagine will be cordially welcomed. In the discussion that followed a good many offensive things were said about medical men, one member going so far as to state that the matter would have to be fought out in the House of Commons, where they (the friendly societies) were the "pets of both political parties." If a spirit of that kind prevails at all generally, then any conference with the profession is likely to be mere waste of time.

Heredity in Pulmonary Tuberculosis.

Since the discovery of the tubercle bacillus, medical opinions with regard to the heredity of pulmonary tuberculosis has undergone a profound change. Thirty years ago, a history of consumption in a family made the most optimistic physician shake his head sadly and frightened life assurance directors almost out of their wits. Nowadays the tendency is all the other way, and there are not wanting those who assert that family history is practically negligible if the individual in himself is healthy and lives an open-air life. In this connection, a paper from the pen of Professor Karl Pearson, entitled "A First Study of the Statistics of Pulmonary Tuberculosis," which has just been published in the Drapers' Company Research Memoirs, is worth study. The number of cases of tuberculosis dealt with was small, namely, 383, but the facts relating to these patients were elaborately worked out, and are handled by Professor Pearson in his usual masterly fashion. The people affected were the middle and lower classes of the inhabitants of Manchester, and Professor Pearson concludes from his study that it proves the all-important genetic fact that the diathesis of pulmonary tuberculosis is undoubtedly inherited, and that the intensity of the inheritance is comparable with that found for normal physical characters in man." He even goes so far as to say that on broad outlines there is no ground for supposing that environment influences the tubercle-disposed man more than the other. Coming from such a source, these views cannot but carry much weight.

A Medical Slander.

It says much for the general good-nature and self-control of the medical profession that there are comparatively few occasions on which their differences lead to an appeal to the law courts. Indeed, the recent conviction at Glamorgan Assizes of a Barry medical man of grave slander against a brother practitioner, carries with it an air of unfamiliarity that is in itself reassuring. The plaintiff, Dr. Kent, of Barry, brought an action against another practitioner in the same town, Dr. O'Donnell, for having uttered at a meeting of the local Education Committee the following words:—"As a medical man I will say fairly and squarely that I cannot support Dr. Kent for any position, because he does not behave as an honourable medical man should to his brother practitioners. He is thought to be a blackleg in his profession." The defendant was unable to bring adequate evidence to support these serious statements. On the other hand, it was shown that although some years ago there was some question as to the ethical propriety of Dr. Kent's return to practise in Barry, yet, on the whole, his action seems to have been approved by the majority of the local medical men. At any rate, there was sufficient doubt to make any cautious man extremely careful in his public references to the matter. We are glad to say that Dr. Kent has vindicated his professional status and conduct, for after a careful trial by an impartial judge, the jury found that plaintiff had been slandered falsely and maliciously, and they awarded him £250 damages. The plaintiff's case was taken up by the London and Counties Medical Protection Society.

The Death of Mr. Thomas H. Wakley

The news of the death of Mr. Thomas Henry Wakley, F.R.C.S., one of the joint editors of the *Lancet*, will be received with universal regret by medical men throughout the United Kingdom. He was the eldest son of the famous Thomas Wakley, the founder of the *Lancet*, who fought many battles on behalf of the medical profession, and at one time sat in Parliament as member for the metropolitan constituency of Finsbury. His son, Thomas, who was educated at University College Hospital, London, and at Paris, held the post of surgeon and, later, consulting surgeon to the Royal Free Hospital. He made various contributions to surgical literature, but was chiefly known as joint editor of the great professional journal founded by his father. In social life he won many friends by the genial and unassuming kindness of his disposition and the unswerving uprightness of his character. In Freemasonry he occupied a prominent position. A fuller appreciation of his interesting career will be found in our obituary columns.

PERSONAL.

H.R.H. Prince of Wales will open the new buildings of the Medical School at the Glasgow University on April 23rd.

Dr. W. Black Jones, of Llangammarch Wells, has been appointed a J.P. for Brecknochshire.

Col. J. Lane Notter, R.A.M.C., presided at the Sessional meeting of the Royal Sanitary Institute held at the Parkes Museum last night.

Professor Jacobs, of Brussels, will read a paper on the "Radical Cure of Prolapsus Uteri" at the British Gynæcological Society on Thursday next.

The Lord Chancellor has placed the name of Dr. Alfred H. Carter on the list of county magistrates for Worcestershire.

Sir Frederick Borden, the Canadian Minister of Militia and Defence, who is coming to the Colonial Conference with Sir Wilfred Laurier, is a medical man. He has long served in the Canadian Militia as a surgeon, and now holds the rank of lieutenant-colonel.

Dr. Fred Evans, Cardiff, has terminated his official connection with Whitchurch, and thus brings to a close a family connection extending for nearly a century. His friends took the opportunity of presenting him with a gold watch.

Dr. William Henry Drummond, Professor of Medical Jurisprudence at Bishop's University, Montreal, and one of the best known men in Canada, has been stricken with paralysis at Cobalt.

Dr. King Houchin, the deputy coroner for East London, has retired from that position, in which he has been succeeded by Dr. James Godding.

Dr. Robert Rentoul of Liverpool,, will deliver a lecture at the Incorporated Institute of Hygiene, London, on Monday next, on "Woman's Health: Our Greatest National Asset."

The will of the late Sir Michael Foster, K.C.B., F.R.S., late Professor of Physiology in the University of Cambridge, and M.P. for the University of London, has been sworn at £4,294.

Surgeon-Lieut. Colonel A. P. O'Connor, C.B., Royal Army Medical Corps, has taken up the duties of principal medical officer, Northern Command, vice Colonel M. D. O'Connell retired.

A CLINICAL LECTURE
ON
ACROPARÆSTHESIA. (*a*)

By ARTHUR J. WHITING, M.D., M.R.C.P.,

Physician to the Tottenham Hospital, Assistant Physician to the Mount Vernon Hospital for Consumption and Diseases of the Chest, and Dean of the North-East London Post-Graduate College.

GENTLEMEN, I wish to speak to you this afternoon about a disease which almost exclusively affects the poor, and of them particularly certain middle-aged hard-working women. It is quite common in working-class districts. As far as my own experience goes, it has seemed especially common in this densely-populated poor part of London. Although it is common and has been known for perhaps a score of years or more, even yet it is not generally recognised by the profession. It is the cause of much suffering and disability, both of which may in some degree be obviated, yet because its nature and ordinary exciting causes are not appreciated the suffering and disablement too often go unrelieved. This disease has been called acroparæsthesia, and it is one of a group of maladies known as angioneuroses—neuroses because apparently a nervous affection, yet no definite structural disease of the nervous system has been found in them; and angioneuroses because the symptoms are mainly, if not entirely, vasomotor. We know that that part of the nervous system which presides over the blood vessels is the sympathetic nervous system, so we must assume that there is functional disease, so-called, of some part of the sympathetic.

Let me remind you of the structural plan of the sympathetic nervous system. On each side of the ventral surface of the spinal column is a ganglionated cord extending from the head to the coccyx; joining obliquely the ganglia of these cords are branches coming from the spinal cord with the spinal roots—the *rami communicantes*—which are themselves in continuity with descending fibres transmitting impulses mainly from the vasomotor centres in the medulla, but also from similar centres in the cord and in the cortex cerebri. From the sympathetic ganglia at all levels fibres pass to the blood vessels generally, the viscera, glands, etc., conducting vasomotor impulses to the vessels, motor impulses to the unstriped muscle-fibre of the viscera, secretory impulses to the glands, and possibly also trophic impulses to the tissues.

Before discussing acroparæsthesia itself, let me enumerate some of the principal functional disorders of the sympathetic nervous system. For our purpose they may be divided into two main groups—subjective and objective. To mention the objective disorders first, we are all quite familiar with the condition known as "dead fingers," a whiteness and numbness of the fingers occurring in apparently healthy people, lasting for a short time and then passing away with perhaps some pain. This hardly passes the physiological limit, but there is an exaggeration of the same, or at least, a similar and more pronounced condition well known as Raynaud's disease—a local syncope or angiospasm followed by a local asphyxia or regional cyanosis—a vaso-dilation, which may go on to gangrene. In the first instance there was angio-spasm; in the second angio-spasm followed by vasomotor paralysis. There is a third type, one of pure vasomotor paralysis, in which the feet become red, painful, and cyanotic when they hang down, an instance of which some of us saw in the out-patient room a short time ago, known as erythromelalgia (I will send round a picture of this). Then there is the condition we have several times observed together, of angioneurotic œdema, transitory circumscribed œdamatous swellings of the skin and subcutaneous tissues (I send round a photograph you have seen before of this condition in the lip of a girl). These are the types of the objective angioneuroses.

The type of the subjective angioneuroses is one—the subject of this afternoon's lecture, acroparæsthesia which, however, has been known as "vasomotor neurosis of the extremities," a name given by Nothnegel, and as "spastic vasomotor neurosis" to distinguish it from erythromelalgia, called "paralytic vasomotor neurosis of the extremities." The name acroparæsthesia was given to the condition in 1890 by Schultze. Paræsthesia are usually described as abnormal subjective sensations other than pain and numbness, as tingling (pins and needles), burning, crawling sensations, but in acroparæsthesia pain is nearly always, and numbness sometimes, present, so to some extent the term is a misnomer. We are familiar with the use of the term acro (meaning an extremity) in acromegaly or largeness of the extremities. By acroparæsthesia then is understood abnormal subjective sensations referred to the extremities—the hands and feet.

I will now describe to you three or four examples of the condition and bring the respective patients before you, after which I will describe the disease more in detail, and then shortly discuss its pathology, diagnosis, prognosis, and treatment.

Case I.—Mrs. R., æt. 59, a widow, first came to the hospital in January, 1904, complaining of a sensation of deadness in the hands and of severe pains in them, which woke her up in the morning, both being worse after having used her hands in washing on the previous day. She first began to be troubled in this way some seven years ago, and the attacks became aggravated two years later when, on the death of her husband, she was obliged to undertake more washing. There was nothing of the same sort in the family, the father died at a good age from a stroke and the mother was still alive, æt. 94.

There was no evidence of alcoholic poisoning, and the knee jerks were brisk. The disagreeable sensations extended above the elbow on the right

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(*a*) Delivered at the North-East London Post-Graduate College, Tottenham Hospital, N., on February 14th, 1907.

side, but never higher than the wrist on the left. The finger tips during the height of the attack were numb, *i.e.*, slightly anæsthetic or hypoæsthetic. Under treatment, and especially coincident with a lessening in the amount of washing an improvement soon became manifest, and in November of last year (1906) she reported that her hands were much better, but not quite right yet, the tingling and numbness still turned to what she described as "dreadful pain," but she said it "was nothing like it had been." The attacks came on about 6 or 7 a.m., shortly before getting up, and would last for several minutes in their severity. She still had to rub her hands before she could dress herself.

Case II.—Mrs. P., æt. 31, the wife of a labourer, came to the hospital on the 2nd of April, 1906, complaining of numbness and pain in the hands, which came on at night after getting warm in bed and were much worse after having done washing during the previous day. She had suffered in some degree from such sensations for four years, but they had latterly become more distressing. There was also, she said, some swelling of the hands at the time. She had to work hard, and was much hampered in her work because she was unable to grip anything till mid-day. Her sleep was much disturbed. She had been troubled with dyspeptic symptoms. She improved considerably under treatment and less work, and particularly so when she gave up washing for other people. She discontinued attending hospital about the end of June.

On November 22nd last she returned with the story that during the cold and wet weather of the few days previous she had had tingling and "numby" sensations of the hands, but they "did not swell yet."

On February 7th (of this year) she reported that her hands had been worse during the frosty weather. The pains now went up to the shoulders, and she could not hold things in her hands, although she could feel them. She was frequently breaking crockery and had more than once cut herself with the fragments. She had not been doing more washing than usual. The sensations of the numbness and gnawing in the hands began directly she got into bed, so that after her weekly washing day she could hardly sleep at all, and the sensations remained insistent for two or three days after. The hands swelled and went a little shiny at the same time. She was unable to finish dressing herself in the early morning and had to come downstairs, have breakfast, and then return to the room to complete her toilet. Hearing in the out-patient room the complaints to me of another patient (the case I have just described), she said when her turn came "that lady must be like I am."

Case III.—The third patient I shall show you is a married woman, æt. 45, the wife of a fitter. She came to the hospital on November 26th last complaining of pain in the left hand, which would wake her up at night and prevent her sleeping. It came on for the first time in October of the previous year, and the paroxysms in succession lasted for about six months, that is until the warmer weather began. They returned with the return of cold weather in October last. The pain in each paroxysm started, she said, in the middle finger and then spread to the whole hand, which went numb and tingled (pins and needles), but it did not change colour. The pain was very bad after doing her own washing so that, she said, she did not get any sleep at all the next night. She found that if she hung it down out of bed feeling returned to the hand until she began to use it again. When it was bad she was unable to carry anything with it and could not pick up anything with it. Physical examination of the heart showed nothing abnormal, and the bowels and catamenia were regular. When she came to the hospital at the end of last month (January 31st) after, as you will remember, a season of very cold weather, she reported that the sensation now affected her feet. For nearly a week she had had hardly any undisturbed sleep. The pain in the left hand would wake her up a dozen times in the night. In the morning she would be unable to shut her hand until after she had passively moved it about for ten minutes or so, and even then she could not dress herself. properly, only with difficulty. Indeed, during the whole of this time she had not been able to use it properly for anything. The finger tips she expressly said felt numb.

These cases I offer to you as fairly typical instances of the condition I am describing. The cases I have shown you are, or may be called, middle-aged women, and that as I have already hinted, is the rule in this disease. In a group of 162 cases collected by Cassirer there were only 12 men, and among 129 cases in 106 the age was between 30 and 60.

About three-quarters of the recorded cases, like the three I have shown you, have been engaged either in washing, scrubbing and other occupation requiring that the hands should be used in water of varying temperature or engaged in sewing or some kind of needlework requiring prolonged use of the fingers. In a number of a group of 43 cases collected by Collins the symptoms could be brought on by immersing the hands in water.

Among other conditions noted as contributing causes are dyspepsia (Collins found some intestinal disturbance in 57 out of 100 cases, and in our second case a complaint of this nature was made), alcoholism, the climacteric, ovariotomy, parturition, pregnancy, influenza, and anæmia. Anything, however, that lowers the general health seems to predispose.

The attacks mostly come on in the early morning between 4 and 6 a.m., but the sensations may persist in a slight degree constantly. When not thus persistent it is said that an attack may occur if the patient falls asleep during the day. It is the rule that the paroxysms are more in evidence in cold and especially in frosty weather; our second patient said she could tell when there would be frost on the ground in the morning by the sensation in her hands during the night.

The classical distribution is in the fingers, but it may be very rarely (as in our third case) in the feet. It usually affects one hand more than the other, and sometimes it commences in one finger. It sometimes affects the tip of the tongue and the lips. In the upper limbs the sensations may extend to the elbow or even as high as the shoulder.

In the majority of cases there are no objective signs whatever, and of these subjective cases many show merely the paræsthesiæ of creeping, tingling, etc.; these should probably be looked on as the pure cases of acroparæsthesia. According, at any rate, to my own experience, still more have somewhat severe pain in addition. In two other groups there are objective signs; in one of these, along with the subjective signs, there is a degree of blunting of sensibility—hypæsthesia; and in the other there are obvious objective vasomotor disturbances, coldness of the hands, pallor, even dead fingers, or as in one of our cases swelling of the hands and shininess of the skin, but the last cases abut on the type of Raynaud's disease on the one hand and erythromelalgia on the other. Thus the types may be described as (1) paræsthesia cases, (2) pain cases, (3) hypæsthesia cases, and (4) objective vasomotor cases.

There is nothing definite in the heredity of these cases, perhaps 50 or 60 per cent., have some neuropathic tendency, but this might apply to many non-nervous diseases, and it is conspicuous, as in our three cases, that there is little, if any, unusual indication of hysteria or neuræsthenia.

There is in this disease no morbid anatomy, so its pathology must be largely conjectural. Without troubling you with the different, but largely coinciding, views that have been held, I would merely say that the weight of the evidence points to the anatomical substratum as a vasomotor spasm and a consecutive stimulation of the sensory nerve endings (as a boy's fingers might tingle and pale or flush after snowballing). There seems in many cases an element of toxæmia or auto-intoxication as there is not only in such obvious things as alcoholic neuritis and facial paralysis of Bell's type, but also in urticaria and perhaps angioneurotic œdema. To my mind a fair simile is with writer's cramp and other trade spasms, and I suggest we may look upon the condition as an occupation—neurosis, the stress of which falls on the vasomotor mechanisms of the extremities—an angio-spasm, and is brought about on the one hand by exposing the hands or even the feet to extremes of heat and cold (in predisposed persons), and on the other by a coincident over-exertion of the fingers in executing fine movements. It is noteworthy that the disease process, whatever it is, is not in any ordinary sense progressive, even eighteen years hava been known to elapse without further development—that is almost as long as the disease has been recognised.

About diagnosis there is very little that needs saying. An ordinary conclusion that is come to when these cases are met with in practice is that it is a form of peripheral neuritis, but besides the absence of anything characteristic of a multiple neuritis the very fact that the symptoms come and go in the way they do negatives this view. However long it lasts, moreover, there is never any muscular atrophy and the knee jerks remain brisk, and we must remember that the latter is a very sensitive reaction. For example, we know that the knee jerks may remain absent for years after recovery from a slight attack of diphtherial neuritis. Still, in the early days of observing such cases, the beginning of tabes, or of diabetic or other neuritis, or even of a threatened cerebral thrombosis (where the symptoms are one-sided) might be thought of—it would not be necessary, I think, to keep these in mind for long. Acroparæsthesia has, in fact, a remarkably definite clinical picture.

As to prognosis, recovery under treatment and general management, partial, if not complete, is the rule. But cases may last for years. In any event life is in no wise threatened.

In treatment the main thing is to modify or regulate the occupation. I have thought the disease might well be called the "charwoman or washerwoman's disease." Let patients be recommended to cease working in these ways as a man showing symptoms of lead-poisoning might be advised to take up some other occupation than that of a house-painter. Let the general health be brought into as good a state as possible, giving, if necessary, iron, quinine, strychnine, arsenic and other general tonics. Dyspepsia has been thought to have a causal relation and certainly nothing but good could come from removing that and intestinal disturbance likely to lead to auto-intoxication. For the general lability of the vasomotor system, obviously present in some cases, bromide in addition might be tried. At any rate, it has seemed to be of service in some cases. Ergot has been suggested on the one hand and nitrites on the other to act directly on the blood vessels. I have no recommendation to make of either from my own experience. As purely symptomatic forms of treatment, gentle faradism, especially in the dry form with the wire brush, has been advised, also the constant current and static electricity. Other methods suggested have been Swedish exercises, liniments with friction, and even hydropathic treatment, including salt-water bathing, but until a fairly advanced stage of recovery is reached the latter methods would seem rather hazardous.

The great thing I would suggest is to first recognise this highly disabling malady and then to attack it by a change in the occupation and every-day life.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Sir Lambert H. Ormsby, M.D., F.R.C.S., Senior Surgeon to the Meath Hospital and to the National Children's Hospital, Dublin, on "Diseases Peculiar to Children."*

ORIGINAL PAPERS.

ON THE PRESENT POSITION OF THE TREATMENT OF TUBERCULOSIS BY MARINE CLIMATES. (*a*)

By WILLIAM EWART, M.D.Cantab., F.R.C.P. Lond.

Senior Physician, St. George's Hospital, London, etc.

An examination of some of the principles of marine climatic treatment and of the requirements of the pulmonary affection, was the subject of the address, which began with some general remarks on Thalassotherapy, or Sea-treatment (sea-air, sea-water, sea-bathing, sea-voyages, and the pharmacology of the sea), and with a brief reference to Quinton's subcutaneous sea-water infusions. *Ocean climate* differs from all others in its exclusively marine character and its *equability*, in contrast with the *Sea-coast climates* which are the *most variable* and offer endless combinations between the features of the coast and those of the sea, none of them being the ideal one for consumption, because not always at its best, whilst some may prove to be *too protective* in the individual case, and others *too active* for some of its complications.

(*a*) Abstract of Opening Address at the Hastings meeting of the Balneological and Climatological Society, March 16th, 1907.

Climate and open-air can take no direct effect upon the bacillus; and the beneficial *effects of the seaside and its sea-air* are mainly dependent upon the patient's power of "reaction" on the one hand and, on the other, upon the all-important effect upon the tendency to catarrh.

Touching the *forms of tuberculosis*, Nathan Raw has recently urged an etiological and clinical distinction between the infection from the "bovine" bacillus and that from the "human" bacillus, which agrees well enough with our climatological data and practice, all assuredly "bovine" infections (surgical, glandular, scrofulous, cutaneous, serous, and visceral other than pulmonary) being almost unreservedly benefited by the sea. This is not always the case with the pulmonary affection, for which alone the "human" bacillus infection would be to blame.

The multiple types evolved by individual predispositions (constitutional, organic, and functional) fall into the two groups: *Uncomplicated Tuberculosis* and of *Catarrhal Tuberculosis, or Phthisis Pulmonalis.* In the first group, tuberculosis may be "latent" and healing, or "declared" and spreading. In the second (which includes the acute caseous form) catarrh is the chief agent of mischief as well as the first object of climatic treatment. To describe as "consumptives" the bearers of latent and spontaneously-healing tubercles, would be inaccurate; and, on the other hand, "tuberculosis" does not depict the varied miseries of catarrh, of pneumonia, and of caseation in the painful record of advanced consumption. Bacillary infection ("tuberculosis") may mean little or much damage, but "consumption" (or, in the Greek vernacular, "phthisis") is always a big affair, and in pathology it spells "catarrh." We now have to reverse the famous dictum of Niemeyer and to recognize that "the worst fate that can befall the patient infected with tubercle is that he should develope phthisis."

The Aerotherapeutics of tuberculosis are thus practically speaking, those of catarrh; but whereas sea-air is curative of some forms of simple non-bacillary bronchitis, it is not always sufficiently dry for the cure of catarrh based upon tubercle. Whether we consider the meteorological factors or are guided by the results observed clinically, it cannot be gainsaid that the altitude is likely, and proves itself, to be more effectual in obviating early catarrh and curing it at any of its stages than the climate of the coast. In this connection, Dr. William Gordon's investigations upon the influence of wet winds are most suggestive, although he has not hitherto formulated any conclusions beyond the broad fact that the prevalence of phthisis is definitely increased by it.

But as we have not any altitudes available in this country we should adopt an opportunist policy and make the most of our unrivalled assortment of "protecting" and "bracing" seaside resorts by careful selection of cases, by progressive elaboration of their clinical treatment, and by measures tending to correct any imperfections of the local climates. The "bracing" resorts possess the highest restorative efficiency; but their suitability for pulmonary tuberculosis is limited. The criterion of fitness for these climates is integrity of the mechanisms of "reaction," which are dependent above all upon cardio-pulmonary efficiency. Thanks to the possession of sound lungs and of a sound heart, the great majority of cases of tuberculosis other than pulmonary (surgical, scrofulous, cutaneous, &c.) are eligible for the bracing resorts and derive there the greatest benefit. Many cases of "latent" pulmonary tuberculosis are for analogous reasons eligible. But "declared" pulmonary tuberculosis even at an early stage, and "early phthisis pulmonalis," cases claim the most careful climatic management, with a view to the avoidance or the cure of catarrh, and need protection from the stronger kinds of sea-air. All cases of "advanced" phthisis, as well as the group of "chronic quiescent phthisis" admit of no alternative; they are to be sent to the milder stations.

The present position of the treatment by marine climates rests upon the recognition of the fact that mere "airing" and "salting" are not competent of themselves to cure the pulmonary complications of the disease when it affects the lung. "Open-air" and "sea-air" are a basis for treatment, but cannot supersede the scientific methods of modern therapeutics. The marine resorts should add to their natural resources increased facilities for a systematic treatment planned upon a combination of the hospital idea and of the sanatorium idea. On this scheme alone can they look forward to an increased curative efficiency.

Meanwhile a much greater field of usefulness is open to them in *prevention.* The sanatorium movement is gravitating in that direction; but the seaside is, *par excellence* the place for the "Prevention Sanatorium" or "Preventorium," the inmates of which should be recruited from the most threatened stages and from the most dangerous surroundings. This is the direction in which a more extensive and systematic use of our marine climates is indicated. Their wider employment for the extirpation of tuberculosis in the coming generation is a possibility and a public duty.

Lastly, the task of improving the local opportunities for climatic treatment is not beyond the skill of modern engineering. Some of our prosperous stations rejoice in a sandy soil suitable for the growth of the pine; others in a mild and sunny hinterland; others in cliffs combining available shelter and altitude. Among them, the city of our welcome is not the least favoured, and may yet secure a future of unequalled efficiency in the struggle against tuberculosis.

AN IMPROVED GAG.

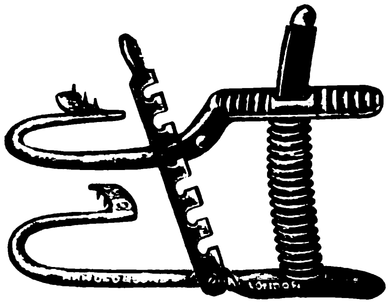
BY JOHN WARD COUSINS.

Senior Surgeon of the Royal Portsmouth Hospital and of the Portsmouth and South-East Hants Eye and Ear Infirmary.

Gags form a class of instruments which require careful adjustment for every surgical case in which they are employed. They are made in all sorts of shapes and sizes; but I do not know of any gag which is sufficient for every purpose, and can be easily adapted to every mouth.

The instrument exhibited in the engraving is a very convenient and simple contrivance, but I do not claim that its qualities render it superior to every other device of the kind. It has, however, in my hands proved very serviceable in staphylorrhaphy, and also in many surgical operations of the mouth, pharynx and tongue.

In the *British Medical Journal* of February, 1888, I ventured to suggest a gag in which the bars were expanded by a strong spiral spring, and fitted with a rack and screw adjustment. It was especially designed for minor operations, and also for the purpose of dental surgery. The improved gag which I now propose, consists of only one strong stem surrounded by a central spring similar to the instrument introduced by Mr. Armandale some time since, and recently modified by Mr. Arbuthnot Lane. The upper bar slides over a round stem, and is attached to the end of the spring, the lower bar is fixed, and both of them are furnished with projecting finger plates, so as to facilitate rapid adjustment and removal. When introduced into the mouth the dental surfaces are expanded by the spring, which is at once compressed and jammed on the stem by the tilting of the bar.



The gag can then be securely fixed in any position by a steel lever, fitted with a series of notches for receiving a tooth attached to the upper bar.

The dental plates can be introduced into the mouth with or without an indiarubber cover, according to the condition of the gums and teeth. Messrs. Arnold have made for me a right and left gag, but I have used the same instrument on both sides of the mouth.

A CASE OF

CHRONIC PANCREATITIS.

By W. I. de COURCY WHEELER, F.R.C.S.I.,

Surgeon to Mercer's Hospital, Dublin.

Considering their comparative frequency chronic diseases of the pancreas have not received the attention in surgery which they seem to deserve, more particularly as they are closely associated with such common affections as gastro-duodenal ulceration and catarrh, and inflammations of the gall bladder and bile ducts. From these conditions chronic pancreatitis arises by direct extension of the inflammation through the common bile duct. The presence of a stone in the pancreatic portion of the bile duct will also cause inflammation in the gland mechanically by the pressure exerted, as well as by the obstruction to the flow of the pancreatic juice. Many other causes are mentioned as responsible for an attack of chronic pancreatitis, thus syphilis has been shown to affect the pancreas in a similar way to the other organs in the body and changes due to the congenital form of the disease have been observed as early as the fifth month of uterine life. Tubercle, enteric fever, influenza, have all been thought accountable for various cases of pancreatitis and alcoholism is supposed to produce the same changes as are familiar in cases of cirrhosis of the liver, but as regards this cause it must be remembered that the relation between alcoholism and cirrhosis is extremely vague and has not been proven. The pancreas undergoes fibrous changes like the kidney and other organs as a result of endarteritis and general arterio-sclerosis. The following is a brief account of a case which first brought this subject under my notice.

"P. C.," æt. 35, was admitted into Mercer's Hospital in December last. He was emaciated and stated he had been losing weight for the past year. For six or seven years he had suffered from a dull gnawing pain in the right hypochondrium and epigastric regions, which usually remained for about two months, and then for a short interval disappeared. He never had ague-like attacks nor pain resembling biliary colic, nor was the pain in any way associated with the taking of food, although vomiting was a fairly constant symptom. The patient was not jaundiced on admission, except for a yellow tinge in his sclerotic, but he assured us that on several occasions when the pain was unusually severe he had become distinctly jaundiced. He always suffered from constipation, and on admission to hospital the stools were clay coloured and offensive. The urine was free from albumen, sugar, and bile. On examination of the abdomen no tumour could be felt, the liver was not enlarged, but there was an area of tenderness on deep pressure, which extended from above and to the right of the umbilicus upwards towards the eighth and ninth costal cartilages. The case was thought to be one of stone in the common duct, and operation advised. The patient was placed with a sand bag under the back at a slightly higher level than the liver, and the table sloped so that the head was slightly raised and the feet low. By this means, when the abdomen was opened, easy access was obtained to the liver, gall bladder and bile ducts, and the area of operation was rendered still more clear by the slipping down of the intestines by gravity towards the pelvis. The liver was raised up and the fundus of the gall bladder first examined, it was found healthy and slightly distended with bile. This alone was evidence against the blockage of the common duct by stone, but not conclusive evidence, for it has been shown that where chronic pancreatitis and stone in the common duct co-exist the gall bladder may be distended in contradiction of Courvoisier's law. The neck of the gall bladder was next examined and found to be included in a mass of adhesions which involved the colon, liver, duodenum, gastro-hepatic omentum and pylorus, and obliterated the foramen of Winslow. The next step in the operation was one of some difficulty and consisted in wiping away the adhesions with gauze sponges and freeing the various organs as far as possible. During this dissection the supraduodenal portion of the common bile duct was exposed and examined, and then traced downwards to the point where the duct becomes lost in the substance of the head of the gland, or, is found in a groove on its posterior surface. The head of the pancreas was now found to be enlarged, hard and nodular, having the feel of an organ in which a considerable overgrowth of connective tissue had taken place. No stone could be felt in the neighbourhood of the posterior surface of the head of the pancreas, but it was now evident that all the symptoms, the emaciation, the pain, and the indefinite attacks of jaundice and indigestion could be accounted for by the pancreatitis. Drainage of the gall bladder was therefore decided upon, the rationale of the treatment being that through the intermediary of the bile passages the pancreas itself is drained, and that there is therefore a relief of tension in the ducts, a consequent subsidence of the inflammation in the head of the gland, and *parri passu* the pressure on the third and fourth portions of the common duct is diminished and the biliary obstruction gradually disappears. It is doubtful if such a result can be obtained in those cases where cirrhotic changes are marked and atrophy of the head has taken place; but these changes are only brought about in the pancreas after a prolonged period of inflammation, and in all likelihood by the time such had occurred glycosuria or other untoward symptoms would have arisen to contraindicate operation. On the other hand the symptoms of chronic pancreatitis lead one to operate long before the hypertrophic stage has given place to marked cirrhosis. I would like to draw attention here to the extreme difficulty of detecting, by the sense of touch, inflammation of the head of the pancreas, unless it is well marked. Opportunities for examining the pancreas in the living are not numerous, and the feel of the gland may create erroneous impressions as to whether it is healthy or inflamed. Robson calls attention to this and describes a typical case of inflamed pancreas as feeling like a hard waxen cast. There appears to be no doubt, however, that it is still more difficult to see changes in the pancreas at a necropsy, for the early swelling due to retained secretion and engorged blood vessels disappears at death. A very careful peritoneal toilet was made, as although in healthy animals the bile has been proved in most cases to be sterile and incapable of producing septic peritonitis, yet in the presence of such conditions as chronic pancreatitis and gall stones, streptococci, staphylococci, and above all the bacillus coli have been cultivated from the bile. The gall bladder was opened and a large drainage tube inserted in the manner recommended by Moynihan and Robson. The tube was stitched in by two layers of sutures in such a way that when it loosened a valvular opening remained in the gall bladder favouring rapid closure of the fistula. It is well to bear in mind, however, that in order to cure inflammatory conditions, whether in the pancreas or in the gall bladder and bile ducts, prolonged drainage is sometimes necessary, and the rapid closure of the fistula should not be encouraged, the reappearance of bile in the stools; the disappearance of jaundice and the absence of micro-organisms in the bile are factors which help to decide when sufficient drainage has been obtained. In my case the tube loosened and was removed on the ninth day after operation; the fistula closed in the following fortnight, and the patient was allowed home one month after his admission into hospital. It is worthy of mention that the patient vomited bile repeatedly on the day after operation and suffered in consequence from insatiable thirst; the vomiting was produced probably by the stimulation of the liver and the filling of the ducts with bile during the operation, and was gratifying inasmuch as it showed, at all events, that the ducts were patent. The bile did not flow extensively through the tube until the evening of the second day, and the stools became normal in colour about nine days after operation. The man is at present working as a labourer, and is free from all pain, but at times he notices his stools become light in colour. The onset of chronic pancreatitis, as in my case, may be very insidious, the patient complaining of such symptoms as indigestion, flatulence, a dull ache above the umbilicus from which he is sometimes free, constipation and clay coloured stools. Sometimes indeed, the stools are bulky and quite out of proportion to the amount of food eaten From such a train of symptoms no diagnosis could be made, but if following on them the patient shows signs of even slight biliary obstruction, the jaundice increasing at every attack until it finally becomes constant, then, especially if the gall bladder be dilated the case is most likely one of either chronic pancreatitis or cancer of the head of the gland. In the absence of dilatation of the gall bladder a stone in the common duct must be suspected. The jaundice in the case of stone is often of a less permanent type than that produced either by malignant disease or chronic pancreatitis, the stone is usually loose and acts like a ball valve, the jaundice, in consequence, coming and going, and being usually accompanied with the pain of biliary colic. From malignant disease of the head of the pancreas it is often impossible to diagnose simple chronic pancreatitis, and even when the abdomen is opened the same difficulty will be experienced in differentiating between hyperplasia and a malignant growth, as in similar conditions of the pylorus. Suffice it is to say that in many cases where a hopeless prognosis was given, simple drainage of the gall bladder produced an absolute cure.

In some cases the onset of chronic pancreatitis is marked by far more acute symptoms than the foregoing. There may be attacks like biliary colic, rigors, nausea and vomiting, severe pain in the right hypochondrium radiating across the abdomen to the left more frequently than towards the scapular regions. Intense jaundice, though not necessarily occurring with the first attack, usually becomes a prominent symptom. It is small wonder that with such an onset chronic pancreatitis has been mistaken in a number of the recorded cases for a stone in the common duct. It must be clearly understood, however, that the two conditions are associated, for if there be a stone in the common duct for any length of time, chronic pancreatitis will certainly supervene and co-exist with the stone. In proof of this in many cases in which a stone was removed from the common duct the head of the pancreas was found enlarged and sclerosed, necessitating deep incisions into its substance in order to remove a stone by the retroduodenal operation. If the stone is eventually passed the chronic pancreatitis usually persists and produces a train of symptoms which exactly mimic those due to the former internal blockage of the duct. From a diagnostic point of view, therefore, it will be seen that two errors are likely to be made. The first is of paramount importance, viz.:—It may be thought that a case of jaundice advanced in years, with a distended gall bladder, in which a tumour can be felt and emaciation is a marked symptom, must necessarily be malignant disease; this is disproved by the recorded cases which demonstrate that a hyperplasia of the head of the pancreas with pressure in the common bile duct will produce a similar train of symptoms which disappear after operation. The second error of mistaking a simple chronic pancreatitis for obstruction of the terminal portion of the common duct by stone is not of so much clinical importance, since modern surgery teaches that in both conditions an operation is called for, and they are so closely associated that a differential diagnosis, though possible, need not be considered. In addition to cancer of the head of the pancreas and gall stones in the common duct, cancer of the liver and chronic cholangitis may lead to symptoms resembling chronic pancreatitis, and the possibility of mistaking any of these conditions for malaria must always be borne in mind. The relation of chronic pancreatitis to diabetes is relevant in one or two particulars to the surgery of the gland. In chronic pancreatitis, arising as it usually does from some extension of inflammation up the duct, the islands of Langerhans are not early involved, and there is apparently no interference with the internal secretion in these cases. Glycosuria is not present until late, but when it does appear, the time for operation usually is passed. In such cases of chronic pancreatitis diabetes is anticipated and prevented by timely operations. Occasionally glycosuria is an early symptom of the inter-acinar type of pancreatitis, the inflammation commencing within the gland and rapidly attacking and destroying the islands of Langerhans, determines the presence of sugar in the urine before other symptoms have exhibited themselves; such a condition of affairs occurs in cases of amyloid disease.

Examination of the urine and fæces will give valuable information in cases of chronic pancreatitis and materially help in building up the diagnosis. The clay-coloured stools are not accounted for so much by the absence of bile as by the presence of undigested fat. Bile in most cases of pancreatitis has been found by chemical means in the fæces, the only cases where it is absent or present in very small quantities are those in which there is a carcinoma of the head of the gland.

Evidence of incomplete proteid digestion in cases of chronic pancreatitis may be found by the presence of undigested muscle fibre in the stools. Mayo Robson points out that the fæces are acid to litmus in cases of early pancreatitis, but alkaline in simple jaundice, a useful clinical test, if future experience shows it to be reliable. Sahli invented an ingenious test to show insufficiency of pancreatic digestion. A gelatine capsule hardened with formaline and containing iodoform is swallowed by the patient. The capsule resists gastric digestion, but is rapidly acted on by the pancreatic juice, in consequence iodine will appear in the urine in from four to eight hours when the pancreatic secretion is sufficient. The presence of alimentary glycosuria is another diagnostic sign worthy of consideration. Two or three ounces of sugar are given before breakfast and the urine tested in a couple of hours. When sugar is present, disease of the pancreas is suspected, and in ten out of fifteen cases where there was alimentary glycosuria and on which a *post mortem* examination was obtained, marked chronic pancreatitis or cancer was found. This test was based on the experimental work done in connection with the relation of pancreatitis to diabetes, when it was shown that although removal of a portion of the pancreas did not produce diabetes, yet the gland was only imperfectly able to perform its duties on carbohydrate metabolism, and so if an animal with only a portion of the pancreas, was fed on large quantities of carbohydrate, sugar temporarily appeared in the urine. The presence in the urine of fat splitting ferments is mentioned among a host of other signs based on chemical analysis, as being in favour of the presence of pancreatitis.

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

Emphysema aud Blood Pressure.

By Leonard Williams, M.D., M.R.C.P.,

Assistant Physician to the Hospital; Physician to the French Hospital in London.

This man, æt. 52, is obviously suffering from emphysema. He is not a player in a brass band, nor is he employed in any of those trades, such as glass-blowing, which are usually considered as predisposing causes of the disease. He is, indeed, a person who, so far as his lungs are concerned, leads a tranquil life, because he is a clerk. I say he is obviously suffering from emphysema because his appearance is sufficiently characteristic. People suffering from this disease have a distinctive physiognomy. They are always cyanotic and generally dyspnœic but their cyanosis is out of all proportion to the amount of their dyspnœa. The dyspnœa is not very marked when they are quiescent but it becomes very much aggravated on slight exertion. I have often called your attention to the fact that dyspnœa on slight effort characterises a condition upon which I have so frequently insisted, namely, functional high arterial tension, and we must be careful not to mistake this condition for emphysema. Fortunately, emphysema is generally very easy of diagnosis. Its pathology, however, is a vexed question. There is the inspiratory theory, the expiratory theory, and the primary degeneration theory. I am not going to discuss these with you, because I do not think they are of importance. The only one which I regard as of any real moment is that which my friend, Dr. Harry Campbell, has brought forward, namely, the theory of primary degeneration of the elastic tissue in the lungs. According to his view, the elastic tissue wears out, and in order that the all-essential elasticity of the lung may be kept in existence, Nature has put this elastic tissue on the stretch, with the result that the lungs occupy a greater space and the thorax becomes enlarged in all its diameters. This theory has never, to my mind, received as much attention as it deserves.

You have often heard me say that emphysema is to the lung what chronic interstitial nephritis is to the kidney. Chronic interstitial nephritis we know to be associated with high blood pressure in the systemic vessels; emphysema is associated with high blood-pressure in the pulmonic vessels. In interstitial nephritis we often have hæmaturia; in emphysema we often have hæmoptysis. The essential condition in interstitial nephritis is fibrosis of the vessels in the kidney; the essential condition in emphysema is fibrosis of the vessels in the ultimate air-cells. The one is invariably complicated with hypertrophy of the left ventricle; the other is invariaby complicated with hypertrophy of the right ventricle. If you will look at this man now that his chest is bare, you will observe the characteristic barrel-shape of his thorax, the widened inter-costal spaces, and the prominent clavicles. You will notice also that he breathes as a woman breathes, that is to say, with the upper part of the chest, and not with his diaphragm; and when you come to examine him you will find all over his chest that percussion note which Sir William Gairdner used to call tympanitic dulness. The heart-sounds are difficult to hear because of the amount of lung which covers the organ; but some of you, I see, have already noticed the epigastric pulsation which is characteristic of this complaint. That epigastric pulsation tells the story of the enlarged right ventricle, which, owing to the atrophy of the pulmonary capillaries, has increased work thrown upon it. This atrophy of the pulmonary capillaries raises the blood pressure in the pulmonary artery, the right ventricle hypertrophies and eventually dilates, the liver enlarges, and the spleen also may become engorged. In this case there is no doubt whatever about the enlargement of the liver and the hypertrophy of the right ventricle, neither, therefore, can there be any doubt about the increase of blood pressure in the pulmonary artery. We know that the blood pressure in the systemic system must always be higher than the blood pressure in the pulmonic system. If it were not so, the medulla would shortly be starved and the patient would die.

On taking this man's blood pressure, however, we find that it reaches only 140 mm. Hg., which, for a man, æt. 50, must be regarded as well within the normal limits, so that it is quite obvious that the systemic system does not find it necessary to increase its own blood pressure in order to overcome the high pressure in the venous system. How are we going to explain this fact? Rindfleish explained it for us many years ago by showing that in emphysema wide communications were formed between the pulmonary arteries and the pulmonary and bronchial veins, thus relieving the tension in the former vessel, but allowing the blood to pass through the lungs without undergoing proper æration.

In most cases of emphysema the systemic blood-pressure is raised to the point where the systemic shall overcome the pulmonic pressure. But where, as in this man's case, the systemic pressure is not unduly high, we may be quite certain that the cause is to be found in those wide communications which Rindfleish has described. That is why these people have a degree of cyanosis which is sometimes very extraordinary. Such a degree of cyanosis as is present in this case, if it were due to any cause other than emphysema, would certainly necessitate rest in bed, and it would almost certainly be accompanied by orthopnœa. In emphysema, however, these vascular communications described by Rindfleish may permit a very high degree of cyanosis without very much distress. On auscultation, this patient illustrates what is, to my mind, one of the most characteristic findings in emphysema, and that is the high-pitched inspiratory sound followed by a low-pitched, and very much prolonged expiratory sound. There are, of course, frequently a great many added sounds, due to the chronic bronchitis from which these patients almost invariably suffer. In a patient who has died with emphysema, post-mortem examination generally shows a considerable degree of atheroma of the pulmonary artery. This is interesting from the point of view of the question of the possibility of high blood pressure being, of itself, capable of producing changes in the vessels which it affects. There is another condition, namely, mitral stenosis, which gives rise to high-blood pressure in the pulmonic system, and here, too, you will frequently find atheroma of the pulmonary artery. To my mind, no further proof is wanted of the fact that high blood-pressure is the primary event and arterial degenera tion is the secondary event, in the vast majority of cases of arterial degeneration, whether the high arterial tension be systemic or pulmonic. The finding of arterial degeneration in two conditions such as emphysema and mitral stenosis, in which the high arterial tension is admittedly primary, is to say the least of it, exceedingly significant.

With regard to mitral stenosis, it is interesting to note that it is not infrequently mistaken for emphysema. The mistake is more easily made than one would imagine, because the distinctive murmur of mitral stenosis is by no means always present. It is particularly liable to disappear when the back pressure in the lung has reached the point of giving rise to active pulmonary difficulty. The dyspnœa, however, of mitral stenosis is more or less characteristic because it is of a panting character, and there is no disproportion between the degree of cyanosis and the amount of dyspnœa. Moreover, in mitral stenosis the systemic blood pressure, inasmuch as it must always overcome the pulmonic, is always high. Except as a terminal event it never falls as low as 140 mm. Hg., because there are no communications, such as those described by Rindfleish, as occurring in emphysema, to relieve the pressure in the pulmonary vessels.

OPERATING THEATRES.

PADDINGTON GREEN CHILDREN'S HOSPITAL.

CASE OF UMBILICAL HERNIA, WITH SEPARATION OF THE RECTI.—**MR. ARTHUR EDMUNDS** operated on a girl, æt. 5, who had been admitted with a recurrent hernia in the middle line. The hernia was not very prominent but formed a distinct bulging with its apex at the umbilicus between the two recti, which were separated for about three inches. The condition had been present at birth, and was becoming more marked, indeed, the weakness of the abdominal wall had progressed to such an extent that the child was beginning to suffer from vague abdominal pains. Separation of the recti was, Mr. Edmunds said, by no means an uncommon condition in children, but it was not common to find the condition so aggravated as to demand operative interference ; usually the two muscles were only separated from each other, by about an inch and, as they develop with the growth of the child, they come automatically into their normal relationship and produce a firm abdominal wall. This natural process of cure was the rule in all the types of hernia at or above the umbilicus which occur in children. One usually finds that some simple strapping appliance or truss suffices not only to restrain the protrusion, but to cure the hernia. There remains, however, a small percentage of cases which resembles the adult type and in these operative interference was imperative. These fall into two main groups :—In the first we have a long elliptical swelling protruding between separated recti, usually with a marked projection just above the umbilicus. In the second type of cases the muscular separation was less marked and there was a simple rounded sac sometimes bearing the umbilicus on its summit, but more usually situated just above it. The present case belonged to the first type. Although the symptoms actually present were slight yet they were progressive, and the weak abdominal wall would have been a very serious drawback to the child as she grew older. Mere removal of the projection in the neighbourhood of the umbilicus, was, he pointed out, quite insufficient to cure these cases and it was necessary to approximate the recti, or better still to overlap them. An incision was made in the middle line, with its centre at the umbilicus, extending upwards and downwards about half way to the ensiform cartilage and the symphysis pubis respectively. The fascial structures were divided down to the peritoneum but this was not opened. There was no true hernial sac and any redundancy of peritoneum would speedily adapt itself to the altered conditions or at the worst remain as a perfectly harmless ridge. This point was, he remarked, of importance as it obviated that exposure of the abdominal contents which was always a serious matter in a young child. The rectus on the right side was now exposed and freed from its sheath throughout the extent of the incision ; the left rectus was freed posteriorly, a matter of extreme simplicity ; a suture was now passed through the whole thickness of the right rectus in such a way as to leave two ends projecting from its superficial surface and a loop on its deep aspect ; one of the free ends was taken and passed by means of a handled needle between the rectus and the posterior layer of its sheath as far towards the outer border of the muscle as possible ; the point of the needle was then made to penetrate the muscle, the suture completely unthreaded and the needle withdrawn. This suture when tightened drew the right rectus behind the left causing the two muscles to overlap by about half their width ; this manœuvre was repeated throughout the length of the incision, three or four sutures being employed. The free edge of the left rectus which was now anterior was sutured down to its fellow. The anterior sheath of the rectus was next stitched up and the wound closed. The wound healed by first intention and the child left the hospital after three weeks. When seen a year later the girl had improved in general health, had lost her abdominal pain and had a good firm abdominal wall.

Mr. Edmunds mentioned that he had done the same operation on another case in which there had been a well-marked sac as well as the muscular separation. The sac had been removed at a previous operation, but the relationship of the muscles had been left unaltered. The wound had healed normally but the scar had stretched, and it was obvious that the hernia was re-forming. The operation described above was performed with the result that a firm abdominal wall was produced with no tendency to protrusion.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, MARCH 15TH, 1907.

Dr. W. R. DAWSON in the Chair.

ABSCESS OF CEREBELLUM.

Dr. W. BOXWELL exhibited an abscess, in right lobe of cerebellum, taken from a boy, æt. 14 years, who, his mother said, had always been an idiot. About Christmas he was struck with a snowball behind the ear, where a lump subsequently arose. For a few days he had a discharge. He was brought into hospital on 8th January suffering from attacks of vomiting, and in a curious drowsy state. The large lump behind the ear was diagnosed as hematoma. He was then in a hectic condition ; he vomited everything given to him, and also at intervals irrespective of food. An operation was performed on 12th January, with a view to finding the condition of the lump and to ascertain if there were any disease in the antrum and sinuses. The lump was found to be a suppurating hematoma ; and, with a view to clearing out possible mischief in the mastoid cells, they were trephined, but no particular sign of disease was found. On further exploration a suppurating track was found leading down through the occipital bone, from which the pus was slowly oozing. This was found to lead under the base of the skull, and a large suppurating sinus was found. The track was drained, but no relief of the symptoms followed. The boy became more and more drowsy, and was again operated on the 25th, the skulls being trephined and the brain explored for abscess. None could be found. Five days afterwards the boy died. At the *post-mortem* there was found on the right side a large cerebellar abscess, which had opened of itself on the under surface, and a pool of pus was lying in the occipital fossa. On exploring the original suppurating sinus with an ordinary bent probe, it passed easily into the cavity, and the cavity had been slowly emptying itself through the sinus and the drain. Examination of the pus showed presence of ordinary pus cocci.

The **Chairman** asked if Dr. Boxwell considered there was any causal connection between the suppurating hematoma and the abscess, or whether the hematoma was altogether a different lesion which became infected by the sinus burrowing into it. It struck him that, for an idiot's brain, it was extremely well-formed and convoluted, and he would like to know if anything had been ascertained as to the boy's degree of mental weakness.

Dr. **Boxwell**, in reply, said the idea was that it was a direct infection from the bone. There was no sign of any mischief through the ear-duct, and there was no disease whatever in the antrum. Whether the hematoma became infected secondarily from the pus escaping through the hole in the bone, or *vice versa*, he did not know. The pus in the cavity was recent. The boy could give no history of himself. His mother said he had always been an idiot, and could not be trusted with a message.

(*a*) SARCOMA OF FEMUR; (*b*) TUBERCULAR KNEE-JOINT.

Mr. L. G. **Gunn** exhibited specimens of above. He did so, he said, because both were diagnosed to be the same condition. Both presented symptoms of chronic inflammation of the knee-joint, which was believed to be tuberculous. In one case the diagnosis was correct; in the other it was very much mistaken.

SACRO-COCCYGEAL TERATOID TUMOUR, WITH FORMATION OF METASTASES IN THE GROIN.

Mr. **Seton Pringle** read a paper on "A Sacro-Coccygeal Teratoid Tumour, with Formation of Metastases in the Groin." The growth had been removed from a man, æt. 57 years, who had first noticed it thirty-five years previously as a small lump in the middle line, behind the anus. Since that time the tumour had grown slowly, till at operation it measured fifteen inches over all, from lower to upper extremity, and eleven inches from side to side, extending from the upper border of the sacrum to the anal margin, and from outside the left margin of the sacrum to well on to the right gluteal region. Two metastatic growths, each the size of a large hen-egg, were present in the right inguinal region, one of these had appeared thirty-three years and the other twenty years prior to the time of examination. By the rectum the hollow of the sacrum was found to be full of growth, but, as the patient was most anxious for operation, the posterior extern pelvic tumour and the secondary glands were successfully removed. At the operation a pedicle of growth was found, extending through the coccyx, which had been almost completely destroyed, connecting the intern and extern pelvic portions of the tumour. The patient, unfortunately, died a year later in the country from intestinal obstruction. Mr. Pringle then described the macro- and micro-scopical characters of the tumour and glands, and gave a short *resume* of the literature of the subject placing the growth in the class of monogerminal teratoid tumours as described by Borst. In conclusion, he pointed out the case differed from recorded cases in three particulars:—(1) The late appearance of the tumour, most recorded tumours having been present at birth. (2) The comparatively simple structure of the growth. (3) The occurrence of metastases.

The **Secretary** (Professor A. H. White) recalled a case of a tumour in the same region which supported the view that such tumours were parasitic. It was from a girl of sixteen or seventeen. A tumour which had been small suddenly took on rapid growth, and contained portions that were typically cancerous, and others that were typically like round-celled sarcoma, besides almost every fully formed tissue that could possibly be found. In the case shown by Dr. Pringle the structure of the tumour was much less complex.

Mr. **Gunn** cited a couple of cases of similar tumours.

Dr. **Pringle** replied.

CEREBRO-SPINAL MENINGITIS.

Dr. **Harvey** exhibited slides from a case of cerebro-spinal meningitis—a girl, æt. 10. She had been perfectly well on the morning of the previous Monday. While swallowing a piece of liver she choked, and, not getting much relief, she was brought to hospital. There she developed great tenderness down the spine. She passed into a comatose condition; her eyes were open, but there was no cornea reflex. She died the same night. Next morning he drew off some fluid by lumbar puncture. The slides which he had prepared, showed a diplococcus in great numbers, even in the original fluid, and outside the cell. They were distinctly non-Gram staining. One of the slides showed a capsule round the cocci—which was said not to exist.

Professor White observed that the cocci shown were all stained much in the same way. In those which he himself had got the irregularity of the staining was most pronounced, some taking it deeply, others only slightly. The regularity in Dr. Harvey's specimens were probably due to the early stage at which the patient had died. With regard to the cocci which exhibited capsules, he had found the same in some of the organisms which he had got from certain cases this year. Weichselbaum and his school denied absolutely the existence of a round capsule in his coccus; but Jäger, who had considerable experience, stated that capsules were frequently seen. Between the supporters of the two there was considerable strife, both on that point and also as to whether the organisms were always negative to Gram. The former school say that those which were positive to Gram were not the specific organism at all. He mentioned the fact that sub-cultures of an apparently pure non-Gram staining organism became Gram-staining as showing that the question of staining was not yet settled.

Dr. **Day** asked if there was any history of discharge from the nose in the case. He had found it in all cases except one, and Continental observers had reported a diplococcus found in swabs taken from fifty per cent. of cases.

Mr. **Gunn** said he had seen the child in hospital, and no history of discharge could be obtained. He was inclined to think she had been ill for a longer period than the parents made out, and that the choking was probably some defect of swallowing. About an hour and a half before death there were five or six fairly typical spots on the child's limbs. After death he saw the body almost covered with them.

Dr. **Harvey**, in reply, said the preparation to which Professor White had referred as showing regularity in staining had been made from the original fluid; but on making some more that day he had noticed great irregularity in the staining; and the appearance of diplococci apparently much larger than the other cocci gave him the idea that the cocci had swollen out.

A TELEGRAM from Strasburg last week states that the small-pox epidemic at Metz had assumed alarming dimensions. The epidemic is seriously affecting trade and industry, and the military doctors, seeing that the civil medical men are unable to cope with the number of cases, placed themselves at the disposal of the town, and are vaccinating people in their homes. Owing to the serious nature of the epidemic the public rejoicings in connection with the Eastertide fetes have been abandoned.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY.

Meeting held at the Town Hall, Hastings, on March 16th, 1907.

After a short address of welcome by the Mayor of Hastings,

Dr. **Wm. Ewart**, of London, introduced a discussion on the

PRESENT POSITION OF THE TREATMENT OF TUBERCULOSIS BY MARINE CLIMATES,

an abstract of which will be found on page 390.

Mr. **Henry Colborne**, M.R.C.S., read a statistical paper on the temperature, rainfall, bright sunshine, and climatic conditions of Hastings, covering a considerable period. After demonstrating the abundant amount of sunshine in Hastings, the highest record in the British Isles save the islands of the English Channel, he referred to the clearness of its atmosphere, when compared with our great cities which lost from three to four hundred hours of bright sunshine yearly through smoke alone, the yearly average in the City of London being 1,143 hours, while at the Kew Observatory there was an average yearly record of 1,568 hours.

Mr. A. **Scarlyn Wilson**, D.P.H. (St. Leonards-on-Sea) said examination of the mortality statistics shows that since 1898 there has been a marked decline in the number of deaths from phthisis registered in Hastings. This reduction is so great (nearly 35 per cent., comparing 1898 with 1906) as to make it reasonable to infer that the stream of phthisical patients which formerly flowed in this direction has been partially diverted into other channels, probably towards the inland sanatoria, which have recently sprung up. If other seaside resorts have been similarly affected, a great change must have taken place in the opinion of the medical profession as to the value of marine stations in the treatment of active phthisis.

Dr. **Anderson-Berry** (St. Leonards-on-Sea) heartily agreed with Dr. Ewart's illuminating address. He wished to emphasise one or two points: (1) That, as Dr. Ewart well said, there is no single method whereby phthisis may be successfully treated. Drugs have their place as well as open air and other hygienic methods. (2) That the patients who do well at marine stations are those whose opsonic index shows a considerable power of reaction present, especially when tested by injections of tuberculin. In answer to a question asked he would add that such a climate as that of St. Leonards is especially favourable in his experience to cases of emphysema upon which have been grafted tubercular processes.

Dr. **Bagshawe** pointed out that the late Dr. Henry Bennet was an early advocate of the treatment of phthisis by the open-air method. All his patients at Mentone were enjoined to have their windows open night and day, and to spend much time reclining in the garden. The importance of rest was especially enjoined. Looking back upon an experience of forty years at Hastings, he was able to point to a long list of patients who had lived through the active stages of pulmonary tuberculosis and had settled down to spend long lives, with arrested damage, some partially, some entirely cured. Such cases bore striking testimony to the advantages to be derived from a sheltered sea-coast climate such as Hastings.

Mr. **George Pernet** desired to call attention to the importance of general treatment in tuberculosis of the skin, especially as regards marine climates.

Dr. **Wethered** said that it might be accepted that the treatment of pulmonary tuberculosis in marine climates was practically one form of the "open-air" treatment of the disease. The essentials were an abundance of fresh air, a full, varied diet, and, in the earlier stages, skilled supervision in the matter of exercise. These requisites might be obtained *par excellence* at English seaside resorts. He laid stress on the importance of studying "individualism" in the selection of cases to be sent to marine climates. Also he was of opinion that residence at the seaside was most valuable in the treatment of patients who had passed some months in a sanatorium, and in whom permanent arrest had not yet been obtained. Several months were necessary before arrest could be procured, and the many attractions to be found at a seaside resort would be of great value in enabling patients to give the necessary time to the treatment without the weariness that necessarily ensues upon strict routine.

Dr. **Percy Lewis** (Folkestone) said that as long as there were consumption hospitals in congested areas, as the City Road and Brompton Road, London, it was necessary to convert the leaders of the profession to the imperative need for treating phthisis out of large cities. He criticised sanatoria treatment, and advocated the advantages of marine climates for the treatment of most forms of tuberculosis.

Dr. **Leonard Williams** said that sanatoria were doing a fine work not so much in curing phthisis as in educating the public in open-air methods. Marine climates could offer no such advantages, because climate without method was useless.

Dr. **St. Clair Thomson** spoke in emphatic terms of the necessity of instruction concerning the open-air methods carried out in inland sanatoria.

Dr. **Tyson** (Folkestone) spoke in favour of marine climates in the treatment of tuberculosis.

ULSTER MEDICAL SOCIETY.

Meeting held Thursday, April 4th, in the Medical Institute, Belfast.

The President, Dr. D. P. **Gaussen**, in the Chair.

Dr. H. L. **McKisack** showed a case of Aortic Stenosis in a child.

Mr. A. B. **Mitchell** read a paper, entitled "Suggestions as to Treatment of some Common Surgical Ailments, from a General Practitioner's Standpoint. The first ailment with which he dealt was the common and troublesome one of nocturnal seminal emissions. In this affection he recommended the use of counter-irritation over the lumbar region of the spine. The form in which he applied it was to blister an area about 3ins. by 2ins., remove the skin, and keep the sore open by the old-fashioned but most useful D'Albyspierre's paper. The same line of treatment he had recently tried in enuresis in children, and though too soon to say decidedly, he believed it promised well. The second ailment with which Mr. Mitchell dealt was the very common and important one of piles. Many patients would not submit to operation, and in cases of internal piles, he advocated treatment by injection, with certain strict precautions. A purgative should be given the night before, and an enema the morning of treatment. The patient was directed to strain down, and a pile being washed with boric lotion, was pierced at its base with a hypodermic syringe, going nearly but not quite through it. Into it is then injected from 3 to 10 minims (generally about 5) of a mixture of equal parts of hazeline and glycerine, with 10 per cent. of carbolic acid added. The needle is withdrawn very slowly, and the patient kept quiet for a few minutes before he goes to his ordinary occupations. If too great a quantity is injected the pile sloughs, but if it is done right it only swells up for a few days, and then disappears. At the first sitting only one should be done, and in a week or so, if the first is well borne, two may be done. Any ulceration about the pile renders it unsuitable for this treatment, and external piles are not suitable. Anal Ulcer and Anal Fissure need not always be operated on. After the free use of orthoform as a local anæsthetic pure ichthyol should be applied on a probe with cotton wool. This treatment is generally successful in two or three applications. In Pruritis Ani and Vulvæ, a saturated solution of chlorotone may be applied on wool, and is often successful. Chronic Abscess was dealt with by Mr. Mitchell at some length. There was no doubt that it was always tubercular, but the pus only contained dead bacilli, the living ones being found in the limiting membrane, wrongly called the pyogenic membrane. Some men advised one to let such abscesses alone in the hope that they might be absorbed, but he could only say he had never seen such a happy issue. On no account should they be simply opened and drained, for though the early results might seem good, soon there would be a mixed infection, temperature would rise, and endless trouble begin. Aspiration might be tried, and was often good if aseptic, but it frequently ended in infection of the skin, and was unlikely to cure. If it was done, he advised the subsequent injection of iodoform emulsion, which could be used with safety after careful boiling, up to 2ozs. being injected. The plan which he himself preferred was to open the abscess freely under strict aseptic precautions, and scrape it out with a flushing curette and boiled water. He did not drain, but merely loosened a stitch the day after to allow any fluid to escape. Tubercular Fistula or Sinus was often very troublesome. He had found far the most efficacious means of dealing with either of these was to inject 2 per cent. formaline into it. It was not a good treatment in a septic sinus, but most successful in tubercular ones.

The paper was criticised by Drs. Henry O'Neill, Fullerton, Calwell, and the President.

CEREBRO-SPINAL MENINGITIS AND PREGNANCY.

Dr. J D. **Williamson** read notes of a case of cerebro-spinal meningitis occurring in a young girl admitted to the Ulster Hospital for Children and Women for Labour. The patient was exactly thirteen years and nine months old, had never menstruated, and would not acknowledge her condition. She was taken ill in the early morning hours of March 5th, and was seen by two doctors, who agreed as to her condition, and sent her into hospital, where she arrived at noon. She then complained of violent abdominal pain, and vomited a little. Temperature was 101°. She was quite conscious. The os was only slightly dilated, and she seemed too ill for labour. Dr. Williamson was sent for, and on arrival at 2 o'clock, found her very ill, but still conscious. Her legs were flexed on her abdomen, and her arms on her chest, and dark spots had appeared on the skin of the abdomen, where none had been seen two hours before. She died at 4 p.m. and at a post-mortem examination a full-term male child was found in the uterus, and signs of cerebro-spinal meningitis in the brain and other organs.

THE THERAPEUTICAL SOCIETY.

Meeting held March 26th, 1907.

Prof. Nestor Tirard discoursed on the

TREATMENT WITH OPIUM IN PNEUMONIA.

He quoted Osler's and other recent text-books which prescribed opium. But in his own practice he never used opium nor morphine, unless after the crisis. In the albuminuria which occurs sometimes it would be harmful. If given for diarrhœa, is that not due to prescribing ipecac. ?

Dr. **French** suggested that the cause of albuminuria was probably blistering.

Dr. **Soper** was in the habit of giving opium and carbonate of ammonia. (He did not say if together and in what form). Also turpentine fomentations. On the whole the members present seemed to disapprove of opium as a routine treatment. Whether opium acts by way of depressing the heart's action was disputed, but it was considered better practice to administer strophanthus 5 m. twice a day from the commencement.

Prof. Dixon then read a highly scientific paper on

HOW DRUGS PRODUCE THEIR EFFECTS.

Carbon and bismuth, he remarked, act mechanically; sodium chloride is absorbed, but sodium sulphate is not. Again, strychnine acts on the spinal cord only, and on no other tissue, but it does not combine with any substance as one chemical with another. Pilocarpine stimulates vagus; so does electrode. They produce a sort of ferment in the terminations of the vagus within the heart muscle and so act in the same way, stopping the heart-beat. Experiments, he said, were made on a cat, already dead. This is a suggested explanation of the specific action of drugs, but in the absence of a clear knowledge of the organic chemistry of ferments, his inferences appeared to be hypothetical.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, April 7th, 1907.

Hæmorrhage in Disease.

Two varieties of hæmorrhage are obtained in infectious maladies: (1) Hæmorrhage of local origin due to intensity of congestion or lesions of the blood-vessels; (2) hæmorrhage from general causes, the result of modification of the humours of the organism. The latter, when slight, is not very serious, but when it becomes repeated and abundant it has the characters of the hæmorrhagic form of infection and is always grave.

M. Roger has studied the causes and treatment of these forms of hæmorrhage in an excellent article of which the following is a *resume* :—

Hæmorrhage from local cause results from several pathological conditions: (1) A particularly intense inflammation may end in rupture of the vessels. This hæmorrhage is generally benign; frequently petechae are observed on the legs in scarlatina; in small-pox, pustules of the legs and hands may be filled with blood, but do not indicate gravity. The same may be said of the mucous membranes; in cases of tonsillitis a sanguinous patch may be observed on the tonsil, in coryza there is frequently slight hæmorrhage from the nose (epistaxis), and blood-spitting may occur in laryngitis or bronchitis, vomiting of blood in gastritis, while slightly tinted stools may be observed at the outset of typhoid fever. Effusion of blood in the parenchyma producing infarctus of the lungs as in broncho-pneumonia, which sometimes passes unperceived and at others cause blood stained expectoration. Hæmaturia is frequently the first sign of nephritis, and is due to the intensity of congestion of the kidney. It is especially observed in those forms observed in scarlatina, pneumonia, or erysipelas.

(2) A certain predisposition favours the appearance of hæmorrhage. Thus persons with varicose veins present ecchymosis of the lower limbs in the course of eruptive fevers and in children suffering from whooping-cough, who contract measles, the rash assumes an ecchymotic aspect.

(3) The extension of the infectious disease provokes abundant hæmorrhage and if a thrombus has not had the time to form, death may result, as in the case of intestinal hæmorrhage of typhoid fever.

Hæmorrhage from general causes is due to divers causes. It can represent an ordinary symptom of infection as in purpura hæmorrhagica. It may result from a lesion of an organ playing an important *role* in the coagulability of the blood—the grave forms of icterus, or splenic disease.

It can also be the consequence of the virulence of the germ which produces the infection, as in the hæmorrhagic form of scarlatina and measles, typhoid fever, and, above all, small-pox, which is the most frequent.

As to treatment, absolute rest and immobility are indicated, as the slightest effort, movement, cough, or colic, may detach the clot and renew the hæmorrhage. Consequently baths should be suspended in typhoid cases and anodynes in the form of opium or chloral administered.

The general treatment should aim at modifying the coagulability of the blood and in these last years two new agents have been employed to this effect—

chloride of calcium, as recommended by Wright and Carnot, and gelatine.

Chloride of calcium is particularly effective in hæmorrhage of the digestive tract. A drachm a day is the proper dose.

Chloride of calcium, 1 dr.
Cognac, 1 oz.
Tincture of cinnamon, 1 dr.
Syrup of orange, 2 oz.
Water, 2 ozs.

A tablespoonful every two hours.

Oxygen water (12 vol) applied to the bleeding surface acts very well but is rather painful.

Carnot proved the advantages of applications of a solution of gelatine to increase the coagulability of the blood. The solution might be at 10 per cent., to which a few drops of formol are added, and finally sterilised by a quarter of an hour's boiling.

When the hæmorrhage is arrested, subcutaneous injections of artificial serum should be made to increase the tonicity and volume of the blood.

LOCAL PRURITUS (ANI, VULVA, &C).

Bromide of potassium, 30 gr.
Supulin, 30 gr.
Calomel, 30 gr.
Olive oil, 5 dr.

BLEPHARITIS.

Icthyol, 10 gr.
Sulph. of copper, 10 gr.
Vaseline, 6 dr.

GERMANY.

Berlin, April 7th, 1907.

TRANSMISSION OF SPIROCHÆTE FROM THE MOTHER TO THE CHILD.

THE *Deutsche Med. Zeitung* No. 19, '07, relates a case in which this took place. In a case of triplets one fœtus (male) was macerated. One child lived a few hours, whilst the third (a female) lived a day. The writer of the article, Dr. Wersilowa, was of opinion that all three fœtuses had reached full term. Far advanced syphilitic changes were present in the two first children. The palms of the hands and soles of the feet, as well as other parts of the body, showed papules. The second child, in addition to the above, had a large hard spleen, while the female child showed no morbid changes. The placenta, which was common, consisted of three parts, and was full of nodules in size from that of a pin's head to a pea. Nothing abnormal was seen about the umbilicus. The mother was syphilitic. Spirochætes were found in the expressed juices of the umbilicus, of the placenta, in section of the heart of the macerated child, in the papules, in section from the placenta, umbilicus, heart, lungs, spleen, the plaques and papules of the second child and spirochætes were therefore found in the placenta and umbilicus and in the organs of the fœtus even when the mother showed no signs of syphilis. He finished up by formulating certain conclusions. (1) The spirochæta pallida is present in syphilitic processes, also in the organs of new born infants affected with hereditary syphilis. (2) The spirochæta pallida may be transmitted from the mother through the placenta and umbilical evil. (3) The presence in the placenta, cord and organs of the fœtus is possible even when the mother shows no sign of the disease.

In eighty cases of hereditary syphilis in the new born the spirochæta pallida had been found in fifty of the number.

At the Fren Vererinyung der Cheringen Berlins, Hr. Israel reports

THE LATER RESULTS OF HIS 94 NEPHRECTOMIES FOR TUBERCULOSIS.

Of 3 patients nothing was known, 21 were dead, 11 as a result of operation, 10 died some years later. In 70 of the living the operation had been performed 5 to 15 years in 15 of them. Those cases had not been taken into account in whom the operation had been done less than one year. The information had been obtained by himself personally wherever possible, where this was not so some other medical man had reported. The following points were to be specially noted:—(*a*) The influence of the operation was almost always favourable as regarded increase in weight, 47 patients had increased in weight (10 to 90 lbs.), 2 patients had maintained their weight, 1 had lost through pulmonary tuberculosis. (*b*) The strength had become better in almost all cases. Disturbances of micturition were common in patients with tuberculous kidneys; they were present even when the bladder was normal, and removal of the kidney relieved the bladder symptoms. On the other hand removal of a tuberculous kidney effected also an improvement in a bladder already affected with the disease. In detail, as regarded bladder troubles, 31 per cent. were free from them before operation; after it 20 per cent. still had slight bladder troubles. Frequency of micturition was normal only in 15 per cent. before operation; but it became so in 60 per cent. after operation. In two patients with bilateral tuberculosis of the kidney there was no improvement, and in 2 others it got worse. A study of the influence of the operation on tuberculosis of the bladder showed that no patient who was free from it before operation acquired it after. The recovery of tuberculous bladders was ascertained partly by the cystoscope, and partly from proof of the gradual disappearance of the tubercle bacilli from the urine. Forty cases were tested in the latter way, 34 microscopically and 6 by animal experiment, and bacilli were found only in 3 cases. Functional improvement with bladder symptoms progressed only very slowly, rapidity being proportionate to the slight degree of the disease. All this was in favour of anatomical healing. These results followed even when the bladder was subjected to the after-treatment. In many cases, however, the functional bladder disturbance persisted even when the bladder and urine were normal. In such cases the bladder had become accustomed to frequent emptying, in many cases it depended on physical causes, as when the patient had previously suffered agonies.

He distinguished 3 stages of bladder disease—(*a*) disease in the region of the mouth of the corresponding ureter; (*b*) of the corresponding half of the bladder; (*c*) different disease. Class *a* ended in normal function in 75 per cent., slight disturbance in 16.6 per cent., serious disturbance in 8.3 per cent. Class *b* ended in normal function 66 per cent., slight disturbance 16.6 per cent., serious disturbance 16.6 per cent. Class *c* normal function 37.5 per cent., slight disturbance 10.5 per cent., serious disturbance 57 per cent. The more extensive the tuberculosis of the bladder, the less was it amenable to treatment.

Regarding the remaining kidney it was ascertained that more became tuberculous unless they were diseased before the operation. In one case non-tuberculous ascending pyelonephritis took place eight years after the operation. Pregnancy was not influenced by it. Of 8 pregnant women, 6 had normal labours at term, 2 had abortion that took place without disturbance on the side of the kidney; 65 per cent. of the cases had been saved by early operation. Early treatment was urgently called for. Experience taught that nearly all tuberculous diseases of the urinary tract proceeded from the kidneys, and they were never recorded spontaneously. The permanent results of nephrectomy were an encouragement to early operation, and the more frequently it was performed, the more would the mortality of the operation diminish.

AUSTRIA.

Vienna, April 7th, 1907.

PSEUDO-HERMAPHRODITES.

HAIM showed to the Gesellschaft two sisters, the eldest, æt. 20, with masculine habits. The first striking features were the voice and throat, the small developed breasts and the hair covering of the body. The genitals had a large unperforated clitoris with elongated prepuce while the index finger could be inserted into a narrow *cul-de-sac*; uterus and ovaries could not be discovered by the vagina. In the vulva oval swellings like hazel nuts represented the testes. They had been brought up as females, but have no sexual feelings.

Multiple Epiphysal Separation.

Hochsinger exhibited to the members a child four weeks old with loose epiphyses, the result of syphilitic osteo-chondritis. Shortly after birth the child ceased to move its limbs, particularly the arms, which seemed to have no power in them. Shortly after this a thickening around the joints commenced.

The child was of premature birth and had four large bullæ on the soles of the feet when born. The father had syphilis thirteen years before the birth of the child but the mother had no trace of the disease before marriage.

The swelling around the joints of the long bones was very painful and tender, with a hollow line above and below the joint in the soft tissue covering the bone, but the skin only was movable over the part. The most notable condition was observable in the upper third of the left femur where it was circular. The upper extremities were quite paralysed at first, but when pricked with a needle or the soft parts nipped, a distinct reflex action could be produced. When exhibited the child could again move its arms and slightly the legs. Passive movement in pronation and abduction also gave pain. The joints were still a good deal deformed and swollen.

The case seems to have been one of congenital syphilis having first Wegner's osteo-chondritis followed by epiphysal separation in the long bones. The Röntgen rays showed a space at the epiphyses and diaphyses. The diaphysial shadow had a shaggy network towards the epiphysis, clearly proving that the lime was irregularly distributed over the bones. The fractured ends appear to have been due to this granulation metamorphosis. The anti-syphilitic treatment has been adopted and appears to be successful so far.

Rontgen Ray Ulcers.

Lang presented a patient, æt. 30, who had been treated in Genoa with the Röntgen rays for malaria in the spring of last year. The rays had been liberally applied to the spleen and with such success that the patient came to his clinic in the month of September last year with a painful X ray ulcer 10½ by 7 centimetres broad. The pain was so extreme that he could not get sleep by day or night, no matter how large the dose of morphia.

Lang resolved to excise and cut out a large portion of the pectoralis major, serratus, and magnus intercostals, covering the raw surface after the Thiersch method in the hope of bringing about a healing condition. Immediately after the operation, the necrosis went on for a time, but now the healing seems to have commenced.

He next recorded the history of a few other cases which had come under his treatment after the Röntgen Therapy, as well as a few that have become ulcerated after the diagnostic application.

A young man, æt. 24, of a psychopathic nature, swallowed a few rusty nails, which required the rays to determine their position. Twelve days after the application a reaction in the skin took place over the site of the rays, and sixteen days later a necrotic ulcer commenced to form over the part where the rays had been applied. He was retained in the medical wards for a year, but the ulcer would not heal. At the end of this period the case was handed over to him to treat it as a surgical case, which he did by excising the ulcer entirely and immediately commencing the plastic operation with the best results. Lang thinks that as soon as it is discovered or suspected the part will ulcerate after the application of the rays, the part should be excised and plastic operations commenced to arrest the degenerative changes that are sure to follow.

Hepatic Cirrhosis.

Gruner recorded the history of a young girl who suffered from cirrhosis and large spleen. One day a varicose ulcer in the lower part of the œsophagus burst and died in thirty hours after from hæmatemesis. The *post-mortem* confirmed the diagnosis. The girl had been in the habit of taking a quarter of a litre of beer daily.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE ALLEGED INCREASE OF INSANITY.

In his annual report, Dr. Easterbrook, Medical Superintendent of the Ayr District Asylum, discusses the alleged increase of insanity, and takes a hopeful view of the facts. The Central Lunacy Authorities, who are in the best position to know, state that the number of persons placed on the register of the insane for the first time in their lives is year by year not increasing to a greater extent than can be accounted for by the increase of the population, which indicates that there is no undue increase in the absolutely new insanity of the country. At the same time the actual number of registered insane has for many years back increased to a greater extent than the population—some 1,858 of the population of Scotland has risen by 56 per cent.; but the number of officially known lunatics has risen 200 per cent. This increase is partially, but not wholly, ascribable to the accumulation of unrecovered lunacy, but there are, in addition a number of unrecovered lunatics who do not come under the cognisance of the general Board. It is not possible by the present method of annual lunacy statistics to arrive at the total picture of mental unsoundness in this country; the nearest approach to the truth could be reached only by retaining all certified persons on the general register until they recovered or died, which would entail a system of notification somewhat similar to the notification of infectious disease. Notwithstanding the apparently gloomy picture of the gradual increase of the total lunacy of the country, the last Blue Book contains the comforting news that during 1903, 1904 and 1905, there were signs of retardation or even of arrest, and in 1905, for the first time, there was no increase on insanity relatively to the population. The receptions into the asylums in 1906, in every case without exception, presented distinct evidence of the possession of a neurotic or neuro-insane constitution, which in Dr. Easterbrook's experience is the essential etiological basis of insanity in the individual. Enquiry into the antecedent history of the patients—temperament, habits, early manifestation of nervous or mental symptoms, minor congenital defects, physical signs of degeneracy (which, however, should be judged of cautiously, since isolated stigmata occur in normal capable persons) or heredity, showed that in no instance could these be excluded, prior to the outbreak of insanity, the existence of a morbidly reacting brain, or bad heredity, faulty modes of life, or previous disease.

Dr. Easterbrook emphasises the importance of recognising and admitting the danger of peculiarities of temperament as a soil on which insanity is prone to develop, and by careful nurture and education of such persons, by attention to the laws of health in later years, and by avoidance of undue stresses, avoiding the breakdown which will ensue if they live like their normal fellow men. All other or "exciting" factors of insanity operate solely on neurotic individuals. Among such was worry, anxiety, overwork, alcoholism, and periods of physiological stress. Another group of patients suffered from general paralysis, and finally the third group was that in which insanity was due to toxæmia. There is much loose talk, at present based on one-sided and insufficient evidence, on the toxic causation of insanity. Poisoning of the nervous system arising from disease or bad habits is an important factor, but only one of many, and lights up insanity only in a predisposed person, not in the absence of the neuro insane diathesis. Take the case of one of the patients who became insane while convalescing from pneumonia, a small slightly built woman, subject for years to migrane, excitable, the daughter of a neurotic man, the sister of a neurotic brother, was not her constitution a more important factor in producing insanity than the pneumonia? Yet the toxic school assert that not only may pneumonia "cause" insanity, but that insanity may be "cured" by an attack of some acute infection. The mere fact that a fever may be but harmful and beneficial, suggests that the insanity is mainly dependent on some other factor.

Take again the cases of alcoholic insanity who form the bulk of the toxic group (12.7 per cent. of the admissions), all presented distinct evidence of the neurotic constitution. Is it not well recognised that many persons can consume vast quantities of alcohol without their nervous systems breaking down. Those who attribute to the elusive factor of toxæmia an all important influence in causing insanity are deliberately shutting their eyes to signs which "he who runs may read."

BELFAST.

Public Health.—The new Fever Hospital at Purdysburn is not long in coming into full use as appears from the report of the medical officer of health for the past month. It appears that 302 cases of infectious disease were notified, including 104 cerebro-spinal meningitis, 89 typhoid and simple continued fever, 58 scarlet fever, 27 diphtheria, and 4 puerperal fever. During the past week the daily number of cases of cerebro-spinal meningitis has not been published, as the Public Health Committee has come to the conclusion that constant bulletins only alarm the public, but as far as can be ascertained there have been only a moderate number of new cases, and no signs of an increase in the epidemic. There are now 40 cases under treatment at Purdysburn, the total number notified up to date being 261, with 136 deaths. During the week ending Saturday, the 30th ult., there were 31 fresh cases.

LETTERS TO THE EDITOR.

RAYNER'S REPRIEVE AND THE PLEA OF INSANITY.

To the Editor of The Medical Press and Circular.

Sir,—Although your correspondent "M.D.,D.P.H.," has been gratified with innumerable others at the reprieve in question, which, as you remark, probably represents the sentiment of the great majority of the medical profession, it is interesting to note that the lay press has been all but, if not unanimous, in strongly condemning the Home Office for yielding to what it pleases to regard as a hysterical outburst of public feeling. This notwithstanding that about half a million of the British public were about to petition the Home Secretary for the reprieve, of which he no doubt had knowledge, and could not, advisedly, turn a deaf ear. On the other hand there is no evidence, I think, to show the writers of the articles in the daily press for the reprieve, represent any considerable section of the public against the reprieve.

There is, I imagine, ample evidence that the condemned man in mind was greatly perturbed and unhinged, suffering from a grievance either real or imaginary, that he was "the illegitimate outcast" of his victim. Further that he was seized with the idea that natural parentage afforded him a strong moral claim in his dire poverty and distress to seek succour out of the abundance which his victim apparently possessed. Although the case has been represented as one of common blackmail, the fact remains that it culminated in homicide, with a determined, yet abortive, attempt at suicide.

Undoubtedly a case of this kind without positive evidence of insane delusion is of great difficulty and delicacy. It is one upon which neither the jurist nor the alienist can afford to dogmatise. We cannot escape the fact that the whole criminal code with its penalties is pivoted and founded on the hypothesis that so-called free will and moral responsibility does to some degree exist. On the other hand the idea of non-freedom of will, although as old as the hills, seems to be gaining in currency nowadays. Possibly the general spread of education which tempts many to dip beneath the surface and think for themselves, accounts for the spread of these ideas. Meanwhile, those who believe in absolute non-freedom of will—in other words, that we are mere organic machines in the universe—may take courage in the thought that the human race has improved and hope the evolutionary processes or machinery may eventually turn out a purer, healthier, and better race than that hitherto produced.—I am, Sir, yours truly,

Clement H. Sers.

Brighton, April 5th, 1907.

THE ANTI-VACCINATION CHAMPION.

To the Editor of The Medical Press and Circular.

Sir,—Mr. Lupton, who holds the proud position of champion of the cult of anti-vaccination in the House of Commons, seems likely to meet the fate of a former member, who, to the frequent amusement of the House, held up alone the banner of "No Popery" for many years. This gentleman discovered the hands of the Jesuits in every political movement, and brought in the end such ridicule upon his attitude that he was once seriously charged with being himself a Jesuit in disguise entrusted with the task of damaging the cause he was ostensibly fighting for. Since I called attention to Mr. Lupton's oration last month he has delivered another of similar length and character, this, like the former, being greeted throughout with continuous laughter. The following excerpt will show that the mirth was well provoked.

Mr. Lupton said "that the carcases of cows from which lymph for the purpose of vaccination had been extracted were sold in the markets. The consumption of this diseased meat led to that physical degeneration among the people which swelled the ranks of the unemployed. The matter taken from the calf contained the germs of cancer and other diseases. This was admitted by medical men, who also said that the organisms might be destroyed by mixture with glycerine. Used as food, were the animals from which the poisonous stuff was taken likely to benefit the health of the people? In consequence of vaccination enforced under the law infants had sickened and died. He mentioned several cases, and exhibited a photograph, regretting that he could not display a screen picture of the horrible sores. There had been Local Government Board reports, but these were kept secret, and from that they could draw their own inferences."

That such fatuous drivel should meet with the ridicule which alone it merits in the House is so far satisfactory, and there need be no doubt anti-vaccination is getting nothing but harm in Parliament from Mr. Lupton's advocacy. I should like to ask once more, what can be the mental calibre of the body of people whom he represents, what respect do their outcries deserve from the Legislature of a civilised State? They are on a level with children and can be safely dealt with only as such.

I am, Sir, yours truly,

Onlooker.

Bradford, March 30th, 1907.

THE ALCOHOL QUESTION.

To the Editor of The Medical Press and Circular.

Sir,—I have before me your leader on Temperance and Legislation of January 23rd, 1901. This leader concludes in the following sentences: "Let them distinguish clearly between alcohol, the distilled product of fermentation, and those more necessary fluids which are obtained by fermentation of the juice of the grape, or the infusions of various grains, in which the small amount of alcohol produced by fermentation plays a very small part in their value as articles of diet. If legislation comes up for consideration, let it be clearly pointed out that alcohol distilled and separated from any fermented solution is quite a different thing from fluids which are simply obtained from natural and wholesome sources, and have gone through the most strange and important change which fermentation produces in them, and renders them of such great value as articles of diet."

It would be well for those who are interested in the alcohol question to consider carefully what is contained in your leader. I see that Mr. Tomlinson, in his letter to *The Times* (April 2nd, 1907) on Dr. Dawson Burns and the Drink Bill, remarks that Dr. Burns' figures "convey the impression that alcohol is made out of air or some equally inexpensive article"; and the fact that Faraday and Hennell, in 1820, obtained traces of alcohol by passing olefiant gas (bicarburetted hydrogen) through sulphuric acid certainly leads one to the conclusion that we must not treat fermentation as a chemical process for making alcohol, and nothing more. "Herodotus ascribes the first discovery of the art of brewing barley-wine to Isis, the wife of Osiris, and a beverage of this kind is mentioned by Xenophon 401 B.C." (Haydn's Dict. Dates.)

As the leading medical journals do not seem to have treated this subject as you did in your leader, it would be well for them to try and clear away on sound scientific grounds the differences that exist in the profession on the various questions that have to be considered before reasonable and sound legislation can be expected.

I am, Sir, yours truly,
Temperance.

Pwllheli, North Wales, April 3rd.

THE SUPPRESSION OF FRAUDULENT ADVERTISEMENTS.

To the Editor of The Medical Press and Circular.

Sir,—Knowing the interest taken by The Medical Press and Circular in the suppression of fraudulent advertisements, I make no apology for calling your attention to the impudent attempt which is being made by a certain firm to foist a worthless disinfectant preparation on the consumer by means of a chemical trick.

In the enclosed advertisement, the manufacturers in question offer facilities for demonstrating their "claim." Their preparation is, of course, provided with a taking name. On analysis it is found to be nothing more or less than a weak solution of chloride of zinc. You will see from the enclosed test form that even pure chloride of zinc is, at best, a feeble disinfectant; indeed, this particular solution has a carbolic co-efficient of 0.02 when tested by Dr. Rideal's method, and is absolutely useless for the purposes for which it is sold.

Of course, a very elementary knowledge of chemistry, which the public do not unfortunately possess, is sufficient to explain the reaction which takes place when carbonate of ammonia (the particular form of ammonia employed by these people in their test in the advertisement) is added to a solution of chloride of zinc; and the public are thus artfully led to believe that this worthless "new disinfectant" must be a powerful deodorant and antiseptic for general use.

I am, Sir, yours truly,
Analyst.

THE ELIMINATION OF THE UNFIT.

To the Editor of The Medical Press and Circular.

Sir,—To palliate a symptom when the cause cannot be got at is often justifiable; it is sometimes pardonable to mistake a symptom for the disease, but it can never be excusable deliberately to treat a symptom when the causes of the malady are known and can be prevented or removed. Nothing can be more certain than that the existence of a large percentage of the unfit among the populations of civilised states is merely a symptom of diseases in the body politic, the main causes of which are well understood, and it is evidently out of the question to suppose that the legislature of any enlightened people will attempt to deal with that symptom by drastic measures until an attempt shall have been made to get at the *fons et origo mali*. The fact that science has for the first time given mankind the power to mould as they please their physical and even their moral future is slowly sinking into the minds of statesmen and gradual progress is already being made, and when the nations rouse themselves and put their social and sanitary institutions on a level with science, a great part of the evils now existing will be speedily put an end to. Malnutrition, rickets, syphilis, typhoid fever, tuberculosis, alcoholism, poverty, filth, bad housing, ignorance and cruelty of parents, all these are causes of degeneration; many of them are in constant action together. How many children are made unfit by the criminal neglect and cruelty of parents. The fact that the Society for the Prevention of Cruelty to Children prosecutes successfully in many thousands of cases annually is sufficiently suggestive of the extent to which the ranks of the unfit may be swelled by this cause alone. It would be interesting if Dr. Rentoul, whose book is reviewed in your paper this week, would some day discuss this question from the point of view in which I have attempted to place it.

I am, Sir, yours truly,
April 4th, 1907. A Student of Sociology.

LONDON AND ITS MILK SUPPLY.

To the Editor of The Medical Press and Circular.

Sir,—In the leading article on this subject in the current number of the Medical Press there occurs the following sentence:—"It seems probable, in the light of the evidence obtained" (by the investigations of the Royal Commission on Tuberculosis), "that the major part of the terrible sum total of infantile tuberculosis, and possibly a fair proportion of the disease in adults, arises from milk infection."

In view of such a strong statement, I shall be much obliged if the writer will be good enough to refer me to one solitary case in which there was even a probability—not to say evidence—that this disease had been communicated by means of milk.—I am, Sir, yours truly,
Geo. Granville Bantock.

14, Upper Hamilton Terrace, London.
April 6th, 1907.

[Our correspondent speaks of "a strong statement," but appears to have overlooked the careful qualifying introduction. "It seems probable that." It is now proved scientifically that "live" tubercle bacilli can be conveyed in milk. If milk thus infected be swallowed by children, there is a reasonable certainty that by the law of averages cases of tuberculosis must result. As a scientific man, Dr. Bantock must be well aware of the extreme difficulty that attends the positive identification of the agency of the conveyance of specific zymotic infection in many cases.—Ed. M.P.& C.]

OBITUARY.

ANDREW SCOTT MYRTLE, M.D.Edin., J.P.

By the death of Dr. Andrew Scott Myrtle, Harrogate has lost one of its oldest and most respected citizens. For nearly fifty years he formed a leading figure in the life of the town, and his death at the ripe age of 82 has left behind a widespread sense of personal and of civic loss. In 1839 he was apprenticed for five years to his brother, an Edinburgh physician. In 1844 he took the degree of Doctor of Medicine of Edinburgh University, as well as the licentiateship of the Royal College of Surgeons. In 1847, after two years spent in locum tenens work, he returned to Edinburgh, where an epidemic of typhus fever was raging; in the combating of this outbreak he worked assiduously until he contracted the disease. For some years he conducted a large practice at Polmont, in Scotland, but ultimately he settled in Harrogate. Here he was a pioneer in bringing the virtues of the Spa waters before the public. Among various books on this subject the best known is "Chronic Diseases at Harrogate Spa," published in 1876. Another in 1887, "Practical Observations on the Harrogate

Mineral Waters," written in conjunction with his son, Dr. T. A. Myrtle, is now in its fourth edition. Deceased for many years held the position of a county magistrate, and was a prominent member of many official and social undertakings connected with Harrogate. He was also a voluminous writer, and made many contributions to current medical literature, of which perhaps the best known are those relating to the Harrogate waters. He leaves a widow, a daughter, and three sons, one of whom, Dr. George Myrtle, will carry on the practice which has so largely contributed to the name and fame of Harrogate.

THOMAS HENRY WAKLEY, F.R.C.S.ENG.

WE regret to announce the death of Thomas Henry Wakley, the senior proprietor and editor of *The Lancet*. Mr. Thomas Wakley passed the eighty-sixth anniversary of his birthday a few days before he died. He was the eldest of the three sons of Thomas Wakley, the well-known coroner and Member of Parliament, who founded *The Lancet* and brought about an era in medical reform. Mr. Thomas Wakley was educated with the intention that he should enter the Church. He entered as an undergraduate at Oxford, but his connection with the University was brief. His father's radical opinions were not acceptable at Oxford, where Wakley found his political and social creed regarded as very like high treason. To the University of London Thomas Wakley then went, and entered the medical department of University College. In the year 1845 he took the diploma of Membership of the Royal College of Surgeons of England, having previously studied also at Paris because of his father's views that the scheme of medical education enjoyed by the Parisian students was preferable to that of the London medical schools.

In the year 1848 he was elected assistant surgeon to the Royal Free Hospital, a hospital which was started in 1828 in a building at Hatton Garden as a protest against the system of letters by which the subscribers to the medical charities of London were able to dispense patronage upon exclusive principles. This hospital made a great stride forward in 1842 when it was removed to its present site, and the appointment formed an admirable opening for young Wakley, who entered into his duties with great enthusiasm. At the end of the next year he passed the Fellowship exam. of the Royal College of Surgeons, and weathered successfully a blackmailing action for malpraxis brought against him by a hospital patient.

Shortly after this, Wakley, whose position as an operating surgeon was now well established, moved to No. 7, Arlington Street, where he enjoyed for many years a good surgical practice, many of his patients belonging to the highest classes of society. While in Arlington Street Wakley made a special study of diseases of the urethra and invented an ingenious dilator which in his hands gave very good results. He was also the first to introduce the use of glycerine into practical surgery, and an article on the point, published in *The Lancet*, attracted considerable attention and incidentally gained for him some reputation as an aural surgeon, as it was in relation to the treatment of affections of the external auditory meatus that his experiments were made. He also wrote the article upon Diseases of the Joints in one of the later of the many editions of Samuel Cooper's famous "Surgical Dictionary."

In 1862 his father died and the editorial conduct of *The Lancet* passed to his brother, the late Dr. James Wakley, but Thomas Wakley as part proprietor of the paper was actively interested in its conduct. His life as an active surgeon was then combined with that of a journalist, but eventually he retired from consulting practice in 1882. He came daily to *The Lancet* office, and acquired such experience that he was able upon the death of his brother in 1886 to assume the editorship in association with his son. Under his guidance as senior editor *The Lancet* steadily kept its place as one of the leading medical journals of the English-speaking race, and maintained the high tone in medical ethics which its founder aimed at. Of enormous activity, physical and mental, Mr. Wakley was never ill and never absent from his duties. In all weather and on all occasions he arrived in the early morning at his office. During the last few years the editorial management of the journal passed more and more to the hands of the son, but to the end of his life Thomas Wakley showed no abatement of interest in the paper. During all the period in which he was associated with the editorship of *The Lancet* great attention was given to the work of the Hospital Sunday Fund, for the fund was largely founded by Dr. James Wakley, and Thomas Wakley desired that the interest manifested by his brother should not be allowed to flag. His sympathy with the welfare of the medical profession was shown by the institution of *The Lancet* Relief Fund, the income of which was supplied by himself and his son as the proprietors of *The Lancet*. He was also a warm supporter of Epsom College, and in 1902 he gave a donation of £1,000, and he was always ready to support the claims of the College upon medical practitioners. He was concerned in the ambulance department of the Order of St. John of Jerusalem and was Knight of Grace of that Order. His last illness was also his first, and took the form of repeated attacks of dyspnœa. He was ill only six weeks, and the end came quietly last week.

We may add for the information of those of our readers desirous of attending, that the funeral service will be in St. Mary Abbot's, Kensington, to-day (Wednesday) at 12.15.

LAURENCE W. K. PHILLIPS, M.D.DURH., M.R.C.S., L.R.C.P., D.P.H.

WE regret to record the death of Dr. L. W. K. Phillips, of Hove. Dr. Phillips was educated at Guy's Hospital, and took the M.R.C.S. in 1880, the L.R.C.P. five years later, and the D.P.H. in 1884. He graduated M.D.Durham in 1898. He was well known at Hove, where he was surgeon to the police and honorary medical officer to the Hove Hospital and Dispensary. He enjoyed the confidence of a large circle of friends and patients, and his funeral was attended by many of his medical colleagues and representatives of many institutions with which he was connected.

HENRY REEKS, M.R.C.S., L.R.C.P.

WE regret to record the death of Dr. Henry Reeks of New Shoreham. Dr. Reeks studied at St. Bartholomew's Hospital, and took the qualifications of M.R.C.S. and L.R.C.P. in 1891. Settling in Shoreham soon afterwards he attained a quick popularity, and was elected medical officer to the infirmary and workhouse. He was also a member of the District Council. Dr. Reeks was a keen footballer and cricketer, and his early death has caused great regret amongst those who knew him.

COLIN M. CAMPBELL, L.R.C.P. AND S.EDIN.

WE regret to announce the death, under painful circumstances, of Dr. Colin Mansfield Campbell, of Winlaton. The deceased gentleman was apparently in his usual health on April 2nd, but between seven and eight o'clock on April 3rd his housekeeper found him lying ill in his room. The efforts of the medical men summoned were of no avail, the patient only lingering about two hours. Death is believed to have been due to an overdose of morphia. Dr. Campbell was a native of Tasmania, New South Wales. He studied at the University at Melbourne, Australia, and afterwards entered the Royal College of Surgeons, Edinburgh, taking the degrees of L.R.C.P. and L.R.C.S., Edinburgh, and L.F.P.S., Glasgow, and some four years ago he came to Tyneside. He was an enthusiastic footballer, and in taking up his residence at Winlaton he associated himself with the Vulcans Rugby Club. As a cricketer he also made a name for himself locally. He was, indeed, a batsman of great merit. Dr. Campbell's ability as a medical practitioner was recognised, and the news of his untimely end was received with sorrow and regret by the people of the Winlaton district, as it will be by footballers and cricketers throughout Northumberland and Durham, for among these he was very popular. Deceased was 35 years of age, and leaves a widow.

WILLIAM DAVID DAVIES.

THE death of Dr. William David Davies, Llantrisant, removes one of the oldest inhabitants of the district. Deceased was born in Newport nearly 80 years ago. At the age of about 28 he turned his attention to medicine. He qualified and went to Llantrisant, where he practised until the time of his death. He held the offices of medical officer to the Llantrisant and Llantwit Fardre Rural District Council, and also to the Llantrisant District of the Pontypridd Union until five or six years ago, when he resigned both positions in favour of his son. He leaves a widow and two sons and two daughters, his eldest son being Dr. Naunton Davies.

SPECIAL ARTICLE

THE UNIVERSITY QUESTION IN IRELAND

SEVERAL events of importance in the battle which is still waging on the University question have occurred during the past fortnight. On March 26th, the graduates of the University of Dublin met under the auspices of the Dublin University Defence Committee in the Hall of the Middle Temple for the purpose of considering the proposed withdrawal of the Charter of Trinity College, Dublin, and the University of Dublin, and their reconstitution as intended by the Government in the interests of the Roman Catholics in Ireland. The meeting was addressed at considerable length by Lord Rathmore, after which, on the motion of Sir Robert Ball, seconded by Professor Dowden, the following resolution was passed :—

"That this meeting protests against any legislation which would transform the University of Dublin into a University comprising Colleges identified with different religious denominations and animated by conflicting educational ideals, and further records its belief that such change would introduce sectarian division into the administration of the University and subject teaching and research to limitations injurious to liberal education and free enquiry. This protest is made, not on political grounds, but solely in the interests of liberal education."

During the past week, two important memorials have been placed in the hands of the Chief Secretary for Ireland. The first of these is from the "Principals, Professors, Former Professors, and Lecturers in the Scottish Universities," and is as follows :—

"We, Principals, Professors, Former Professors, and Lecturers in the Scottish Universities, actuated solely by academic reasons, and in no spirit of hostility to the Government, desire to bring under your notice our views in regard to the proposal to cancel the Charter of the University of Dublin, with the object of associating within it Trinity College and a number of other colleges of recent, or even future foundation. Hitherto the University of Dublin has been "one and indivisible," with Trinity College. During the three hundred years of its existence it has gathered around it noble traditions, and has rendered incalculable service to the State We would most respectfully submit that we regard with repugnance the proposal to sever the intimate and historic connection between the College and University, and to destroy the identity and independence of an Institution which has contributed so much in the past to the advance of knowledge and the spread of higher education, not only in Ireland, but throughout the Empire at large. We do not think that an ancient seat of learning, justly proud of its past and present usefulness, should be forced against its will into a federation which it believes would be destructive of its prestige and its efficiency. Apart from the considerations referred to above, we do not consider that a federation of widely separated colleges under the University of Dublin is a solution of the Irish University problem which is likely to achieve any measure of success. Experience has shown that even in cases where the federated Colleges are of similar age and origin, in near propinquity to each other, and animated by similar sentiments and aspirations, failure has attended such combinations. How much more is such a scheme likely to fail where, as in Ireland, the different elements it is proposed to unite are already discordant. This memorial is presented in no spirit of antagonism to reasonable claims of the Roman Catholics of Ireland in respect to University education. Our concern is entirely with the preservation of the University of Dublin and Trinity College, an institution which commands our admiration and respect."

Attached to the above memorial are the names of 199 professors, lecturers, and other officers of the Universities of Aberdeen, St. Andrews, Edinburgh, and Glasgow.

The second memorial is from the Principals, Professors, and Heads of Departments in the Constituent Colleges of the University of Wales. It is couched in very similar terms to that presented by the Scottish Universities, but is of greater length. It possesses a special interest of its own in that it represents the views of the staff of federated Colleges in Wales with regard to a proposed scheme for the federation of Colleges in Ireland.

On Saturday last, a letter appeared in the daily papers from the Secretaries of a Committee appointed to ascertain the opinions of the Roman Catholic laity in Ireland with regard to Mr. Bryce's scheme. The Committee sent out the following Declaration for signature :—

"That the Government's scheme of Irish University Reform, designed to secure educational equality for Catholics through the foundation and endowment of a great College in Dublin as a constituent College of a re-modelled Dublin University, merits our strongest support; and we affirm our conviction that to be in consonance with Catholic ideas, and acceptable to the Irish people, such new College must be granted (1) whatever faculties in Arts and Science, equipment, academic privilege, and public endowment any other constituent college of the common University may possess; and (2) the fullest possible measure of autonomy."

The Secretaries now announce that in the short time which has elapsed since the declaration was first offered for signature they have received over a thousand signatures. The *Freeman's Journal* devotes some twelve columns to the list of names, which include those of a large number of prominent Catholic laymen. On the other hand, we note the absence of a large number of equally prominent names.

On the same day that this list appeared, the *Irish Times* stated that "the Government has abandoned definitely the intention of introducing an Irish University Bill in the course of this Session of Parliament."

This very definite announcement was followed later in the day by an equally definite announcement made by Mr. Birrell to a deputation from the Province of Connaught to protest against the exclusion of Queen's College, Galway, from the proposed scheme. In his reply, Mr. Birrell referred to the announcement "that his Majesty's Government had abandoned the projected legislation for this University question," and continued:—"There is not a word of truth in that statement. There is no subject in which the Government takes a greater interest than in this, and our determination to deal with it at the earliest possible moment remains unaltered and unaffected. . . . . Therefore, we shall certainly proceed as quickly as we can to lay our proposal before Parliament."

MEDICAL NEWS IN BRIEF.

Lord Lister's Eighty-First Birthday.

On Thursday last a meeting, convened by the Lister Institute of Preventive Medicine, took place at the Royal College of Surgeons of England. Some short time ago a committee of some 200 members was formed with a view to celebrating in some suitable manner Lord Lister's 81st birthday, which event took place last Friday. This committee was representative of the medical and scientific leaders of Great Britain and of foreign countries, and it was interesting to note that Professor Tilanus, representing the profession in Holland, and Dr. Madsen, of the Danish Academy, were present at the meeting; thus two of the first countries to adopt antiseptic surgery were represented.

The President of the College of Surgeons, Mr. Henry Morris, was voted to the chair, and was supported by some 50 members of the committee, among whom were:—Sir Thomas Smith, Sir William Church, Mr. Jonathan Hutchinson, Sir Felix Semon, Sir Lauder Brunton, Dr. Ferrier, Surg.-Genl. Branfoot, Mr. Reginald Harrison, Professor William Osler of Oxford, Mr. Watson Cheyne, Mr. Rickman Godlee, Dr. Sims Woodhead of Cambridge, Mr. Henry T. Butlin, Colonel Bruce, Professor Keatinge of Cairo, Mr. Mayo Robson, and Dr. C. J. Martin, Director of the Lister Institute.

Dr. Martin made a few remarks as to the object of the meeting, and read the following telegram from the Pasteur Institute in Paris:—"On the occasion of the eightieth anniversary of Lord Lister, we beg you to present to the renovator of surgery the felicitations and the homage of his admirers of the Institut Pasteur." It was felt that, owing to Lord Lister's age, no festival or dinner could be held, but, as a mark of appreciation of his writings, it was decided to form an Editorial Committee to collect and publish them, which, when completed, are expected to occupy two volumes of about 500 pages each. To carry out this work the following were elected as the Editorial Committee:—Sir Hector Cameron, Mr. Watson Cheyne, Mr. Rickman Godlee, Dr. Dawson Williams, and Dr. C. J. Martin.

A small deputation, bearing the best wishes of the meeting, waited on Lord Lister on the following day and extended to him birthday greetings.

The Recent L.G.B. Vaccination in Ireland.

A joint deputation from the University of Dublin, the Royal College of Physicians, and the Royal College of Surgeons, waited on the Chief Secretary yesterday in connection with the Local Government Board's recent Vaccination Order, which they asked to have cancelled. The members of the deputation were as follows:—Dr. James Little, Regius Professor of Physic in the University of Dublin; Dr. Joseph Redmond, President Royal College of Physicians; Mr. Henry R. Swanzy, President Royal College of Surgeons; Mr. John Lentaigne, Vice-President, Royal College of Surgeons; Sir John W. Moore, F.R.C.P.; Dr. Andrew Horne, F.R.C.P.; Sir Arthur Chance, F.R.C.S.; Mr. Thomas Donnelly, F.R.C.S. Mr. Birrell, having heard the representations made by the deputation, undertook to give the matter his most serious attention.

Royal College of Surgeons in Ireland.

The following is the prize list of the Royal College of Surgeons in Ireland for the Winter Session, 1906-1907:—

Descriptive Anatomy.—Junior: J. T. Duncan, 1st prize; T. Dowzer, 2nd prize. Senior: H. G. P. Armitage, 1st prize; W. Swan, 2nd prize.

Practical Anatomy.—First year: T. M. Thomson, 1st prize; F. W. Warren, 2nd prize. Second year: W. Swan, 1st prize; H. G. P. Armitage, 2nd prize.

Practice of Medicine.—C. Green, 1st prize; G. S. Levis, 2nd prize.

Surgery.—G. S. Levis, 1st prize; W. R. Burton, 2nd prize.

Midwifery.—H. W. White, 1st prize; G. S. Levis, 2nd prize.

Physiology.—H. M'Adoo, 1st prize; O. G. Connell, 2nd prize.

Chemistry.—P. F. Crowe, 1st prize; J. T. Duncan, 2nd prize.

Pathology.—I. Scher, 1st prize; C. Greer, 2nd prize.

Physics.—J. T. Duncan, 1st prize; T. Buckley, 2nd prize.

The lectures and practical courses of the Summer Session commenced on Monday, April 8th.

Doctor Robbed.

At New Mills on April 3rd, Edwin Sharkett, 17, who had been arrested in Manchester, was charged with stealing a gold watch, value £40, the property of Dr. Frederick Ashurst, of Hayfield. The youth's mother is housekeeper to the doctor, and the watch was missed from the pocket of a waistcoat hanging in the hall, following a visit by the lad on February 13th. Robert Jones, travelling showman, Ancoats, stated that he agreed to buy the watch for ten shillings, Sharkett having told him he found it in a waistcoat on a hedge at Hayfield. He sold the watch the same day for £3. Questioned by the magistrates, Jones said he was in the habit of giving 1s. 5d. each for watches to give to those who "throwed" at his cocoa-nut stall, and he bought this watch for that purpose. Sharkett, who pleaded guilty, was sent to one month's hard labour, while Jones was advised to be very careful in future.

A child whose relatives reside in Old Cross Street, Tipton, has been certified by medical men to be suffering from spotted fever. Precautions have been taken to prevent the spread of the disease, the patient having been isolated and the house thoroughly disinfected.

Various forms of infectious diseases are prevalent in the King's Norton district, and it is probable that some of the infant schools will have to be closed for a further period at the expiration of the Easter holidays. The rapid increase in the number of cases led to the infant schools being closed a fortnight ago.

On April 2nd, the Metropolitan Asylums Board reported that a case of spotted fever had been admitted to the Eastern Hospital from Shoreditch.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Forcible Dilatation of the Cervix Uteri, and Vaginal Caesarean Section are compared by Müller (*Zentralbl fur Gyn.*, 1907, Nr. 11). He shows that while both Bossi's method and the vaginal Cæsarean section of Dührssen are undoubtedly of value, that one method is more suitable for some cases than the other. Firstly, he says that Bossi's method requires less practise and operative skill than Dührssen's. The lacerations of the cervix, which are the most important complication of instrumental dilatation, may be prevented in the majority of cases. The danger of infection during the employment of Bossi's method is not serious, since it can also be prevented to a certain degree. When the cervix is very firm and rigid, the canal completely closed, and immediate delivery is indicated, for example, in eclampsia, Müller recommends the vaginal Cæsarean section. If the cervix is a little dilated, or soft, elastic, and dilatable, and the internal os is already partially obliterated, Bossi's method is the better, if at least thirty minutes can be spared for its employment. This, according to the writer, will be the suitable treatment for most cases of eclampsia, threatened rupture of the uterus, uterine inertia, placenta prævia, &c., and also for some cases of abortion. The author concludes that since no case is like another both methods have their strict indications to recommend them to the obstetrician. G.

A Case of Vagitus Uterinus is recorded by Stock (*Zentrallbl. fur Gyn.*, 1907, Nr. 11). He says he was called to a woman in labour because the child lay transversely. The membranes had ruptured two hours before, and there was prolapse of the right hand. At the moment when the writer was about to bring down a foot, he heard quite distinctly a short cry in the interior of the uterus. Version was easily performed, but the extraction which followed immediately was difficult. The child was born in a state of asphyxia, but was revived after ten minutes. It died when a year old of pneumonia. In the author's opinion every vagitus uterinus is due to disturbance of the placental circulation. G.

Laparotomy in Cases of Irreplacable Retroverted, and Retroflexed Gravia Uteri.—Küstner (*Monatssch fur Gebund Gyn.*, Bd. xxv. Hfh. 2) records the case of a primipara, æt. 23, whom he had treated a year previously for an incomplete abortion. She had then a fixed retroversio-flexio. She has now come for treatment again on account of ischuria paradoxa. Retroflexion of the gravid uterus was diagnosed. All attempts at replacement even under anæsthesia were unsuccessful. It was therefore decided to do a laparotomy. There was a large mass of thin adhesions binding the retroflected uterus, which was between four and five months pregnant, the ovaries, tubes, peritoneum of the rectum and of the posterior wall of the pelvis, together. After separation of these the uterus was brought into anteflexion and a Smith pessary inserted. The convalescence was uneventful. The pessary was removed when the patient was leaving the hospital. The uterus retained its position of anteflexion during the remainder of the pregnancy. The author maintains that in cases of incarceration of the gravid uterus, the treatment shall not be altogether confined to the protection of the urinary bladder, where possible by the induction of abortion. One should endeavour above all things to bring the uterus into its proper position, even through a laparotomy. There is nothing, he says, by which recovery of a severely injured bladder, as far as such is possible, is better or with more certainty promoted than by placing the uterus in its proper position. G.

Ruptured Extra-Uterine Pregnancy with free Hæmorrhage into the Peritoneal Cavity.—Haim and Lederer (*Monatssch fur Geb. und Gyn.*, Bd. xxv., Hft. 2) record their experiences from twenty-seven cases of ruptured extra-uterine pregnancy, the average age of the women being 30½ years. Four were nulliparæ, nine primiparæ, and the remainder multiparæ. In about half the cases there was previous disease of the genital system. Although gonorrhœa is not always the predisposing cause of extra uterine pregnancy, it is so in very many cases. In two cases the last menstruation had occurred four months previously, in five three months, in seven two months, in seven one to two months, in three one month, and in three two weeks. On the average, the extra-uterine pregnancy came to an end from the second to the third month. The cause of rupture is certainly an erosion of the tubal wall by the growing placental villi. The contractions of the Fallopian tubes are, however, a most important factor in causing the rupture. The authors then describe the different symptoms—anæmia, pulse, temperature, vomiting, tenderness, and dullness of the abdomen, the result of pelvic examination and the discharge of blood per vaginum which they found in sixteen cases. The right tube was the seat of the pregnancy seventeen times, the left nine times. The authors condemn exploratory puncture or curettage in order to make the diagnosis certain. Their treatment is as soon as symptoms of internal hæmorrhage appear find out the source of the bleeding and control it. To do this, they most usually perform laparotomy. As complete a removal of the extravasated blood must be performed as is possible without danger to the patient from prolongation of the operation. They put in a Mikulicz's bag at the conclusion of the operation. Of the twenty-seven patients who were operated on, four died. The convalescence of the others was practically uneventful, and averaged twenty-six days. The after-results were, as a rule, good. In some cases the women had normal intra-uterine pregnancies afterwards. G.

A Contribution to the Question of Eclampsia is made by Gutbrod (*Monatssch. fur Geb. und Gyn.*, Bd. 24, Hft. 5) as follows:—His patient, æt. 40, pregnant for the fourth time, suffered from very severe eclampsia during her first two labours. He saw her at the beginning of her fourth pregnancy, as the last pregnancy had ended in an abortion, but particularly following the advice of Lomer, he gave her iodide of potassium as a prophylactic against eclampsia. During the fifth month of her pregnancy, she threatened to abort, but this was prevented by the usual treatment. The author did not see the patient again till a year and a quarter later, when he was called to her on account of severe eclampsia complicating another labour. She had several convulsions. The urine contained 2 per cent. albumen. Under treatment her labour was soon at an end, and the convulsions ceased. The author then learned that the previous labour before which he had given potassium iodide, had passed off quite easily and without any disturbance. He believes that he sees in this a proof of the efficiency of iodide of potassium as a prophylactic against eclampsia. G.

Mechanical Dilatation of the Cervix Uteri in Obstetrics.—L. H. Leicester (*Jour. Obstet.* and *Gynæcol.*, March, 1907). In this paper the author records his experiences of sixteen cases treated in the Eden Hospital, Calcutta. In seven dilatation was resorted to for eclampsia, in six for rigid cervix, in one each for induction of labour, hydatid mole, and placenta prævia. The instrument used in the first six cases was Bossi's model; in the remainder, Preiss's modification of the same. This latter is far simpler, lighter and easier to clean than Bossi's dilator. Of all the various forms of mechanical dilators he considers that de Seigneux's is undoubtedly the best pattern and least likely to tear the cervix. With the exception of some lacerations of the cervix in four cases, only one of which required suturing, there was no untoward effect which could be attributed to the method of dilatation, and the author thinks these dilators have a distinct place in obstetrical practice, but that the number of cases in which their use is indicated is limited. As to whether it is safe treatment in placenta prævia in any but cases comparatively early in pregnancy, he is exceedingly doubtful, as owing to the friable nature of the lower uterine segment in these cases, there must be a very grave risk of laceration and very serious hæmorrhage. The instrument when in use requires to be very carefully inserted and dilatation to be very slowly proceeded with, a careful watch being kept by the aid of one finger on the cervix. When the cervix is felt to be in the least unduly stretched, dilatation should cease for a short interval, and then resumed more slowly and cautiously than before. This caution is especially necessary if this method is adopted in any case before the cervix is taken up, because, under these circumstances, there is a greater risk of extensive laceration, and for this reason it should only exceptionally be employed in such cases. F.

Prognosis of Pregnancy in Patients with One Kidney.—Ferguson, (*Jour. Obst. and Gyn.*, March, 1907). Nephrectomy is now no uncommon procedure for various diseased conditions of the kidney, and it follows that obstetricians will occasionally be confronted with the question—Should a woman with one kidney be advised to marry and run the risk of becoming a mother? One would, on the whole, prefer that patients who only possess one kidney, even though apparently a healthy one, should, if they marry at all, delay marriage till after the menopause. But one could not, however, give such uncompromising advice, and each case would require to be judged on its own merits. The writer would be strongly inclined to urge in the interests of prudence, that marriage be delayed till at least three years from the operation of nephrectomy, so as to give the remaining healthy kidney ample time for compensatory changes to occur under the influences of the varying vicissitudes of ordinary life—in fact to establish and consolidate a condition of matters which will enable the one kidney safely and easily to do the work usually undertaken by two. If the remaining kidney be diseased, and there is a possibility of child-bearing, marriage should be out of the question. Whenever a pregnancy occurs in a patient with one kidney she should be most carefully watched, her urine being examined and tested regularly during the whole duration of pregnancy, with a view of immediately bringing the pregnancy to an end should she show any evidences of renal inadequacy which fail to respond to treatment. Special care should be taken that the excretion of urea is not diminished, and in this connection it is well to remember the excretion of urea in healthy pregnant women seems to be considerably less than is usually supposed, varying from 20 to 24 grammes in the 24 hours. There is no doubt that urea is always diminished in the toxæmia of pregnancy, and this diminution is of more value, and an earlier indication than either the presence of albumen or casts, both of which latter may be absent even in bad cases. F.

A Case of Premature Birth of Twins.—Martyn, Cambuslang, N.B. (*Brit. Med. Jour.*, March 16th, 1907) records a case of considerable interest. The patient, a primipara, æt. 23 years, expected to be confined about August 10th, 1906, her last menstruation having terminated November 8th, 1905. She first felt fœtal movements early in April. Premature labour, however, took place, and she was confined of twins on June 1st. Both children were females. The exciting cause was hæmorrhage, probably of accidental nature. The first born infant survived but a few hours, the second, much smaller, followed the first rapidly, it cried well at birth. A week after delivery this child weighed only 1 lb. 14 oz., from then till June 30th, it gained nothing in weight, but after that increased progressively till on October 6th it weighed 6 lb. 10 oz. From the onset the child took the breast and throve. The case is remarkable in that without any incubation treatment so premature and small a child should have thriven so well.

A Case of Villous Tumour of the Uterus in a Woman Aged 84 Years—Hysterectomy—Recovery.—Bland-Sutton (*Journal of Obstetrics and Gynæcology of the British Empire*, March, 1907) reports a case of this very rare condition occurring in an old woman. The patient suffered from a blood stained vaginal discharge, the character of which made those in charge of her suspect cancer of the body of the uterus. She was, however, in excellent health. In order to make certain the diagnosis the uterus was curetted, and after microscopic examination was pronounced cancerous. It was thought, however, that the advanced age of the patient contra-indicated operation. Mr. Bland-Sutton saw the case in consultation with a view to operation, and after due consideration, taking into account the patient's excellent health and the small size of the uterus, advised operation. Vaginal hysterectomy was performed by him, and the convalescence was rapid and uneventful. The uterus was hardened in formalin solution, and bisected in its sagittal axis. The uterus was found to be filled with a soft yellowish mass, growing from the endometrium on the posterior wall. Sections cut in such a manner as to involve the walls of the uterus and growth, showed the free portion of the tumour to consist of compound villous processes covered with columnar epithelium, with the exception that the investing epithelium was identical with that covering the normal epithelium, the tumour exactly resembled a villous tumour of the bladder. A further careful examination of the base of the tumour revealed that it consisted of the peculiar cells which compose the reticulum of the normal endomerium. No infiltration of the wall of the uterus was discovered. He considers it from the histological standpoint non-malignant. He has met with one other case similar to the above in a multipara, æt. 54. The present case was also in a multipara.

Chorea During Pregnancy.—Wm. Fletcher Shaw (*Jour. Obstet. Gynæcol.*, April, 1907). In this communication are recorded 11 cases of chorea of pregnancy. The first two cases were treated on traditional lines; the results were bad. It was then decided to try a totally different antitoxæmic treatment, by which the patients were put on a milk diet and elimination was increased. Nine cases were treated in this way with the best results. The idea underlying the experiment was that the toxæmia of pregnancy lowers the resistance of the nervous system, and puts it on a state of heightened irritability, so that it responds to stimuli, chemical, emotional, etc., which would not otherwise produce any result perceptible by ordinary clinical methods of observation. The treatment in these cases consisted of keeping the patient quiet in bed, restricting diet to milk until signs of improvement, when milk foods were allowed; fish and chicken being added when the choreiform movements had practically ceased, and ordinary diet when quite gone for some days. Elimination was increased by acting on the bowels by means of jalap, and on the skin and kidneys by a simple saline mixture. Thyroid Extract was given (30 grains per diem) in five cases with very good clinical results, but as four other cases were treated exactly the same, except that no extract was administered, recovered quite as rapidly, it would appear that the extract does not play a very important part in the treatment. The pregnancy should not be arrested as a rule, as it is generally unnecessary and harmful to the patient as well as to the child. F.

NOTICES TO CORRESPONDENTS, &c.

☛ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to his rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

LUTON M.D.—The Finsen Light treatment of Lupus is according to many authorities both tedious and unsatisfactory. Some good results have lately been reported from the injection of iodoform emulsion. There is a great deal to be said for the surgical measures of excision and scraping. The latter, in skilful hands, leaves a little scar, and recurrent nodules (if any) can be promptly dealt with.

K. R. (Bromley).—Certainly, we shall be very pleased to have the article. A case of fracture of the coracoid process of the scapular is worth publishing, especially as you say it resulted in this case from indirect violence.

ROUND IN A MILK-CART.

A **WELL-KNOWN** Birmingham doctor had an amusing experience the other day. He usually covers his round by means of a cab, the driver before starting each morning receiving instructions at which houses he has to call, and the order in which the visits shall be paid. The other day the doctor came out of a patient's house in the neighbourhood of Moseley, but, instead of entering the cab as usual, walked across the road to examine a placard which had attracted his attention. Cabby, thinking his fare secure inside, drove off, but when he arrived at the next stopping place was surprised to find that there was no sign of the doctor. He hurried back, but being unable to find his employer, drove off in the direction of the round it was arranged he should take. The doctor in the meantime, finding himself deserted availed himself of a passing milk float, and in this he continued his calls until cabby once more discovered him.—*Birmingham Daily Mail.*

RUSTICUS X. asks if it is advisable to send a patient suffering from chronic urticaria to Schlangenbad in Germany. Also if there is good hotel accommodation there and what is the nature of the "cure." Perhaps some of our readers will supply the desired information.

MEDICAL STUDENT.—If the ill-treatment continue we would advise you to go to the Dean of your school and lay all the facts before him. This does not necessarily involve official inquiry or action on his part, but in any case he would probably advise you as to the best course to pursue in a difficult situation.

☛ **DR. — BARRETT.**—We have communicated with the author of the Lecture, and will let you know the result.

M. CH. The work is in its sixth edition, and is, we understand, as popular as ever.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 10th.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5.30 p m.: Adjourned Discussion on the Present Position of the Treatment of Tuberculosis by Marine Climates (opened by Dr. A. Street, Westgate-on-Sea). Paper :—Dr. N. H. Forbes : Church Stretton as a Health Resort.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m. : Meeting.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.). —8.30 p m. : Discussion on Epilepsy. First Evening : Dr. F. Beach (Historical), Dr. G. Holmes (Pathology), Dr. P. Stewart (Masked Epilepsy), Dr. Mercier (Epileptic Insanity).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. : Mr. J. Clarke: Clinique. (Surgical). 5.15 p.m. :—Lecture :—Dr. N. Tirard : Some Recent Cases of Hæmaturia.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—Cliniques :—2.30 p.m. : Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, APRIL 11th.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. : Specimens will be shown by Mr. B. Jessett and Dr. Swanton. Paper :—Prof. Jacobs (Brussels) : The Radical Cure of Prolapsus Uteri.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson : Clinique. (Surgical.) 5.15 p m.: Lecture :—Mr. M. Morris : The Treatment of Some Common Skin Affections.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m. : Gynæcological Operations (Dr. Giles). Cliniques : Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m. : Medical In-patient (Dr. Chappel).

FRIDAY, APRIL 12th.

WIMBLEDON AND DISTRICT MEDICAL SOCIETY (Worple Hall, Worple Road, Wimbledon).—9 p.m. : Paper :—Mr. H. Tilley : The Diagnosis and Treatment of Certain Nasal Diseases frequently met with in General Practice.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. : Papers :—Mr. G. H. Makins and Mr. P. Sargent : A Note on the Value of Anti-colon Bacillus Serum. Mr. L. McGavin : A Modification of the Method of applying Prepared Filigree of Silver Wire to the Cure of Large Inguinal Herniæ in Males. Mr. W. G. Spencer : Acute Solitary Suppuration in the Psoas and Iliacus Muscles.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. : Mr. S. Stephenson : Clinique. (Eye).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—9.30 a.m. : Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m. : Surgical Operations (Mr. Edmunds). Cliniques : —Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m. Medical In-patient (Dr. Leslie).

Vacancies.

Torbay Hospital, Torquay.—House Surgeon. Salary £100 per annum, with residence, board, and washing. Applications to H. J. Packe, Secretary.

Bradford Royal Infirmary.—House Surgeon. Salary £100 per annum, with board and residence. Applications to John Barron, Secretary.

The Royal National Orthopædic Hospital, 234 Great Portland Street. Resident House Surgeon. Salary £200 per annum. Applications to the Secretary.

North Staffordshire Infirmary and Eye Hospital, Hartshill, Stoke-on-Trent. House Physician. Salary £100 per annum, with furnished apartments, board, and washing. Applications to the Secretary and House Governor.

Lancashire County Asylum, Winwick, Warrington.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

West Riding Asylum, Wakefield.—Pathologist and Assistant Medical Officer. Salary £140 per annum, with board, furnished apartments, washing, and attendance. Applications to the Medical Director.

Royal Victoria Infirmary, Newcastle-upon-Tyne.—Director for the Bacteriological Laboratory. Salary £100 per annum. Applications to the Secretary of the Honorary Staff.

Sheffield Union Hospital.—Resident Medical Officer. Salary £100 per annum, with apartments, rations, etc. Applications to Albert Edwd. Booker, Clerk to the Guardians, Union Offices Westbar, Sheffield.

Sheffield Union Hospital —Resident Assistant Medical Officer. Salary £80 per annum, with apartments, rations, etc. Applications to Albert Edwd. Booker, Clerk to the Guardians, Union Offices, Westbar, Sheffield.

Cornwall County Asylum, Bodmin.—Third Assistant Medical Officer. —Salary £140 a year, with furnished rooms, rations, laundry, and attendance. Applications to Medical Superintendent.

Fife District Asylum, Cupar-Fife.—Junior Assistant Medical Officer. Salary £120 per annum, with rooms, board, and attendance. Applications to the Medical Superintendent.

Appointments.

CAPES, ROBERT, M.R.C.S.Eng., L.R.C.P.Lond., Medical Officer to the Camberwell Provident Dispensary.

DRAKE, JOHN ALEXANDER, M.B.Lond., M.R.C.S.Eng., L.R.C.P.Lond., Consulting Physician to the Pembroke and District Infirmary.

ELDER, EDWARD A., B.Sc., M.B., Ch.B.Edin., Senior House Surgeon at the Blackburn and East Lancashire Infirmary.

HAMILL, J. M., M.B., B.Sc.Lond., an Assistant Inspector of Foods in the Medical Department of the Local Government Board.

HOSFORD, ALFRED STROUD, M.R.C.S., L.R.C.P.Lond., Senior Resident Medical Officer to the Royal Hospital for Diseases of the Chest, City Road, E.C.

MELLISH, J. S., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Tetbury District of the county of Gloucester.

NETTLE, WILLIAM, M.R.C.S., L.S.A., Medical Officer of Health for Liskeard (Cornwall).

PEREIRA, J. A. WENCESLAUS, M.D.Brux., M.R.C.S.Eng., L.R.C.P. Lond., Honorary Surgeon to the Exeter Dispensary.

POSTLETHWAITE, JOSEPH M., M.R.C.S., L.R.C.P.Lond., Junior House Surgeon at the Blackburn and East Lancashire Infirmary.

PULLIN, BINGLEY GIBBES, M.R.C.S., L.S.A., Medical Officer for Sidmouth (Devon).

RICHARDS, S. H., M.B., C.M.Edin., Clinical Assistant to the Chelsea Hospital for Women.

SAYRES, A. W. FORTESCUE, M.D.Brux., L.R.C.P.Lond., M.R.C.S., D.P.H.Lond., Surgeon to the Exeter Dispensary.

SCOTT, SYDNEY R., M.B., M.S.Lond., F.R.C.S.Eng., Aural Surgeon to the Evelina Hospital for Sick Children.

SMITH, S. MAYNARD, M.B., B.S.Lond., F.R.C.S.Eng., Assistant Surgeon to the Victoria Hospital for Children.

Birth.

GREENE.—On April 4th, at Richmond House, Turvey, Beds., the wife of George Watters Greene, M.A., M.D., of a daughter.

Marriages.

MAY—MITCHELL.—On April 6th, at St. Peter's and St. Paul's Church, Chingford, Essex, George Ernest May, M.R.C.S., L.R.C.P., of Ware, Hertfordshire, second son of the late Harry May, M.D., of Parkstone, Dorset, to Racbael Marguerite, second daughter of the late William Augustus Mitchell, of Danes Hill, Bengeo, Hertford.

Deaths.

MITCHELL.—On April 2nd, at Topcliffe, Thirsk, Yorkshire, Thomas Carter Mitchell, M.R.C.S., F.S.A., in his 70th year.

WAKLEY.—On April 5th, at 5 Queens Gate, London, Thomas Henry Wakley, F.R.C.S.Eng., eldest son of the late Thomas Wakley, M.P., aged 86 years.

BRAYE.—On April 3rd, at 20 Ingersoll Road, London, John Gregory ("Jack"), youngest son of the late Hardwick Hubert Braye, M.R.C.S., L.S.A., of South Hackney.

GILLAM.—On April 3rd, at Hillside, Hollington, St. Leonards-on-Sea, Jane, widow of George Jules Gillam, M.R.C.S., L.S.A. Aged 71.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, APRIL 17, 1907. No. 16

NOTES AND COMMENTS.

Coventry Dispute. THE Coventry fight is continuing, and the eyes of the medical world will be focussed on it for many weeks to come. The conditions at Coventry are typical of those in many other towns, except in that Coventry has its machinery far better organised, and consequently can fight more systematically and strenuously. If the medical men are beaten, then a severe blow will be dealt to concerted action in the profession, for Coventry is a fight for principle and principle only. But we do not believe they will be beaten. The staff of the dispensary, that is those members of it who resigned, are far too well known by their patients for desertion to take place, and the prospect of "blacklegs" is not likely to keep or attract members to the dispensary. As one of the dispensary members wrote to the *Birmingham Gazette*, last week, "I would not like to be a patient under any of these imports, as only those of questionable ability who have been unable to do any good on their own account would apply." As far as we know no "imports" have been brought in, and for the sake of professional honour we trust none will be, but if the people of Coventry are as intelligent as the correspondent of the *Birmingham Gazette*, any such outsider is bound to fail in keeping alive a system against which the profession has decided. The dispensary has had an ample period of grace, and has decided in a way which strikes us as distinctly offensive to pursue its own course. The medical men have countered in the only way possible.

Thomas Beecham. THE death of Mr. Thomas Beecham brings to notice the significant fact that it is possible by what is called "business ability" to amass a fortune out of some every-day drug, while the discoverers of medical principles of enormous life-saving and pain-reducing potentiality have to be content with viewing the advantages that their ability and industry and benevolence have conferred on human beings. If we contrast the career of Beecham, the vendor of pills in the market place who rose to vast wealth through harping on the weakness of his fellow men, with that of Lord Lister, whose magnificent work has made the whole world his debtor, and who never made a penny out of his discovery, the reflection is borne in on one that a State which confers its favours so unequally must be sadly out of joint. Thanks to Beecham's legal troubles the extent of his income has long been public property, and it certainly was of sufficient dimensions to tempt a poor man to leave his every-day routine and indulge in a course of blatant advertisement. The world's work in medicine is done unostentatiously and unselfishly by medical men, and the world's wealth is scooped up by those who do not hesitate to trade on the generosity with which the profession communicates its knowledge to all men for the benefit of mankind. Medical men are said to be "unbusiness-like"; their fellow creatures may thank heaven that they are.

"Ranji" as Sanitarian. THE battle of Waterloo was said by Wellington to have been won on the playing fields at Eton. Is the vast problem of the sanitation of India to be solved on the cricket grounds of Lord's and the Oval? It seems like it. We little dreamt when "Ranji" was delighting the Surrey crowd with his hook strokes and late cuts that when he came into his kingdom his first care would be for its hygienic organisation. No sooner, however, has he assumed his Jamship than he has set about in a determined fashion to remedy the filthy conditions under which his subjects have been accustomed to live and to suffer. He has got together a sanitary corps whose members go about the city of Diwan cleaning and disinfecting plague-stricken houses, and removing the displaced inhabitants to healthy huts till their own hovels are fit for occupation again. Additional medical men have been sent for to help forward the work of plague-prevention, and the Jam is seeking by persuasion and education to get people to conform to irksome restrictions which are designed to minister to their well-being. The plague in India has become such a commonplace that people in England are no longer concerned about it, and the attitude of the central Government is one of resigned despair. If Prince Ranjitsinghi is able to show them the way to rid a state of plague, even his cricket triumphs will pale before the *kudos* such success should bring him.

Seamen's Protest. AN awkward position has been created at Swansea by the action of the Shipping Federation in insisting on medical examination of all seamen before they are allowed to sign on a ship sailing from that port. The employers no doubt feel that with their new and heavier responsibilities under last year's acts they must be more careful to guard themselves against engaging men suffering from infirmity or disease; which, indeed, is very natural. On the other hand the seamen quite as naturally feel that the benefits of those acts will be considerably diminished if they are liable on a doctor's fiat to be prevented from following their employment, especially when the doctor is the servant of their employers. The solution of the difficulty which has these two distinct sides is not easy to see. The free-born Briton naturally likes to have his liberty to the full extent, and also wishes to enjoy the insurance privileges of his dragooned German confrere, and it is by no means easy to see how apart from State insurance, or compulsory payments to friendly societies, the opposing interests are to be reconciled. Other ports besides Swansea are likely to insist on medical examination in the future, and the question may easily become acute, and call for much tactful and statesmanlike handling.

School for Invalids.

The battle is not always to the strong nor the cure always to the quack. There are, *mirabile dictu,* even failures among the irregular practitioners, and of such would seem to be Mrs. Wingett, of Evesham, who lately started a school for invalids, but who has had to close her doors. Why success did not attend her ministrations it is impossible to say, for judging by the notice of the school, which we reproduce below, she was quite as little educated and quite as self-confident, and quite as offensive as most others of her kidney. The notice we refer to adorns the board in front of the school, and runs as follows:

Notice!
A School for Invalids
of all descriptions,
Where Doctors, Physicians, and Hospitals
Have Failed Lessons will be Wrote
or taught by **Mrs. Wingett,**
that will restore health and limbs if attended to
and **Paid** for.

What element of effrontery was wanting, we wonder!

Havens once more.

The ineptitude of machinery of the law in dealing with that class of people who are eccentric and turbulent without being certifiable is illustrated again by a fresh outbreak on the part of Dr. Havens, of Clacton. To the case of this gentleman we have called attention twice already, and we know that the local bench have in vain invoked the aid of the Home Office to enable it to deal suitably with this unfortunate man. His latest escapade took place last week at Clacton, where he was charged with pointing a gun at his next-door neighbour, assaulting him with a spade, and struggling with him on the edge of the cliff. The offences having been proved, the defendant was sent to gaol with a month's hard labour without the option of a fine, and was required to find sureties to keep the peace for twelve months. It is hardly comprehensible that some definite arrangement cannot be made whereby this gentleman might be preserved from being a source of danger to himself and the neighbourhood.

LEADING ARTICLE.

ARMY MEDICAL REFORM.

Now that the question of Army reform is a burning problem in politics, the time is opportune for the setting of the house of the Army Medical Department in order. A nation at peace is apt to forget the stern lessons of war, but of our own countrymen it may be said that successive Governments have done their best to meet the gross defects of system and of administration revealed by the late campaign in South Africa. The total casualties of that war, compiled from official sources, have been given as follows:—

Deaths.	Non-Com. Officers and Men.
Killed in action	5,256
Died of wounds	1,835
Prisoners who died in captivity (cause of death not stated) ...	97
Died of disease	12,911
Accidental deaths	770
Total	20,870

Invalids sent Home.	Non-Com. Officers and Men.
Wounded	8,221
Sick	63,644
Not specified which	449
Total	72,314

A glance at these figures illustrate in a most graphic manner the relative mortality of actual battle and of camp diseases. On approaching the problem we are led to reflect in the first place that it is all, or nearly all, preventable disease with which the Army Medical Corps are called upon to deal. The difference between the disease-incidence of a campaign conducted under ideal sanitary conditions and those of, say, the Peninsular War, would simply be parallel to the death-rate of to-day in the cities of London or of Dublin under modern hygienic conditions as against their terrible mortality in the middle ages. What has been done by civilians among a civil population can be done no less surely by army surgeons working in camps. It is true that special difficulties, more particularly perhaps in the matter of transport, must necessarily be met with in active warfare, but difficulties in such a case should exist only to be overcome. That they are not insuperable has been shown by the experience of the Japanese Army in the late Russo-Japanese war, when the ratio of their diseased to wounded was 1.15 to 1, and of the numbers who died from disease compared with the killed in action, 0.3 to 7.1. This magnificent result was mainly due to the immunity of their troops from epidemic diseases. The Japanese, prodigal and reckless of human life as they were in the face of the enemy, took such precautions in the care of the sick and wounded and in the sanitation of their surroundings that hardly a life was lost from purely preventable medical causes. These apt pupils of the East have not only acquired the art of Western warfare, but have learnt the lesson of its medical science, and have found out in their own supremely clever way how to get at the core of the situation in practice. The task of reorganisation of our Army Medical Department is clearly one of no small difficulty. We may anticipate that the Secretary for War, Mr. Haldane, who has taken it in hand, will not be above availing himself of any hints that may be available from our allies in the East. It is to be hoped that the Government may not be led into the error of reducing the Medical Department. In our opinion the inadequate strength of the Army Medical Department in South Africa was answerable in no small degree for much of the "breakdown." Happily, the period during which active recrimination was a possible factor in the case has lapsed, and the task before us now as a business-like nation is to reorganise our Army Medical Department on such a basis that the nation may use the thews and sinews of her Army to the best advantage in all future campaigns.

CURRENT TOPICS.

Lord Lister and the Royal College of Surgeons (England).

The following letter has been sent to Lord Lister on behalf of the Council of the Royal College of Surgeons of England:—"Dear Lord Lister,—The Council of the Royal College of Surgeons, at their meeting on the 10th inst., deputed us to write and convey to you the sincere good wishes of every member of the Council on the completion of the 80th year of your age. Crowned with honour and regarded with grateful esteem and admiration as you have been for years past, we have heard with great gratification of the further evidences of universal homage which have reached you from all parts of the world on this occasion. But by none are these feelings of esteem and homage more profoundly and genuinely entertained for you than by the members of the Council of this College. We recall with pride and satisfaction that for eight years you occupied a seat on this Council; that your services to the science of surgery have been commemorated by us in making you one of the very small number of recipients of the Honorary Medal of the College; and that your portrait was presented by Fellows and Members of the College in 1897 as an expression of respect and admiration for you as a man, and as a tribute to you as a great benefactor of the human race. This portrait we regard as one of the most valued possessions of the College, and we delight in the fact that it will convey to our successors, for all time, the likeness of him who is, and will always be regarded as, the greatest master of Modern Surgery. We are sure we shall be expressing the thoughts, not only of the present and of ex-members of the Council, but also of every Fellow and Member of this College when we say that you, more than any other who has ever lived, have succeeded in applying scientific and practical surgery to the benefit of mankind, and to the sparing of human life and suffering. The blessings which have followed from your life's work have been innumerable, and the knowledge that they increase and become, as time passes, more and more manifest, must, we feel assured, be a source of extreme happiness and consolation to you in your distinguished and honourable retirement. We are, dear Lord Lister, yours very truly, Henry Morris, president, Edmund Owen and Rickman, J. Godlee, vice-presidents."

The Cost of Sweating.

Medical men probably see more of the evils of sweating than any other class of society. Not only do they visit the poor in their overcrowded tenements, but they see them also in crowds at their surgeries, as well as in the outpatient rooms and wards of hospitals and other medical charities. The story that is laid before them is written in the bold hieroglyphics of want and starvation that sooner or later become stamped on the face and frame of the sweated workpeople. Only last week in London, the richest city in the whole world, two terrible cases of sweating came to light. In one case a coroner elicited from a witness that her family was evicted by the landlord because they could not pay the rent. They made trousers at twopence a pair, and earned in all some five or six shillings a week. In a second case an alien charged with theft was found to have appropriated purses which he was making at twopence a dozen, with the help of his family, he himself supplying the requisite glue and paste out of his own pocket. Now that the Government has safeguarded so amply the future bodily welfare of domestic servants, it would be well if they could find a little time to deal with the case of the sweated work-people. In the long run society has to pay for the workpeople whose health is sacrificed to the greed of the sweating capitalist. Sweating is a bad bargain for the poor and for society, not to mention the harassed medical practitioner, all of whom help to pay the piper.

Public Health in Egypt.

The great administrative powers of Lord Cromer in Egypt have nowhere been more beneficial and conspicuous than in the department of public health. Out of the chaos of numberless centuries the foundation of a system of national sanitation has been evolved. The obstacles in the way of the reformers have been so many and so serious that they might well have appeared insuperable to an ordinary man. The natives, both by tradition and temperament, are averse to the ways of modern hygiene. In the case of ophthalmia, for instance, it is notorious that the brushing away of flies from the affected lids is regarded as a violation of religious teaching. In spite of that attitude, however, a vigorous campaign is being conducted against that scourge, which gives rise to a vast amount of suffering and disability throughout the country. A new ophthalmic hospital will be opened this year at Tinkah to replace the tents in which patients are at present being treated. Some of the other difficulties that have faced the authorities may be gathered from the facts that the Government Anti-rabic Institute has been working since 1906, and that a new asylum has recently been opened at Kahnka. Then, again, excellent results are reported from Major Ronald Ross's campaign against mosquitoes in Port Said, which is said to have greatly diminished the incidence of malarial fever. During last year no fewer than 31,000 in-patients and 128,000 out-patients were treated in Government hospitals. Altogether, the recently issued blue book that contains Lord Cromer's report on the public health administration of Egypt for the year 1906 offers a reassuring proof of the beneficence of the British dynasty in the career of the ancient kingdom of Egypt.

The Reform of Medical Education.

A MEDICAL Congress is being held in Paris, and among the subjects for discussion is the important one of the reform of medical teaching. Educational methods, whether lay or professional, are a moot subject, upon which the last word will probably not be said for generations to come. What is true of education generally applies with equal force to the medical curriculum, which covers a whole galaxy of arts and sciences. The tendency has been more and more to turn out the qualified man full of reflected knowledge upon all branches of his profession. Too often his brilliancies fade into nothingness in the rough and tumble of practice, as he finds himself unable to draw a tooth, to pass a catheter, to perform a tracheotomy, or to diagnose a fracture of the skull. Indeed, most medical men would probably agree with any proposal to extend the practical side of medical teaching. A good solid course of instruction in baby feeding and baby ailments, for instance, would be of inestimable value to the future general practitioner, who is now compelled to spend much of his time in chemical, biological, and other laboratories, doing work which he will in later life have neither the means nor the opportunity of following up. One of the difficulties in the way of effecting any change in medical teaching is the fact that reform would have to begin with the teachers. In the far future it seems likely that medical teachers will receive salaries so ample as to relieve them from the distractions of private practice, their professional skill and experience being gathered solely in the hospitals.

Federal Universities.

THE opinions of the professors and teaching staff of the last remaining federal university in the British Isles on the subject of the federation, proposed by the late Chief Secretary, for their adoption in Ireland, possess a value above that possessed by the opinion of any other similar body of men. In the memorial to which we referred in our last issue, and which was sent by the University of Wales to the Chief Secretary, the following very striking passage occurs :—" We are convinced, by our own experience in the administration of the only remaining federal University in Great Britain, that a federation in which Trinity College should be united with the new College in Dublin, and the existing Colleges at Belfast and Cork, would possess none of the elements which are essential for the successful working of the federal system. In considering the conditions which would exist in the proposed federation, our attention is naturally drawn to their total dissimilarity from those of our own Colleges. They are of the same educational type ; they differ little in age or size ; they possess common ideals ; their partnership was entered upon voluntarily. In the new federation there would be joined together institutions widely diverging in type, with dissimilar conceptions of the aim of a University, and great difference in magnitude and traditions ; and, above all, the union is one which has been declared to be distasteful by all its members, and is strenuously resisted by the one which must, for some time at least, remain the most important. To force a union under such circumstances is, we believe, to court certain failure !" The memorialists also add that " the suggestion that the higher teaching in certain subjects should be given by University, as distinguished from College, Professors, is impracticable in a University in which there is no local union between the Colleges. If attempted, it could only result in the degradation of the Colleges which are situated at a distance from Dublin to the position of institutions of something less than University rank."

The Opsonic Treatment of Pneumonia.

IT is a hideous and dangerous practise which is being adopted by one after another of the leading journals—that of publishing popular medical articles on new subjects. If their object were to instruct the public in ascertained and responsible medical facts and theories, the influence exerted might be very good ; but that is far from their purpose. The idea is to stimulate the palate, jaded with horror and sensations of every sort and kind, to react if possible to medical flummery. There is nothing easier in the world for an unscrupulous writer than to overhaul the medical journals and serve up half-a-dozen fresh " discoveries " every week, each as tentative, ephemeral and disappointing as the rest. The most pretentious form of this pernicious craze is that in which medical terms and facts are used in profusion without regard to the reader's intelligence, merely with the object of making him believe he is sitting at the very fount of science. This last week some flamboyant stuff about the opsonic treatment of pneumonia has been going the rounds, and we venture to think those who have read it are about as wise as to pneumonia and opsonins as when they started. The chief facts ascertained up to date appear to be that the mortality rate of pneumonia in America is 40 per cent., and that opsonic treatment has pulled it down to rather less than 30. The wonder is rather how the pneumonia mortality rate ever got to 40 ; even in this benighted country we can do better than that, even without opsonins. The danger of printing this sort of flap-doodle in lay papers is that any value a new method is found eventually to possess, is discounted in the eyes of the public by the innumerable disappointments which they have already experienced in hearing of its action through these untrustworthy sources.

A Disease or a Vice.

It is not often that the doings of an ecclesiastical assembly are of special interest to us as medical men, but, nevertheless, the debate on temperance matters in the Synod of the Church of Ireland last week really centred round a point on which medical men must eventually come to a decision, although at present they are far from being agreed. Mr. Norman Barnett, F.R.C.S., moved a resolution stating that the present system of dealing with inebriates was based on "the wrong assumption that drunkenness is entirely a vice and not largely a disease," and demanding such a change in the law as would enable magistrates to commit inebriates to inebriate homes for periods of not less than a year. His views met with considerable opposition from some of the clerical members of the Synod, and eventually the resolution was watered down to a mere demand for greater facility in committal to inebriate homes. Without going into the vexed question as to where drunkenness and other drug habits stand in regard to the border line between vice and disease, we are of opinion that any power put into the hands of magistrates must be carefully guarded, and the Synod did well to reject the proposal in the form in which it was put forward.

The Hygiene of the Hop-picker.

The hop and fruit-picking industries of Kent have long been a by-word among decent people. The hoppers who flood this "garden of England" are drawn from the poorest and most uncivilised denizens of East London, and it is not a matter for surprise that they should bring their filthy habits and predatory ways with them. But it is a scandal that the employers of this form of labour should in the past have exercised so little care in catering for the inrush that it has been impossible for these poor creatures to live in anything approaching decency. Even the outbreak of typhoid which decimated Maidstone ten years ago and was clearly traced to the hoppers' excreta did not cause the inhabitants to rise up and insist on proper arrangements being made. The Local Government Board has done well at last to send an inspector, Dr. Reginald Farrar, to report on the matter, and from his report just issued, it seems that with the passing of individual enterprise and the creation of joint-stock fruit-farming companies, some attempt is being made to cope with the housing, sanitary, and other difficult points in the situation. Dr. Farrar found things were not as bad as anticipated, but they are still bad enough. Water when supplied is in many cases either clarified sewage or open to gross contamination; pig-sties and cowsheds—the latter in use for cows—are provided as sleeping-places in some counties, and men and women herded indiscriminately together in others. It will not tend to give people a keener appetite for the strawberries to know under what conditions they are picked, and most of us would probably prefer, apart altogether from the moral principles involved, to pay a little more for our fruit and know that we run less risk of contracting filth-diseases.

PERSONAL.

H.R.H. Princess Louise, Duchess of Argyll, will open the new Out-patient Hall of the London Temperance Hospital on May 14th.

The Duke of Northumberland, K.G., will take the Chair at the annual dinner of the Royal Sanitary Institute at the Langham Hotel on May 15th.

M. Roussilbe's legacy to found a prize for the study of Dermatology has been accepted by the Academy of Medicine of Paris.

Dr. William Cowper, of Frognal Lane, Hampstead, has been the subject of a brutal assault and is very seriously injured.

Dr. and Mrs. James Greenwood, for many years resident in Canonbury, celebrated their golden wedding on April 3rd at their residence at Leyton, Essex. They were the recipients of many valuable presents.

At a meeting of the Committee of the Chester Infirmary last week, Dr. Cyril Dobie was appointed honorary assistant surgeon, and Dr. A. Douglas Hamilton, honorary assistant physician.

Dr. A. McQueen, of Scotland, Ontario, met with a sad death on April 7th. As he was travelling to Winnipeg by train he by some means fell from the car, and the injuries he received proved fatal within a short time.

The Jacksonian Prize of the Royal College of Surgeons for the year 1906, on "The Diagnosis and Treatment of those Diseases and Morbid Growths of the Vertebral Column, Spinal Cord, and Canal, which are amenable to Surgical Operations," has been awarded to Mr. Donald John Armour, F.R.C.S.

Alderman Sir Marcus Samuel, late Lord Mayor of London, has offered to give £2,000 towards the erection of the new operating theatre and the anæsthetic room at the West Kent Hospital, Maidstone, provided that an equal sum is contributed for their endowment. Towards this amount £400 has already been promised.

The honorary degree of LL.D. of the University of Edinburgh, was bestowed on Sir John Tweedy, F.R.C.S., lately president of the Royal College of Surgeons of England, at the Graduation Ceremonial in Edinburgh on Friday last.

The Grand Prix at the International Exhibition at Milan (1906) in the Section of Hygiene has been awarded to the exhibit illustrating researches conducted in the Wellcome Physiological Research Laboratories with a gold medal to each of the Collaborators, Dr. W. Dowson (Director) and Dr. Barger.

Spotted Fever at Leamington.

Newburn Urban District Council last week decided to make cerebro-spinal fever, or "spotted fever," compulsorily notifiable. A case of the disease has occurred at Leamington, and the sufferer, a child, has been removed to the hospital.

A CLINICAL LECTURE
INTRODUCTORY TO
THE STUDY OF DISEASES PECULIAR TO CHILDREN. (a)

By SIR LAMBERT H. ORMSBY, M.D., F.R.C.S.,

Senior Surgeon to the Meath Hospital and Co. Dublin Infirmary, and to the National Children's Hospital.

GENTLEMEN,—You will ask me, in commencing the "Study of Diseases peculiar to Infants and Young Children," how they differ from those affections met with in adult life. Well, in reply to this question many answers could be given to prove that it is advisable to make a special study of such diseases, inasmuch as in the majority of instances the little patient cannot and will not give the practitioner the slightest help in making his diagnosis, which is not so in the study of the same or other diseases in adult life. This gives me the opportunity of informing you what great advantages a large well-equipped children's hospital confers on the community of large. The principal objects of such an institution are briefly:—

(1) A building constructed up to date for the reception and successful treatment of all non-infectious medical and surgical diseases peculiar to infants and young children.

(2) The attainment and diffusion of special knowledge regarding the diseases of children by medical men, students, and others, making a special study of the subject.

(3) The training of nurses for sick children.

With reference to these three objects I could enlarge at great length. However, I will briefly say, the diseases of children must be studied more or less as a speciality, for the correct investigation of such affections requires much special study and constant observation, as children of tender age are seldom, if ever, able to give the physician much help verbally (except by a cry) by way of indication. For this reason all the symptoms and conditions must be carefully observed and scientifically reasoned out, before a correct diagnosis can be arrived at.

The second object, the attainment and diffusion of knowledge regarding the diseases of children, is all important, for such knowledge directly confers a great benefit on the general public because it enables one to know where special advice can be obtained in cases of sudden illness or accident occurring among young children, and also, it may be the means of diminishing the enormous death rate among infants in large cities owing to ignorance in feeding and general management.

The third object, the training of nurses for sick children, is perhaps as important as the two preceding ones. Nurses for infants and young children require a great many qualities if they are to be a success, such as love for children, great patience, great tact, great attention to detail, gentleness, and must know and study "the little ways" and habits of children from babyhood upwards.

In days gone by the entrance to the profession for the student was by a system of apprenticeship, and under this old plan the professional knowledge thus acquired was, to a large extent, traditional, that is to say, it depended largely on the particular medical practitioner to whom the young student was apprenticed. In other words, if an apprentice had the good fortune to be placed under a really good and able instructor in the study of the diseases of children, which forms so large a part of the business of the general practitioner, he would in time become fully acquainted with this very important branch of his profession.

Again, in the various universities and colleges there is very little provision made for the practical instruction in diseases of infants and children. In some there is an attendance required (such as a course of lectures of three or six months duration on the diseases of women and children). But I fear this special subject does not appear to be considered as important as it should, as I am of opinion that the public would naturally expect to find that some provision had been made in the different medical schools and colleges for the teaching of this special branch of medicine and surgery to the students. Specialism in nearly every branch of medicine and surgery to-day is a most important feature, and what further development it will reach in the near future it is impossible to say. But no matter what specialism a practitioner may hereafter devote his whole attention to, it would be better for him at first to engage for a few years in general practice so as to obtain a thorough and comprehensive grasp of disease in all its forms before taking up the study of a given special branch suitable to his abilities and tastes.

In the clinical investigation of disease in infants and young children a practitioner is confronted with enormous difficulties. But before proceeding further we must understand that early life is divided into two periods, viz.: Infancy and childhood. Infancy commences at birth and terminates on the complete eruption of the milk teeth, an event which, as a rule, occurs about the end of the second year. Childhood then begins and extends from this age to the period of puberty between the thirteenth and fifteenth year. In conducting the investigation of disease in an infant or a child it is useful to proceed in systematic stages and methods, viz.:—(1st) By questioning the parents or attendants; (2nd) by inspecting the infant or child; (3rd) by physical examination of the little patient.

I.—QUESTIONING THE PARENTS OR ATTENDANTS.

In infant and childhood life this mode of obtaining accurate knowledge concerning the condition of the patient is one of the means we have to adopt for eliciting information. We therefore depend, to a large extent, on the testimony and report of those who are constantly about the patient. Parents, nurses, and servants at times can give the physician excellent clues and help in this way, and although they may not be remarkable for their intelligence in other matters they can be valuable observers when their powers are guided by affection and regard. Besides being always about the child and knowing every turn and peculiarity as well as the habits and disposition they will often detect any deviation from the child's ordinary health much quicker than the physician will during his short and casual visit. As this mode of obtaining information requires some definite order we might divide our means of interrogation into three:

1. The family history, as a rule, gives help and may be of use as regards whether the infant or child is the subject of transmissable or hereditary disease such as tuberculosis, syphilis, etc., and whether other children of the same family have been similarly affected, or whether any of them have died, and at what age, and from what cause, or if similarly affected, if they recovered, what period it took to recover, and the treatment adopted.

2. We must then investigate accurately concerning

(a) **Being the subject of a Lecture delivered to the students attending the National Children's Hospital during the Session 1906-7.**

whether the child is fed at the breast, or artificially by means of the bottle, and if by the latter the composition of the food employed; then its whole environment must be considered as regards its sleep, food, exercise, and general hygienic surroundings.

3. The next important point is to question the attendants, how and when the attack came on? Get them to fix the exact date when the child was quite well, and then state from that time the changes which came over the child, as regards its sleep, food, irritability of temper, cough, convulsions, diarrhœa or vomiting, heat of skin, pale or flushed face, as the case may be.

II.—INSPECTION OF THE INFANT OR CHILD.

When a baby or small child is suddenly brought into the presence of the doctor for the first time for examination it requires the greatest care and tact on his part not to frighten the child or make it cry, for if it gets frightened, disturbed, or cries, it will only make it harder for the physician to arrive at a correct diagnosis as regards the little patient's real condition. If the baby is asleep tell the nurse not to awake it suddenly, much can be observed by the experienced child's doctor while the little patient sleeps—the heat and colour of the skin, the restful or unrestful position the patient reposes in, the regularity of the respiration, whether slow or quick, whether full or shallow, whether laboured, or sighing. Then the frequency and character of the pulse can be felt much easier when the patient is asleep. Suppose the child is awake when you see it for the first time do something at once to attract its attention by showing it a toy or some tinkling instrument—your watch is very useful to show a child and let it feel it. A physician accustomed to examine many little children will need to be most resourceful and will find by judiciously getting the child or baby's confidence at once, he will have very little difficulty in his future examination, and it will not be disturbed by a violent crying fit. It is better at first to talk to the mother or nurse, and apparently take no notice of the child and so allow it to take a good look at you and all the new surroundings of your consulting room, and if the child can run about let it do so without restraint, and the little patient will soon feel at home, and you can then conduct your examination with much more ease, quickness, and satisfaction. I never consider an examination complete without removing all the child's clothes; as much can be ascertained by complete inspection of the child's naked body. This sometimes makes the child cry, but still it is far better to have a full examination than a partial one. However, wait for a moment or two till the child gets accustomed to you before asking this to be done.

When a child is really sick and "out of sorts" the mother or nurse will have noticed it, and that is the reason why you have been sent for to see the child, or the child has been brought to you, therefore, you need not waste time by endeavouring to ascertain whether it is sick or not, as by its history, appearance, etc., the fact will be obvious. Your business, as a physician, is to ascertain to what extent the child is ill, what is the complaint it suffers from, and what is the best treatment to be adopted which will speedily effect a cure.

1. *The Face.*—It is surprising how much can be learned by an experienced eye by simply looking intently at a baby's face. Take a healthy infant and carefully observe it in a peaceful slumber. What an expression of perfect repose and healthy contentment is here apparent. When it is ill and "out of sorts" what a remarkable change is observable. The face is pale and contracted. The eye is dull and glassy and has lost all its brightness, with twitching of the eye-lids and lips, the faint and continuous whining cry, showing the child is in pain, and the constant wriggling or writhing in its little cot or in the nurse's arms, shows that it is ill at ease. Dilatation of the alæ-nasi, with or without heavy breathing, indicates impeded respiration, the result of broncho-pneumonia, or a pleuritic attack.

Then when the healthy child is awake look at its bright eyes together with its cheerful happy expression, observant of everything and smiling at all around it. This expression of countenance is greatly altered by the onset of any illness just as a storm changes the whole aspect of things after a period of peace and sunshine. The change being in proportion to the severity of the attack. An expression of pain and anxiety is quickly delineated in the face, the features become pinched, and the eyes and mouth become drawn and contracted. Pain undeniably sets its mark upon the facial muscles of expression, and by noting the features affected it is often possible to fix the seat of disease or derangement. Thus, contracting of the eyebrows denotes pain in the head, sharpness of the nostrils pain in the chest, and a drawing of the upper lip pain in the abdomen. It has been said, and said correctly, that the upper third of the face is modified in expression, in affections of the brain. The middle third in diseases of the chest, and the lower third in lesions and diseases of the abdominal viscera.

2. *Posture.*—When a healthy child is lying in its little cot or bed it slumbers on in the most peaceful manner, it rests in an easy and comfortable position, the breathing is quiet, regular, and silent, and the only movement that can be observed is the gentle rise and fall of the abdomen and chest in respiration. When a child is ill the whole scene changes. The infant tosses and turns about, and is only content when rocked in the cradle or taken up and fondled or walked about with, in the nurse's arms. The older child whinges and cries and begs to be taken out of bed and raised, many positions are assumed, according to the presence of various diseases. In abdominal and peritonitic pain the child lies on its back with the legs well drawn up, so as to relax the abdominal muscles. Restless movements of the head or burying of the head into the pillow, or where the head is bent back as the child lies on its back indicates cerebral and meningitic trouble.

Persistent lying on the face and burying the face into the pillow so as to hide the eyes from the light is an evidence of photophobia. When the thumbs are tightly contracted on the palms of the hands it is just possible a convulsion may be pending. In the last stages of febrile attacks the patient lies quiet and stretched out and is unable to move hand or foot from sheer debility, and in stupor and coma the body is also still and immobile from the same cause.

3. *State of the Skin.*—The condition of the skin in infants and young children is very important, and much can be learned by a careful observation of its external tegumentary covering. In the new-born infant the colour of the skin varies from a deep to a light shade of red. After a week or ten days the skin assumes its typical healthy appearance. Lividity of the eyelids and lips is a sign of imperfect aeration of the blood, and points to pulmonary or cardiac disease. Marked blueness of the whole face is a sign of "morbus cæruleus," and indicates a congenital malformation of the heart or a non-closure of the "foramen ovale." A yellow discoloration of the whole skin with a yellow hue in the conjunctive indicates jaundice, whereas an earthy tinge of the face is met with in chronic intestinal diseases, a waxy pallor in renal diseases and paleness in any diseases attended with exhaustion. The eruptions met with are numerous and varied. Eczema perhaps of all the skin eruptions is the most common. The skin in a child is very variable as regards the ranges of temperature, and is not at all as regular as it is in adult life.

4. *Mode of Drinking or Taking Nourishment.*—This is important for, by watching an infant sucking at the breast, or the teat of the bottle, much knowledge can be obtained both of the strength of the child and the condition of its mouth, throat, and respiratory organs. If the mouth is any way sore the nipple is held only for a moment or two and then discarded with a faint cry of pain. When the throat is affected swallowing is performed in a gulping manner, and an expression of pain passes over the face and no more efforts are made than is just required to satisfy the pangs of hunger. Under similar circumstances older children drink little and refuse solid food altogether.

An infant suffering from any bronchitic or pneumonic affection sucks spasmodically, and pauses now and then to get its breath. In older children the act of drinking is carried out in the same way with numerous interruptions. If the finger is placed in an infant's mouth in health it sucks vigorously, if weak or debilitated it is hardly able to grasp it, and if it does it sucks faintly and imperfectly.

5. *Character of the Cry.*—Crying, it has been said, is the chief, if not the only, means that the young infant possesses of making known its pain, displeasure or discomfort. Even long after the powers of speech are developed the cry is the common channel of complaint to those around. Incessant unappeasable crying is often due to hunger or pain in the head or abdomen. Conditions of general distress, great debility and malaise predispose to fits of fretful crying, the paroxysms being excited by any disturbing influence such as the presence of a stranger or change of nurse. When the cry has a nasal tone it indicates a swelling of the mucous membrane of nares, pharynx, or the presence of enlarged tonsils or adenoids. A loud brassy cry frequently announces the onset of an attack of spasmodic croup. In membraneous croup and in extreme exhaustion the cry is faint and inaudible.

6. *The Character and Condition of Breath.*—The breath of a perfectly healthy infant or child should be odourless or what nurses call "sweet." It may just after taking nourishment smell of the milk or other food taken, but this lasts only a very short time. Any persistent sour smell from the breath is an indication that the child is not in health. Fœtor of the breath is observed in such affections as aphthous and ulcerative stomatitis, also in a more aggravated form in ozoena and necrosis of the nasal and maxillary bones. Decaying teeth give much the same odour, though it is less strong and penetrating. Sour breath is present in infants especially when there is gastric fermentation and gastro-intestinal catarrh. What is known as a feverish breath has a heavy sweetish smell. It is met with in infantile disorders accompanied with high temperature such as measles, scarlatina.

7. *Character and Frequency of the Pulse.*—To obtain anything like an accurate idea of the pulse it must be felt when the patient is perfectly quiet. The best time to feel it is when the child is asleep, but unless it is felt with the greatest care the child is likely to awake, and then it will doubtless indulge in a fit of crying and will as a matter of course raise the pulse rate so that it is hard to ascertain its average character and frequency accurately. With very young infants it is very hard to feel the radial pulse at the wrist. It may be felt over the anterior temporal artery on the forehead, or it may be ascertained by means of the stethoscope over the heart itself. The pulse in an infant from birth to the second month averages from 130 to 160, and from the second month to the sixth month 120 to 130, and from the sixth to the twelfth month 110 to 120, and slows down gradually to the age of puberty. In scarlatina a pulse of 160 need not alarm, in fact its frequency is quite common.

8. *The Temperature.*—This fluctuates considerably in infants and young children. It may be roughly ascertained by feeling the face, forehead, or body with the hand. But to be accurate the thermometer must be used, and it may be placed in the mouth, rectum, axilla or groin. If placed in the mouth the thermometer must be held, and the mercury carefully watched as it rises. If the child cries it will have to be removed and placed in the axilla, in either groin at side of scrotum or labia, or if one requires the temperature to be really accurate the rectum had better be selected. In an infant it must be remembered that the temperature in the rectum is one degree higher than the axilla and in the groin about one degree lower than the axilla. Rapid and transient rises attend slight catarrhs and gastro-intestinal attacks. The degree of elevation marks the type of pyrexia present. It is moderate at 102. Severe at 104 or 105, and very severe when it reaches 107.

9. *The Respiration.*—In infants and children the breathing is mainly abdominal, or costo-inferior, and it is not till the age of puberty that the breathing can be said to be (in the female) costo-superior. Therefore, when it is necessary to count the respirations, the hand should be lightly placed on the child's abdomen over the epigastrium, and the respiration should be counted by the second-hand of the watch. As regards the rate: Soon after birth the number of respirations is 44 per minute, and from two months to two years 35, and from two to twelve years about 23. During sleep the frequency is reduced nearly 20 per cent. Rapid breathing is generally met with in the elevation of the body temperature, and found in all cases of febrile states, also in thoracic and abdominal pain. Diminished frequency is found in certain brain diseases, such as chronic hydrocephalus and in the last stages of tubercular meningitis. Perfectly healthy breathing is carried on through the nasal passages so softly and without noise that it is difficult to perceive it. When there is any stoppage in the throat or partial obstruction of the nasal passages by adenoids, the breathing is carried on through the mouth, and gives the child a marked change in aspect and appearance. "Mouth breathing" is very common, and, in my opinion, frequently is the main cause in the production of adenoids.

10. *Movement of the Bowels.* The daily number of evacuations varies considerably in children, depending on age, food, and surroundings. During the first six weeks of life there are generally three or four stools in the 24 hours. After this time, up to the end of the second year, two movements in the day is the average. After this the frequency of defæcation is the same as in adults, once in the 24 hours. The character, such as odour, colour, consistence, of stools is very important, and present a very valuable means of diagnosis. From this it will serve to show how much can be learned from the examination of the stools and the importance of making a personal inspection of them.

11. *The Voiding of Urine.*—It is impossible to say how often a healthy infant will void its urine in the 24 hours. It is subject to great variation—it depends on the temperature, the time of year, the amount of exercise, and general surroundings. It may be every hour during the day and three or four times during the night. The urine of a healthy infant should not stain the diaper, the fluid being clear and colourless. It has, as a rule, a low specific gravity, 1003 to 1006, and slightly acid reaction. Painful micturition is found in inflammatian of the urethra, a tight prepuce, a highly acid state of the urine, or the presence of stone in the bladder. The normal daily amount voided in the 24 hours is subject to variations. Between two and five years average quantity voided, 15 to 25 ounces; five and nine years, 25 to 35 ounces; nine and fifteen years, 35 to 40 ounces.

12. *Vomiting.*—This is a very common occurrence in infants and young children, and must be distinguished from regurgitation of the contents of the stomach which seem to come up without effort, and occurs when the infant sucks in the milk too fast and more than it can conveniently digest, and the stomach relieves itself by regurgitation of the undue supply, this may be considered a sign of health rather than of disease. Retching and purging is frequently met with in young infants who are improperly fed, and is a common symptom of gastro-intestinal catarrh, enteritis, or colitis. The vomiting of mouthfuls of curdled milk, or partially digested food is an indication of fermentation and the formation of acid in the stomach, and that digestion and assimilation is not taking place.

III.—PHYSICAL EXAMINATION.

In the physical examination of the infant and young child, it is better to adopt some regular methodical order of examination, and, as I said before, the physician must use all the tact, judgment, gentleness, and resourcefulness in his power in order to carry out a successful physical examination of his little patients. He must before he does anything to the child endeavour to gain its confidence. Various children have to be approached in different ways, and the person who has the greatest experience will at a glance know best how the little patient before him has to be humoured into acquiescence and good behaviour during the examination. Before stripping the body, observe the condition of the pulse, respiration, and temperature; then, when the clothes are removed, inspect the muscular development of the body and the limbs, winding up with the mouth, tongue and fauces. Much information will thus be derived by following this order of examination.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor Wm. Carter, M.D., F.R.C.P., LL.D. Lond., Senior Physician to the Royal Southern Hospital, Liverpool. Professor of Therapeutics in the University of Liverpool. Subject: "Some Cases of Nervous Disease."*

ORIGINAL PAPERS.

THE NON-OPERATIVE TREATMENT OF MALIGNANT DISEASE. (*a*)

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The methods of treatment I am going to discuss are not intended as substitutes for surgery. The opinion of our profession is unanimous in favour of an operation whenever possible, once cancer is diagnosed. There must always however, be a residuum of cases in which surgical methods cannot be adopted. In spite, too, of many and increasing triumphs, cases do recur; the surgeon then may still be the patient's best friend, as for instance when he does a palliative colotomy. Such treatment, however, is beyond my province, nor do I propose discussing proceedings which profess no more than relief of symptoms. This paper is limited to some three or four new courses of treatment, credited with a chance of cure, if undertaken at an early stage; whether they ever effect that desirable result or no, they may be useful for other reasons to those who have to see the case through.

The diagnosis of cancer presents almost insuperable difficulties, especially as some surgeons now question an opinion backed by microscopic examination. Extremists may insist that none of the cases cured by the means we are going to consider were genuine cases of sarcoma or carcinoma. I shall not attempt to fight that contention, but at once take up a safer position, and say that it is important to know remedies that have been successful in conditions which so closely resemble cancer as to mislead the most experienced. I use the word cancer in its widest medical sense, and attempt no definition.

The electrical methods of treating cancer may be temporarily put on one side, as another member of this society has promised a paper on that important subject.

In a few words we may dismiss Doyen's serum, an anti-toxin obtained from horses; Doyen starts with the assumption that cancer is due to the micrococcus neoformans, and prepares his remedy accordingly; it has, however, been discredited by other surgeons in France, while in this country, Paine and Morgan, after careful trial in a series of cases at the Cancer Hospital and elsewhere, have come to the conclusion that the serum is always useless, and sometimes dangerous; occasionally it set up severe pain.

I pass at once therefore to review the treatment by trypsin, so indefatigably advocated by Shaw-Mackenzie. This is placed first, because it was the means of curing a mouse inoculated with cancer by Beard, a success not achieved to my knowledge by any other method. The trypsin-dosed mouse is alive to-day, while another, used as a control, and therefore not treated, died after exhibiting the usual symptoms of advanced cancer. Treatment consists in the injection of 15 minims of a 2 per cent. solution, the dose being repeated every other day, and increased each time by 5 minims. The needle may be passed into the abdominal wall, or the gluteal region, or into the neighbourhood of the tumour; the best results are obtained when such local application is practicable. The medicine may also be administered by the mouth, and lately there have been used in addition preparations of intestinal glands containing "secretin," or "erepsin" and "enterokinase." Strict asepsis is necessary; there is no contra-indication to the method, which, even when unsuccessful, gives rise to no unpleasant symptoms. The action is a digestive one, the tumour gradually disappearing. Trypsin dissolves cholesterin, and Shaw-Mackenzie has demonstrated that this property is shared by certain other drugs, such as chian turpentine and sodium oleate solutions, which have been used for cancer. Chian turpentine, by mouth administration, was thoroughly exploited in Birmingham some twenty-five years ago, when it fell into disrepute. As Shaw-Mackenzie claims to have afforded relief by subcutaneous injection, I may remind you that this treatment consists in injecting 5 minims of a 20 per cent. solution of chian turpentine in olive oil, and increasing by 5 minims on alternate days up to 60 minims. The preparation should be deeply injected into the buttock, after sterilising the site of injection, local anæsthesia may be induced by a piece of block ice, followed up if necessary by eucaine. The action probably consists in cutting off the nutrient supply to the growth.

Oleate of soda injections were recommended by Webb of Melbourne, in 1901; one drachm doses are used, pain being obviated by eucaine; the effect is enhanced by internal administration of ox-gall, whose palliative effects in cancer have been known from the earliest times. The beneficial action of these cholesterin-dissolving substances depends for explanation on Webb's theory that "cell proliferation is due to the deposition of cholesterin in the tissues, either locally from injury or some nutritional disturbance in the liver, associated with deficiency of the bile soaps, which normally hold cholesterin in solution." Of these drugs Shaw-Mackenzie claims trypsin to be the most efficacious and explains that it has the effect, which pepsin has not, of breaking up glycogen; glycogen is always present in the cancer mass. In advanced cases trypsin is of value in checking fœtor and hæmorrhage.

The next drug, cinnamate of sodium, was recommended by Drage last year; he suggested either cinnamate or orthocinnamate of sodium, 30 minims of the former in a 10 per cent. solution, or 25 minims of the latter in a 22 per cent. solution; one of these should be injected once or twice a week for three months. In his more recent paper he seemed to pin his faith to the coumarate. Like Shaw Mackenzie, he holds out no prospect of a cure unless treatment is commenced early, but apart from such a desirable issue, commends the method for controlling symptoms, particularly hæmorrhage, pain, and discharge. Drage states that the same procedure acts well in tubercular cases, and pleads for its use in the pre-cancerous stage; many chronic and obscure abdominal conditions clear up if dealt with in this way. I have used it in two cases, and can support some of the claims advanced, but no favourable influence was exercised on the fœtor of the discharge. My experience points to the coumarate being the more valuable drug, and to the advantage of pushing it; I worked up to double the quantity of the solution recommended. At the same time three months seems to be insufficient. In one of my cases this treatment was discontinued after three months, and the progress of the disease then appeared to be much more rapid; on resuming after an interval of six weeks, an inhibitory action was again in evidence. No bad symptoms resulted. The action is an extensive leucocytosis; Drage says that "what causes a large increase in the most organised cells will also cause such

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(*a*) Paper read before the Midland Medical Society.

an alteration in the environments of cells which have reverted to the genetic type that an arrest in their inversion is possible and probable.

I wish next to give you a few details of a drug in which I am specially interested, namely, an infusion of violet leaves. When first used the infusion was made by the patient or his friends by the simple process of pouring a pint of boiling water over a handful of leaves, and then straining 24 hours later; half the liquor was drunk during the succeeding 24 hours, and the other half used for local application. Mr. Whippell Gadd made some investigations from a chemical standpoint, and came to the conclusion that the active principle was a glucoside, viola-quercitrin, of which there is 5 per cent. in a properly prepared infusion. He has placed on the market a purified solution of the glucoside in which alcohol is used as a preservative. The treatment appeared to be one with possibilities; accordingly I began using it in two cases where the resources of surgery had been exhausted. At the same time I undertook a series of pharmacological experiments in order to place the treatment on a scientific basis; this was, I believe, the first pharmacological study of the drug. I will not weary you with details, as they have been placed in full before the Therapeutical Society, and published in the *Medical Magazine* for November. On the board is a diagrammatic scheme of some of the tracings I have taken. The net result of the experiments has been to show that the drug is non-toxic in ordinary quantities, but far from inert. It depresses all muscular tissue, particularly the heart, and in consequence causes a marked fall of blood pressure. There is no effect on the central nervous system, but the nerve endings are so influenced, both after local and internal administration, as to constitute this preparation an analgesic of great value. One of the most conspicuous clinical actions consists in diminishing the fœtor of discharge; this has been noticed by many observers. It is not due to liquor violae glucosidae being antiseptic, for it is not; it seems almost certain, however, that after absorption, the active principle is split up into something else, with disinfectant properties. The obvious action is to control pain, hæmorrhage, and discharge; it is therefore beneficial in cancer. As a matter of fact it is a drug with a wide sphere of usefulness; possibly, though first introduced for cancer, it may ultimately be used even more for other conditions. The only drawbacks are the nauseous taste, and tendency to cause dyspepsia; they are, however, largely discounted by the fact I have established that the best results are obtained by hypodermic injection. It will be interesting to see further results of this method of administration, which had not been attempted previously. I recommend injecting half to one drachm of liquor violae glucosidae twice daily, near the tumour if possible, but as with the cinnamate I think the drug should be pushed. I took one and a half ounces without ill effect. The depressing action prevents its use when the heart is feeble; there is no other risk; the drug is so active and so rapidly eliminated that any bad symptoms develop immediately after administration, and are therefore under control; cardiac stimulants constitute the antidote. Among numerous cases reported, nothing really alarming has been noticed. Liquor violae glucosidae is a valuable palliative in cancer; to be anything more it must be given at a very early stage. Gordon has recorded several successful cases; from a study of these it appears that the cure is effected in a few weeks, if effected at all; after a time it loses its power. The clinical results are foreshadowed by the pharmacological experiments, which indicate a rapidly produced action with the subsequent development of tolerance. It ought, therefore, to be given the first trial, as it is soon known whether it is going to help or not. If not, little time has been wasted, before other treatment is instituted. There is no objection to running more than one of these methods at the same time, although their action is not the same. In both my last two cases, violet leaves and cinnamate of sodium were used simultaneously. The action of violet leaves is not digestive; precisely how it acts we do not know; several details, such as the mode of elimination, are still moot points. The lowering of blood pressure and antiseptic action after absorption must both contribute towards a favourable result, which is possibly due to diminished nutrient supply to the growth, combined with a shelling-out process due to the shortening of any contractile fibres present. As a rough guide to a choice between various methods I may say that while trypsin is indicated at a very early stage, I do not recommend it so much later, when only a palliative is aimed at; then, if hæmorrhage is the chief trouble the cinnamate should be used; for offensive discharge and pain violet leaves is the drug *par excellence*; as a hot fomentation it often acts like a charm.

Diet must next occupy our attention. Food has considerable influence on the general condition, and the previous health must sometimes determine the incidence of cancer. With this assumption I suggest a change in diet, directly a diagnosis is made, on the ground that the course adopted antecedently cannot have been a prophylactic one. I recommend a decided variation from the previous plan, rather than the prescribing of any particular scheme. There are many systems worth trying, and I would just mention two—(1) the two-meal system; (2) a purin free diet. In cancer one or both would appear to be the right course. The stuffing and stimulating systems have been given such an exhaustive trial, and have been so conspicuously unsuccessful, that experiment might well be made of quite different methods. Such thoughtful and observant men as Sir James Paget and Sir Mitchell Banks have indeed connected cancer with over-feeding. At this point we may call to mind that in Ireland during the potato famine the death-rate from cancer fell considerably. Possibly some medical men believe either plan of diet suggested would accelerate a fatal issue. From experiments repeatedly carried out for months at a time during the last eight years, I can assure them that their fears are groundless. As a matter of fact, we should be doing our patients a real kindness; scarcely anything increases sensitiveness to pain more than do stimulants and generous feeding; few courses diminish it more than an abstemious and spare diet. I do not say one of these schemes will suit everybody. Something, however, on these lines will be of value, especially if the precautions I have elsewhere insisted on in connection with a change of diet are enforced. In my paper on the action and the results of violet leaf preparations will be found notes of a case treated by violet leaves, cinnamate of sodium and a purin free diet. These were instituted after an abdominal section had revealed that surgical treatment was impossible. The patient ultimately recovered. This case is referred to now, not so much as an instance of a cure of cancer—for the disease was probably not cancer after all—as an example of the beneficial action of these courses of treatment even for a patient almost *in extremis*. If one of them were adopted at the time of operation a great step would be taken towards reducing the risk of recurrence. An operation is sometimes undertaken when, according to Mr. Pearce Gould, the mortality for the particular patient is 100 per cent. Regarded as an adjunct to surgery, violet leaves or other drug, and diet, might reduce the risk to nothing per cent.

How do matters really stand? We have no cure for advanced cancer, that is certain. I am, of course, ignoring surgery for the moment. Even at the commencement a cure is but seldom effected with all our resources. Would it not be well, then, to aim at prevention?

It may at once be asked, how can you prevent cancer when you do not know its cause? Sometimes we know more than we will admit, and long ago I joined sides with Professor Clouston when he said that if, instead of eternally clamouring for fresh facts and more statistics, we would sit down and make all possible deductions from the information already available, we should find we really know enough to be able to teach the public how to almost entirely prevent disease. Is it quite true, as is sometimes said by those who overlook the obvious in a vain search for what is occult and perplexing, that we know nothing about cancer? On the contrary, it seems to be generally admitted that the cause is irritation. It is scarcely necessary to remind you of the evidence in favour of this view, derived from the fact that cancer occurs chiefly in situations exposed to irritation; or do more than call to your minds the frequency with which it is grafted on an old ulcer of the stomach, or a lacerated cervix. Everything which irritates the tissues, especially if the irritation is long continued, must tend towards cancer, which can scarcely have a single origin. Some day perhaps the precise organism associated with its incidence will be determined; that discovery would not really be so valuable as the one already made, that irritation is the root of the mischief; even when the pathologist can tell us exactly how and why cancer develops, we shall probably have to hark back, just as in the case of tubercular disease, and prevent it by a prophylactic mode of life which had been suggested years before. Victims of cancer have usually had warning symptoms for many years, but the invidious distinction between functional and organic disease, combined with the fatal policy too often advocated of waiting to meet trouble till trouble comes, frequently militate against a correct interpretation of the writing on the wall. The laboratory will seldom boast a greater triumph than the finding that healthy tissues are the best germicides.

To prevent cancer all sources of irritation must be removed; this will never be completely achieved, and so we can never hope to eliminate cancer. We ought, however, to succeed in greatly reducing its frequency. To do this we must set our standard of health much higher than we usually do, and avoid all known sources of irritation to our systems. I agree with Keetley that much may be done in this direction, and commend to you his suggestions that special care should be taken of the mouth and teeth, and a sufficient and regular toilet and protection advocated for the nipples and genital organs, both of which, among the lower classes at least, are often shamefully neglected; frequently they are polluted by stale secretion, especially during lactation. A caution must be added as regards constipation; this should be taken far more seriously; those who gloss it over as not inconsistent with health do not know the meanings of words. It is of course, a clear indication that the diet is unsuitable and should be treated accordingly. I cannot agree with Keetley's first suggestion that all food should be sterilised, because we know that animals fed entirely on sterilised food soon die. Had he confined himself to recommending that the loaf should be prevented from rolling in the gutter before reaching the consumer, and the joint not exposed to the dirt and dust wafted upon it by every wind that blows, I should have been in complete agreement. Personally, I cannot accept the dictum of the Cancer Commission that diet has nothing to do with cancer. No one is in a position to say so yet; the subject of dietetics, well worthy of a lifelong study, is only in its infancy. No proofs can be given connecting cancer with diet. We know, however, that the non-meat-eating countries, have a much lower death-rate from cancer than we have; in lower Egypt it is 1 in 1,028, as compared with our 1 in 29. On the other hand, the excessive meat-eating countries, such as Australia and New Zealand, are near our mark. Again during the last 50 years, while cancer has been increasing so much, the one marked change in our diet has been the much greater consumption of meat, as shown by the statistics of Chalmers Watson and others. These facts prove nothing, but must make the judicious ponder. We now know that meat can never be got free from ptomaines, and the more we know of ptomaines the less we like them. We also know that the viscosity of the blood can be increased by a meat diet, as shown by Burton-Opitz, of New York, thereby increasing friction, and so possibly causing irritation. In this connection Chalmers Watson's experiments as to the effects of an excess of meat on rats, and similar work in France on birds some years previously, must occur to thoughtful men.

There are many other sources of irritation in food, but time is too limited to refer to more than one, namely, salt. Salt has often been put forward as a cause of cancer, and health enthusiasts long ago eliminated it from their diet. The scientific as a rule scoffed, but the definite proofs discovered during the last year of its irritating action and the benefit effected by physicians in Germany and elsewhere, who have withheld it in cases that were doing badly, indicate that perhaps, after all, it was not such a wild idea to place salt among the many sources of irritation which tend towards the development of cancer. It is significant that in Austro-Hungary, the highest mortality from cancer is found in the province of Salzburg, where the production of salt is the chief industry. The two-meal system already referred to was promulgated over two hundered years ago by Luigi Cornaro, whose estimate of the proper amount of food was much the same as Chittenden's; this has ever since been practised from time to time by a certain number. The non-meat diet for cancer was advocated nearly a hundred years ago. Should we adopt either of these suggestions now, we might well hope to escape the reflection so dreaded by some, that we are like the Athenians, and patronise only what is new. In conclusion, I would say that some may think I attach too much importance to diet; if the imputation could be made with truth, I should still welcome it; the subject has been in the past so neglected by medical schools that till someone goes to to the opposite extreme we shall never attain that happy mean which has always been the ideal of the profession.

OPERATIVE TREATMENT OF TRAUMATIC PSYCHOSIS.

By BERNARD HOLLANDER, M.D., M.R.C.S., L.R.C.P. LOND.

CAN mental derangement at least in its early stages, be remedied by surgical treatment? The unanimous answer will still be "no," although, as I have shown in my work on "The Mental Functions of the Brain," there are nearly a thousand cases on record in which the disease has been limited in extent and localisation of the symptoms was possible. In my own experience the hypothesis of localisation has helped me to trace in a large number of cases the cause of the morbid change to injury, sometimes apparently so slight as to be neglected at the time and I am of opinion that in all such cases where the symptoms can be localised and an injury can be traced to the same region, although apparently not severe, an exploratory trephining operation should be made as likely to reveal pathological changes.

In the following case the symptoms of severe mental depression and a transient attack of word blindness enabled me to conclude that the disease was originally limited to the neighbourhood of the supramarginal and angular gyri, and that it had subsequently spread downwards over the posterior temporal area, judging by the symptoms of irritability and delusions of suspicion, whereof we have a hundred cases on record in which the disease was confined to this region Finding on enquiry that this part had been actually injured, though there was no outward visible sign, I felt certain that pathological changes would be discovered on trepannation, and advised operation to which the patient, himself an experienced physician, readily agreed. The result, as will be seen, was in every way satisfactory.

J. L. D. M., doctor of medicine, æt. 39, negative family history, no previous illness, received a kick from a horse on right side of chin in 1898, followed by severe frontal headache and neuralgic pains. A year later he had a heavy fall from his cycle on the right side of his head, leaving no visible signs of injury, but followed by hemicrania of great severity, preventing any intellectual work, and by definite character changes. He became emotional, anxious, very depressed, accused himself of unpardonable sins, developed suicidal ideas, grew suspicious, easily offended, irritable and profane, erotic and subject to uncontrollable fits of sexual excess. He suffered also from obstinate constipation, persistent insomnia, and had sensory disturbances in left arm. He sought relief in change of scene by travelling, but to no effect, and his strange conduct frequently led him into difficulties. In Spring, 1905, he had symptoms of word-blindness, and a transient attack of paralysis of right side of face and left half of body. The depression and headache increased and all medical treatment failed to cure him. Believing in the possibility of localisation of mental functions, and hoping that, if his symptoms were localisable, operation would show pathological changes and give relief, he came to London.

On examination, on October 3rd, 1905, he appeared depressed, emotional, showed strong suicidal tendency, and complained of intense headache on right side, and a burning sensation just posterior to right parietal eminence.

October 9th, 1905.—Operation by Mr. William Turner, M.S., F.R.C.S.; chloroform anæsthesia. When the head had been shaved, a scar became visible 2 inches behind right ear, 2 inches long, commencing behind parietal eminence in the situation of the angular gyrus and extending vertically downwards corresponding to the posterior part of the temporal convolutions. A semi-circular flap was made, extending from the tip of the ear to the occipital protuberance. The scar tissues were found firmly adherent to the bone, and had to be forcibly detached. Two trephine openings were made, one 1 inch in diameter, and the other 11-16 inch, just below, and a little behind the other, and joined together. The bone over the angular gyrus was found thickened and hardened, with scarcely any diploe, and the dura mater was adherent to it. When the bone was removed, the dura mater bulged into the opening, but showed no signs of pulsation, although the pulse of the patient at the time was quite strong. On cross incision of the dura mater a stream of clear fluid escaped. The membrane was opaque and thickened, but the brain appeared normal, and on examination the neighbouring parts revealed no pathological changes. The dura mater was stitched together and the periosteum over it, the portion of bone not being replaced. A drainage-tube was kept in scalp-wound for three weeks. Patient during this period had still occasional attacks of depression and irritability, headache and trigeminal neuralgia, but with the closing of the wound all symptoms disappeared.

November 15th, 1905.—Wound quite healed. Trephine openings felt through scalp. Brain felt pulsating beneath, but no protrusion. No tenderness of surrounding nerves. General condition quite well.

February 20th, 1907. Patient reported himself as absolutely well both mentally and physically. The only trouble he had had since the operation a year and a half ago was a severe attack of colitis, which had no relation to the original brain trouble. In his own words, he feels his former self as before the accident in 1898. Moreover there has been no return of the insomnia, the severe headache and the neuralgic pains, from which he had suffered for a period of eight years. The attacks of mental depression, his morbid suspicion and all suicidal thoughts, the erotic feelings, and morbid sexual symptoms have likewise entirely disappeared, and he has resumed interest in all the affairs of life. Surgically the head was perfect in appearance and there was no tenderness anywhere.

THE MEDICAL TREATMENT OF GASTRIC ULCER.

By S. A. ARANY, M.D.,

Consulting Physician at Carlsbad.

The progress and development of surgery made it possible that cases of gastric ulcer and its complications, which have been considered as fatal in former years, are amenable to surgical treatment and recovery. It is undeniable that numberless people owe their life to the skilful and timely intervention of the surgeon's knife, but, on the other hand, there is very little doubt as to the fact that many a surgical intervention, however skilfully performed, has accelerated the patient's death, who, under proper and carefully prolonged medical treatment, could have enjoyed his life and fairly good health for many years to come.

It is not very long since the operative treatment of appendicitis has been introduced, and nowadays its employment has become so universal that medical treatment of that ailment has almost gone out of fashion. I say medical treatment has gone out of fashion, as it is fashionable to recommend a patient who suffers with some symptoms of appendicitis to undergo an operation whether there be immediate necessity or not. Now, in one-third of the cases the surgeon reveals that there was nothing the matter with the appendix; in another the conscientious surgeon may find the appendix in a condition that would have improved with less risk under a proper medical treatment; and finally, in the last third of the cases the surgeon will find that his intervention is really wanted.

I consider it just as grave a mistake to send a case in which medical treatment may be successfully employed under the surgeon's knife as to hesitate with the operation in a case in which medical treatment proved to be of no avail.

I look upon the operation of appendicitis as an *ultima ratio*, and am of the same opinion as far as gastric ulcer is concerned.

The operative treatment of this latter disease is also very much in vogue, and the profession resort to it much oftener than needful. It ought to be looked upon as an *ultima ratio*, and its indications, which I beg to give in the following, deserve to be well considered :—I only avail myself of the surgeon's help: If the patient's life is in danger (1) through fulminating hæmorrhage which cannot be arrested; (2) through perforation; (3) inanition caused either by the fact that the ulcerated stomach cannot retain any food, or by contraction and adhesions

I have lately read a good many papers advocating surgical treatment in preference to medical treatment, and some of the authors even went so far as to state that medical treatment effects only in 25 per cent. of the cases a cure.

This is a very small percentage, indeed, and I cannot account for it under any consideration, unless I am to suppose that the cases referred to have been a collection of unusually severe cases. For well-known clinicians as Leube, Ewald, and Cohnheim's statistics average between 50 and 70 per cent., but as many of their patients comprise hospital patients who cannot always be depended upon, as, after their leaving the hospital, we very rarely know how they were getting on, I beg to quote my statistics, and shall confine myself to cases of whom I hear from time to time, not taking into account such cases as I have seen once or twice in consultation.

The number of my cases is eighty-two, all of whom I have known from two to ten years. Out of the eighty-two eleven have died from the following diseases:—Six died from cancer, after having enjoyed from four to seven years' fairly good health after their treatment for gastric ulcer; two have been operated upon for hæmorrhage twelve and sixteen months respectively after their treatment, and died soon after the operation; one died of perforation, one of diabetes, one of apoplexy.

The remaining seventy-one are enjoying fairly good health; of course, some of them have to live carefully and are in need of some treatment from time to time; but do patients on whom a gastro-enterostomy has been performed do differently? Is it the rule, or is it the exception, that robust health of a normal constitution has been restored by the operation?

If medical treatment is not always successful there are principally three reasons which account for it: (1) Late diagnosis; (2) wrong treatment, under which heading I also comprise treatment which has not been continued for a sufficiently long time; (3) carelessness and disobedience on the patient's part.

The Diagnosis of gastric ulcer is not quite so easy as our text-books have taught us. We have learnt in school that in gastric ulcer the patient complains about violent pain in a localised spot, which occurs almost immediately after meals. The pain is localised in the right hypochrondrium, and is in most cases followed by vomiting. But in what a cluster of diseases do these symptoms appear? Don't we meet them in ordinary gastralgia, nervous dyspepsia, gall-stones, and nephrolithiasis? Doesn't the primary stage of cancer show the same symptoms? But the text-book points out two more very important symptoms, namely, hyperchlorhydria and hæmatomosis. As far as the first is concerned, it is a symptom on which in a great majority of cases we can depend but it cannot be looked upon as a *conditio sine qua non*. According to Ewald's investigations, only in 34 per cent. of his cases was hydrochlorhydria present, whereas in 57 per cent. the acidity was normal, and in 9 per cent. the acidity was found to be sub-normal. Out of my eighty-two cases the acidity was tested in sixty-eight cases, out of which latter in sixty-three cases hyperchlorhydria was established, and in the remaining five the acidity was normal. Hæmatomosis is very often the only symptom which raises the practitioner's suspicion as to the nature of the disease, but it is of quite frequent occurrence that hæmorrhage remains unobserved, as in many cases the amount of blood is very small, and in other cases vomiting does not take place, and the fæces are not paid attention to.

Palpation is but of secondary importance; it very rarely reveals the seat of the ulcer, and owing to the hyperæsthesia of the patients, very often misleads the examiner.

If the text-book doesn't supply us with all the information we want, practise teaches us that a patient suffering from gastric ulcer is very rarely so emaciated and cachectic as a sufferer from cancer; he also recuperates very soon after the acute symptoms have left him, and enjoys, in contrast to the latter, a very good appetite, has a clean tongue, and no nasty taste in the mouth, as is usually the case in dyspepsia and cancer. The fear of food, in contrast to the loathing of food in other stomach troubles, is also very characteristic in gastric ulcer. These and several other little things must guide the practitioner in making a diagnosis, in which case diagnostic errors and ill-effects from medical treatment will not be experienced.

Treatment.—In the acute stage of the disease the patient must be confined to bed for eight or ten days. Absolute rest will best alleviate the pain and hæmorrhage. For the latter I usually employ the ice-bag and make the patient swallow ice. This usually stops the hæmorrhage; should it prove insufficient, a hypodermic injection of 1 c.c. of a 0.1 per cent. solution of adrenalin will in most cases stop the bleeding. Instead of the ice-bag, Leube and others recommend hot applications, which I prefer to use in the second stage of the treatment. Very effective is the administration of magistery of bismuth, first recommended by Matthes, and chiefly advocated by Kussmaul and Ewald. The latter recommends as large doses as 20 grammes per diem; he prescribes the drug in a watery solution to be taken in three portions. The drug is to be taken for a protracted period, and Ewald never noticed any ill effect even if 600 or 800 grammes have been consumed. Matthes' object in administering the bismuth is that the latter forms a coating round the stomach wall and protects it from further injury.

With the same object Cohnheim prescribes his oil-treatment, but the oil is not so well tolerated as the bismuth, although its action on the hyperchlorhydria is undoubtedly beneficial, and has, if anything, a high nutritive value.

I remove the ice-bag on the third or fourth day and replace it by cold compresses which are changed every hour. On the same day, the patient, who has hitherto been fed by the rectum, gets small quantities of milk (preferably cold, boiled milk in the first few days). Or if the latter is not tolerated, bouillon. The amount of milk or bouillon must not exceed two pints per diem in the first three days of alimentation per os, and all we can add is a raw egg or two, which must be well beaten up in the milk or bouillon, and is mostly well tolerated by the patient.

At the end of the first week the patient is put on a mild Carlsbad treatment, as first prescribed by Leube. The latter gives his patients a tumblerful of luke-warm Muhlbrunn, which decreases the acidity of the stomach and also acts as a mild aperient. I prefer to administer the Muhlbrunn fairly hot—about 140° F.—and give the patient three wineglassfuls in the course of two hours. Now the quantity of milk may be increased, and porridge and soft-boiled eggs may be added. As a rule, on the tenth or twelfth day the patient is quite relieved of pain and feels fit to leave his bed. As soon as this stage is reached I increase the amount of Carlsbad water to three tumblerfuls a day, and in cases of constipation add a teaspoonful of Sprudel salts to the first tumbler. This goes on for from four to five weeks, and in the three weeks of treatment I replace the compresses by a termophore, to be employed during the night. Dietary concessions must also be made, as the patient will now possess a good appetite and require some solid food. This, however, must be done very carefully, as many a relapse has been caused by an over-generous diet. I wish to emphasize this fact, as latterly a certain part of the profession in Germany is rather in favour of a generous diet even immediately after the hæmorrhage, intending thereby to increase the patient's power of resistance. How risky this theory is it is needless to explain, and my general rule is to keep the patient on milk, porridge, rice pudding, fish, fowl or greens for at least two months, and even afterwards to advise him to abstain from beef, pork, game, pastry and bread. This latter, in any shape, is very badly tolerated, and should be replaced by gluten biscuits.

For the anæmic condition of the patient I prescribe, in preference to the usual preparations, the Levico water, containing iron and arsenic in such quantities as are easily assimilated by the patient, availing myself of the *stronger* spring, and start with a tablespoonful after each meal (*i.e.*, three tablespoonsful a day); at the end of the first week two tablespoonsful, and at the beginning of the third week three tablespoonsful, are administered three times a day. Then I decrease the dose by a tablespoonful each week, and recommend a fortnight's pause, after which the patient undergoes a second course. This usually suffices to improve the anæmic condition and the patient's nutrition in general, as I advise to take the Levico water in milk.

Now the question of spa-treatment has to be considered, and authors are unanimous in recommending Carlsbad in these cases. It is not only on account of its alkaline-saline springs, which are undoubtedly a very important healing agent in the treatment of gastric ulcer that Carlsbad is to be recommended; the dietary conditions speak just as much in its favour. Patients having recovered from the acute symptoms of gastric ulcer must be very careful as to their diet, and cannot be left at large. They must be under certain restrictions, and must not be given a chance of breaking the rule. The dietary conditions in Carlsbad are just adapted to this, and contribute to a great extent to the excellent results obtained there. For an "after-cure" the patient is best sent to the mountains or to the sea, and if he continues to exercise care it is very unlikely that he will experience a relapse. This is the course I adopted in all of my cases, and the result obtained was more than satisfactory.

CLINICAL RECORDS.

TWO CASES OF "MISSED ABORTION."

By JAMES DUNLOP, M.B., C.M.

Formerly Assistant Physician at Glasgow Royal Infirmary.

Case I.—Mrs. H. F., æt. 22, married on 6th September, 1895, was menstruating at the time. Again altered on 1st October and 1st November, and ceased in December and January, 1896. She believed herself then to be pregnant, and was alarmed when on February 7th she seemed to alter again.

I first saw her on February 8th, and treated her for a threatened miscarriage, but made no *per vaginum* examination. In three or four days the discharge stopped (it was not more in amount than her usual menstrual discharge), and she remained ten days in bed.

She was a rather anæmic and nervous but quiet woman, and engaged me to attend her confinement, which was calculated for August 20th. In March no discharge occurred; but on April 14th a slight discharge again came on, and I was asked to see her. Two days later I called and examined her, as she did not look like a woman five months pregnant. I could not get a very good chance of a bimanual examination, and declared to her that in my opinion she was not pregnant at all, or, if so, that she was certainly not five months pregnant. I prescribed some iron tonic for her anæmia and allowed her up.

I did not see her again until I returned from my holidays in August, on the 29th of that month, when I got the following story: In May and June she had an imperfect menstrual period. In July she altered for one day. On August 19th she was sick and vomiting, and had severe diarrhœa, and a little red vaginal discharge with sore legs, and thought she was going to alter.

About 1 a.m. on August 20th (curiously enough the day of her expected confinement), she had severe colicky pains in her abdomen, and was seen by my Locum tenens (Dr. Archie Young), who gave her a sedative draught. She thought it painful menstruation, but about 12 noon on August 20th she had a miscarriage—the specimen before you, which came away entire and was preserved in spirit for me by Dr. Young.

I was now confronted with the awkward fact that I had in April declared my belief that she was not pregnant. My answer was that she might have become pregnant after that date, as the ovum did not look more than three months size, and now the whole truth came out.

When I told her on April 16th that I did not think her pregnant, and that the irregular menstruation was probably due to her anæmia, her mother took her to another doctor (since deceased), who examined her at the end of April or beginning of May, and likewise declared his belief that she was not pregnant, but advised that she should have no sexual intercourse for some time, and she declares that from April 16th when I saw her, till September 1st, when I got a detailed history from her, she had no marital intercourse (I have no reason to disbelieve her statements), and that the miscarriage of August 20th must have been lying in her womb previous to April. The probability is that the ovum died in February, when she had the first hæmorrhage; but the measures taken to prevent the miscarriage had been too successful, and kept the uterus quiet in spite of the ovum having died.

Case II.—Mrs. J. C., æt. 37, fourth pregnancy, last menstrual period in end of March, 1905. Had some bleeding in the end of June till July 5th, when I was asked to see her, and advised her to remain in bed. She was three weeks in bed, and had a little bleeding occasionally all the time. When it ceased she got up, and saw nothing for two weeks, when she again had a little discharge for two days.

She kept all right till end of October (a day or two ill then). On Christmas week there was a good deal of discharge for three days. It stopped again till January 3rd, when it again commenced, and on January 5th, 1906 (the date of expected confinement), after some hours of pain, this specimen was passed entire. Her breasts got smaller after July, and she went to Millport for a fortnight in September. In October I told her it was a "missed abortion," but advised her to wait on nature bringing on her pains as she had no discomfort and continued at her daily duties up to the new year. I curetted uterus the same day that the ovum was discharged, and she made a very good and rapid recovery.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

EXTENSIVE HÆMATOMA OF THIGH AND LEG.—Mr. PEYTON BEALE operated on a youth, æt. about 14, who had been admitted two days previously suffering from a contused wound on the outer side of the right knee, together with a very extensive swelling occupying practically the whole of the thigh and leg from the apex of Scarpa's triangle to the ankle. It was certain that a wheel of a van had passed over the boy's leg, but there was no evidence to show exactly where or in what direction. There was pulsation in the femora and popliteal arteries, but none in either the anterior or posterior tibial; it was therefore assumed that the poplital had been ruptured just above or at its division into anterior and posterior tibial, and it was also evident that the swelling of the leg and thigh was due to an enormous hæmatoma. Immediately after admission the temperature rose to about 101°, and varied between 100° and 102° for the next two days; this temperature, it was assumed, was due to absorption of fibrin ferment only. On the third day multiple incisions were made in the skin of the thigh and leg; an enormous quantity of dark liquid blood and blood clot was washed out with an irrigator. It was now seen that the whole of the skin was stripped away from the deep fascia of the thigh and leg, and that in the region of the popliteal space there was a considerable amount of blood-clot between the muscles and tendons. Much of the fat of the superficial fascia was necrosing, and where it presented in the skin incisions it was found rolled up into small masses looking exactly like pieces of omentum, such as are found in strangulated omental hernia. As many as possible of these pieces of fat were removed and gauze drains were inserted into each incision. During the following week a very considerable amount of skin sloughed away, commencing with the bruised part on the outer side of the knee. Investigation showed that the sloughing was aseptic except where the contused wound had been, and here there was a localised sepsis, quite small in extent. The temperature remained between 100° and 102°, and later on was gradually getting higher. Some dulness in the region of the spleen was observed, but there was no evidence pointing to any extensive thrombosis in any of the veins. Dr. Dalton, who kindly saw the case, pronounced the chest normal, and was unable to find any distinct evidence of splenic infarct or endocarditis such as might account for the rise in temperature. Mr. Beale remarked that it was at present quite impossible to account for the rise of temperature which was proceeding; there was no evidence to show that any septic trouble was in progress, and he could only conclude that there must be some thrombosis going on in one or more deep veins. It was fairly certain, he said, that the wheel of the van had passed obliquely over the leg, knee, and thigh, and in all probability the popliteal vein as well as the artery had been ruptured.

HÆMATOMA OF THE ABDOMEN.—The same surgeon was asked to see a youth, æt. about 16, who had been operated on by one of his colleagues three weeks previously for suppurative appendicitis; at the operation there had been a considerable amount of hæmorrhage from a vessel in the appendix mesentery; within the last few days a large and firm tumour had been forming in the left side of the abdomen and pelvis and the temperature had been steadily rising, so that it became necessary to explore the abdomen in order to ascertain the cause. On making an incision over the tumour, it became at once apparent that the latter was a very large intra-peritoneal hæmatoma, and from the odour of the blood when exposed it was quite clear it was infected with the bacillus coli, and was just on the verge of breaking down to form a large abscess. The blood and clot were freely removed and the cavity irrigated with hot sterile salt solution, and a large gauze drain inserted. Mr. Beale remarked that many of the cases of suppurative appendicitis in which abscesses were found some weeks afterwards in the left side of the abdomen were caused by suppurating hæmatoma, the infection being the bacillus coli.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, APRIL 12TH, 1907.

MR. CHARLES SYMONDS in the Chair.

MR. LAWRIE MCGAVIN read a paper on

A MODIFICATION OF THE METHOD OF APPLYING PREPARED FILIGREES OF SILVER WIRE TO THE CURE OF LARGE INGUINAL HERNIA IN MALES.

MR. MCGAVIN referred to the difficulty at present experienced in attempting a cure in cases of very large or recurrent inguinal hernia. The frequency of recurrence of hernia, even after operations in skilled hands, and the success met with in dealing with very large abdominal hernia by Bartlett's method, had led him to modify that method of filigree implantation to meet the requirements of hernia in the inguinal region, the object in view being the establishment of an operation which should justify the term "radical cure," and do away with the use of any form of truss. The method he had adopted was that of utilising two separate filigrees, an iliac and a pubic section, of special pattern, for the purpose of defending the whole inguinal region without the sacrifice of the testis and cord. The pubic section was placed upon the peritoneum between the internal abdominal ring and the pubes; the posterior wall of the inguinal canal was then re-made over this by Bassini's method, the conjoined tendon being sutured to Poupart's ligament. The cord was then laid in position, and the transversalis and internal oblique muscles being incised outwards towards the iliac spine, the peritoneum was peeled back from their deep surface; a bed was thus provided for the iliac section which was placed on the peritoneum in such a manner that its inner third lay upon the cord at its exit from the internal abdominal ring, overlapping for a distance of threequarters of an inch the outer end of the pubic filigree. The divided muscles were then united over this iliac section, and the aponeurosis of the external oblique muscle was closed over the whole area as far as the external abdominal ring. The results in all the cases done had been entirely satisfactory. In all of these cases, although quite beyond the scope of the ordinary operation, the method had produced an inguinal region so firm and hard that no truss or support of any kind had been worn since the time of operation, nor did it appear possible that any yielding of the scar could take place. In no case had any complication referable to the presence of the filigree arisen, nor had any of the filigrees to be removed. Pain and discomfort were entirely absent. The author had now adopted the method described as a routine practice in all cases of recurrence, and in all cases of very large hernia.

MR. WALTER G. SPENCER thought that Mr. McGavin's suggestions constituted an important advance in surgical technique. There was no doubt that Bartlett's method was of the greatest value in the management of large abdominal hernia. He related the details of a difficult case of this condition he had recently to deal with.

DR. DOUGLAS DREW congratulated Mr. McGavin on his excellent results. He had used filigrees in several cases of large ventral hernia, and in one case, in a woman, of inguinal hernia. He thought it was not necessary to remove the filigree even if fluid collected and had to be let out. The filigree method was far superior to the device of darning with silver wire that was often adopted, because it was so much quicker.

MR. A. E. BARKER had had no experience with filigree, but considered it might be of great value in bad cases. He had obtained excellent results in a large number of cases treated with the darning method, which, though tedious, had the advantage that one was not beforehand restricted to the extent and variety of procedure to be adopted.

Mr. McGavin, replying to a remark of Mr. Spencer's, said that one advantage of the Bartlett method was that no pad or truss of any form need be used afterwards. As to the size of the filigree, it was better to use one too large than too small, for in the latter instance there was a hypothetical possibility of recurrence.

Mr. W. G. Spencer described a

CASE OF SOLITARY ACUTE SUPPURATION IN THE PSOAS AND ILIACUS MUSCLES,

which occurred in a quite healthy boy, æt. 13. The boy died four days after the onset without being relieved by the incision made the day before. There had been no history of strain; the pus yielded a pure cultivation of staphylococcus pyogenes aureus; the only lesion found after death was the acute suppuration in the right psoas and iliacus muscles; everything else was found normal; there was no distant septic focus. Apart from the cases arising by extension from the uterus, appendix, spine, &c., there were a number on record, in which a slight strain along with some distant septic focus, such as chronic otorrhœa, has occasioned acute and fatal suppuration. In other such cases the distant septic focus has been apparently the cause without any strain, and again in others a strain has proved sufficient without any distant septic focus being revealed at the post-mortem. Both the above antecedents had been absent in Mr. Spencer's case. At present there appears to be no sufficient explanation of cases, which, to judge by the number on record, form a distinct affection.

Mr. Charles Symonds had seen two cases that recovered. He thought the best explanation was that of a general infection. He related a case of this that manifested itself locally in the pectoral muscle though a very slight injury of this.

Mr. Drew said that impetigo was an occasional mode of entry of such infections in children.

Dr. De Havilland Hall related three cases of abscess of muscle, in which there had been great difficulty in diagnosis.

Dr. Essex Wynter said that a number of cases existed in foreign literature. He detailed a case that had run a typhoid course, and which after death had been found to be one of suppurative psoasitis, the organism being bacillus pyocyaneus.

Mr. Gordon Watson likened the cases to acute osteomyelitis. He related two cases of staphylococcic psoasitis occurring during the puerperium, apparently apart from parametritis.

Mr. McGavin discussed the anatomical reasons why the psoas was so frequently selected for these occurrences.

Mr. G. H. Makins and **Mr. Percy Sargent** read a note on the

VALUE OF THE ANTI-COLON-BACILLUS SERUM.

The paper contained a tabular statement of the histories of 25 cases of acute appendical peritonitis treated by injections of a multivalent serum prepared from different strains of bacillus coli communis. The serum had been prepared by Dr. H. H. Dale, of the Wellcome Research Laboratories, at the instance of Dr. L. S. Dudgeon, by the following process. A horse was immunised by receiving fourteen injections of 10 c.c. of seven days' broth culture of eight strains of bacillus coli from cases of puerperal fever, at intervals of seven days; seven injections of 5-20 c.c. of a washed culture of B. coli of unknown origin, at intervals of 10 days; one injection of 5 c.c. of three weeks' growth in lactose broth of seven strains of unknown origin; seven strains separated by Dr. Dudgeon from cases of peritonitis; and eight strains from cases of puerperal fever. In all cases the cultures injected were killed by the addition of 0.1 per cent. chinosol. The twenty-five cases were of the severe type, six of them probably being such that no good effect could be anticipated. Of the whole twenty-five, nine, or 36 per cent. recovered. In all the others improvement followed the use of the serum, toxic symptoms were relieved, localisation of the infecting area was effected, and in cases that died the end was delayed considerably beyond the period usual in the disease. It was claimed that the general improvement in the patient's comfort, the sequence of quietude or sleep, a definite fall in the pulse-rate and temperature (either temporary or continued), and the relief in many cases from vomiting, obtained by the use of the serum justified its more extensive trial. The results appeared to prove that the treatment exerted a definite curative influence on the disease, and that it was in no way harmful or dangerous. A successful case of treatment of an acute infection of the urinary tracts by colon bacillus, under Dr. H. G. Turney, by the use of the serum, and a report on the treatment of three cases of puerperal sepsis by Dr. A. K. Gordon, of Manchester, were also alluded to.

Dr. Leonard Dudgeon thought the serum of very great value, provided it was used early enough. It was without action, however, in the chronic cases with no constitutional symptoms.

LIVERPOOL MEDICAL INSTITUTION.

Meeting Held Thursday, April 4th, 1907.

Mr. Frank T. Paul, F.R.C.S., President, in the Chair.

SUPPURATIVE CHOLECYSTITIS.

Mr. T. C. Littler Jones read a note on suppurative cholecystitis, with perforation of the gall bladder, mentioning three cases under his care which had recovered. In one case the gall stones, after perforation of the gall bladder, had collected in a large perinephritic abscess. This abscess had then opened into the pelvis of the kidney; some of the stones being passed out of the body through the urinary tract, others being removed from the kidney at the time of the operation. Some of the stones were partially encrusted with a deposit of phosphates. The other cases were acute, and in both after the peritoneum had been cleansed, the gall-bladder, the site of the perforation, and the abdominal incision were each separately drained. He attached much importance to early diagnosis, to the method of draining, and to the way in which the gall bladder was stitched to the abdominal parietes, attempting where possible to have the edges of the incision into the gall bladder invaginated in order to facilitate the early closing of the biliary fistula.

BENIGN CYSTS IN LONG BONES.

Mr. Robert Jones and **Mr. David Morgan** read a note upon benign cysts in the long bones and reported four cases, three of which appeared in the proximal phalanx of the index finger and one in the centre of the ulna. After referring to the literature an attempt was made to simplify the differential diagnosis both by differences in X-ray appearances and by other clinical signs.

THE ROLE OF MERCURY IN MODERN THERAPEUTICS.

Dr. Wm. Carter, in his paper on the above subject, did not include any consideration of the employment of the drug in the treatment of syphilis. He thought its use was neglected, and mentioned (1) cases of lymphatic block with enormous swelling, but no escape of fluid through Southey's trocar; (2) peritonitis; (3) of cerebral meningitis, even when suspected to be tubercular; (4) of chronic cardiac disease when death appeared to be imminent—in all of which the free use of mercury either internally or by inunction, and in meningitis accompanied by blistering of the scalp, was followed by relief, and where the organic changes were not such as to render recovery impossible, by recovery. Five cases were mentioned of the control of the delirium which sometimes accompanied rheumatic fever, and of the persistent headache of robust men in whom there was no fever by 5grs. of calomel, even though the purgative effect were less than that produced by other cathartics. He showed three bottles, in one of which bile alone had been kept for ten days; in a second, bile with 2½ grs. of calomel, and a third in which calomel had only been added to the bile after the terribly offensive odour which characterised the contents of the first bottle had been developed; and asked if the freedom from, and correction of, decomposition in the two latter might not possibly help to explain the utility of the drug. Its insolubility allowed it to be conveyed to the duodenum unchanged, where it came into contact with the bile and pancreatic, fluid, over which latter it could be shown to exercise a similarly antiseptic action; and it was not unreasonable to suppose that absorbable toxins were so influenced by it as to be rendered harmless.

Dr. F. H. Barendt regarded mercury as second only in importance to opium, and in cutaneous medicine, apart from syphilides, mercurial preparations were among the most valuable in treating chronic skin diseases. He extolled the use of Unguenti hydrargyri, subchloridi linimenti hydrargyri, and Unguenti hydrargyri iodidi rubri in brawny infiltration as a result of chronic eczema. Internally the alterative action of mercury could scarcely be over-estimated, and he drew attention to its administration in psoriasis after the eruption had been removed by external medication, as a prophylactic against recurrence. He quite agreed with Dr. Carter that it was most important to give exact instructions to the patient even at the risk of stating the self-evident.

Dr. Sumner considered that the intestinal antiseptic property of mercury was indirect, being in a great measure attributable to the increase in the output of bile, which acted as the best of all intestinal antiseptics.

Dr. S. Kellett Smith drew attention to the danger of administering mercurials to feeble old people with septic mouths. In such cases dangerous salivation might ensue from even single doses of calomel or blue pill. He had found phenolphthalein in 8 grain doses a good purgative when there was reason to fear any ill-effect from a mercurial.

Dr. J. Lloyd Roberts referred to the benefit derived from the occasional use of mercurial preparations in the treatment of chronic valvular disease of the heart, where failure of compensation was threatening.

Dr. T. R. Glynn, Dr. Bennet, Dr. E. T. Davies, and Dr. Chas. J. Macalister also took part in the discussion.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

CLINICAL MEETING HELD FRIDAY, APRIL 5TH, 1907.

The President, Dr. Leonard Mark, in the Chair.

The following cases were shown:—

Mr. Aslett Baldwin: Disseminated sclerosis following injury. Tabes with opthalmoplegia and epithelioma of the tongue.

Mr. Laming Evans: True traumatic flat foot due to dislocation between the astragalus and the scaphoid.

Dr. Fry: Endothelioma of the tonsil.

Dr. Rice Oxley: Tumour of the neck.

Dr. F. S. Palmer: Facial palsy in a child of three months. Disseminated sclerosis following injury.

Dr. Chisholm Williams: Lupus of the nose treated by X-Rays. Epithelioma of the nose treated by X-Rays. Recurrent carcinoma of the breast treated by X-Rays.

Dr. Andrew Wylie: Cases of laryngeal paralysis.

The cases were discussed by Mr. Percy Dunn, Mr. D. Armour, Mr. Percy Paton, Dr. G. Alderton, Dr. Buttar, and others.

Cancer in Essex.

Dr. Thresh, Medical Officer of Health for Essex, has reported to the Essex County Council that the mortality from cancer in the county was increasing yearly. He predicted that at the present rate of increase cancer in a few decades would cause more deaths than any other disease. It was decided to ascertain, if possible, the relationship, if any existed, between cases reported and pre-existing cases.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, April 15th, 1907.

Treatment of Uræmia.

Hitherto uræmia has been considered the result of the accumulation in the blood of urea, uric acid, extractive and colouring matter of the urine, &c., but at an advanced period, at least, of the affection, certain substances such as the chlorides are found to be in insufficient quantities in spite of the milk diet, and even disappear completely.

This phenomenon, remarked formerly by Mehu, was the object of close clinical study by Professor Huchard, some time ago, when he showed its importance as regards the prognosis of the malady as it signifies, generally, approaching death. When this fact is apprehended chloride of sodium must be furnished without delay by the mouth, enemas, and subcutaneous injections.

The physician, says Dr. Huchard, should not wait for the ultimate symptoms of uræmia—convulsions, coma, Cheyne-Stokes dyspnœa, as it might be too late; he should be ready to act on the first symptoms—dyspnœa, resisting the exclusive milk diet, and a certain pallor of the integument from vaso-constriction, generalised muscular asthenia attributed too frequently to the milk diet.

The treatment should consist of three irrigations—that of the stomach, the intestines, and the blood.

Irrigation, or washing out of the stomach, is one of the most difficult to make acceptable to the patient. But the attendant must impose his authority and insist on the necessity of the disagreeable operation. Frequently the stomach contains an excess of acid and consequently a quantity of very virulent toxines. The liquid to be employed may be Vichy water or artificial serum.

The intestine should be thoroughly washed out by means of a long soft catheter. Two quarts of boiled water, to which are added 4 drachms of chloride of sodium, should be injected two or three times a day.

Irrigation of the blood is obtained by injecting subcutaneously into the cellular tissue from 6 to 20 ounces of artificial serum, repeated twice or three times a day. These injections increase the arterial tension, favour diuresis, and introduce into the organism a considerable quantity of serum.

Besides the above, which forms the essential and almost exclusive treatment of uræmia, purgatives might be given and sometimes blood-letting might precede the subcutaneous injections. Drugs called "antiseptics" are of but little use.

Treatment of Warts.

The common warts, or dermo-epidemic excresence, are observed in young subjects on the fingers, back of the hands, or feet, and sometimes in other regions of the body. They appear to be due to the presence of the bacterium porri (Cornil); they are auto-inoculable, and multiply abundantly. Any acid is good for their destruction—nitric, acetic, hydrochloric, chromic acids, or the thermo-cautery.

Slight cases may be successfully treated by the application of black soap. A thin layer of soap is spread on a piece of linen and wrapped around the hand each night. In the morning the parts are washed in warm water to remove the soap, and powdered with talc or oxide of zinc.

Where the application of soap causes too much irritation of the skin, it may be replaced by the following preparation recommended by Kaposi:—

Flowers of sulphur, drs. 5.
Glycerine, ozs. 2,
Acetic acid, drs. 2.

This paste is especially employed for the numerous warts of the back of the hands and of the face.

Different preparations of collodion are frequently used:—

Salicylic acid, grs. 15
Collodion, drs. 2

Or,

Corrosive sublimate, grs. 4
Collodion, drs. 2

This latter is very irritating to the skin and should be applied with care.

Juvenile sessile warts form colonies on the face, back of the hands, and wrists. Their treatment require more prudence than the ordinary common warts on account of the extreme irritability of the skin in young subjects. The superficiality of the lesions excludes the employment of caustics. According to Professor Du Castel, applications of black soap or ointments of salicylic acid and resorcin are sufficient, but even these should be suspended as soon as the skin shows more or less redness.

Senile warts are generally observed after age 50, and appear on the face, neck and body. They belong to the class of *noli me tangere* of the ancients, yet it is always good practice to remove them, as they frequently represent the first step towards epithelioma. They should be treated in the same way as the common wart.

The effect of medical or internal treatment of warts is very doubtful and many dermatologists place no confidence in it. However, calcined magnesia in small doses continued for weeks has been said to have been successful.

The tincture of thuja accidentalis has been recommended in 20 drop doses three times a day.

Nocturnal Erections.

Bromide of potassium, grs. 40
Lupulin, grs. 20
Sugar, grs. 10

For one wafer; to be taken at bedtime.

GERMANY.

Berlin, April 14th, 1907.

At the Verein für Innere Medizin, Hr. Boenrainger related a case of

Death After an Exploratory Puncture.

A woman, æt. 80, was brought into the Klinik with a diagnosis of pleurisy. There was cardiac weakness along with bronchitis; examination showed dulness below and to the left, with lessened pectoral fremitus. A pleuritic effusion was suspected, and an exploratory puncture was made by an assistant in the seventh intercostal space, about 8 cm. from the vertebral column. Immediately after the puncture the patient gave a violent cough, expelled some bright red blood mixed with mucus, and died in a few minutes with symptoms of suffocation. The autopsy showed a slight injury of the pulmonary pleura. There was no exudation in the pleural cavity, and only a little blood; the left lower lobe of the lung was empty of air, much reddened and containing blood in the bronchi. The needle on entering had penetrated a dilated vessel and a bronchus, the blood had flowed into this, and the patient in her weak condition had been unable to cough it up, and succumbed to its suffocating effect. The case shows that even an exploratory puncture is not free from danger.

Hr. Goldscheider spoke on

Psycho-reflex Symptoms of Disease.

He said that the reflex seemed to be a quite simple affair. From the data acquired by the physiologist, one had constructed diseases from the reflexes—reflex diseases, reflex symptoms. Now we saw that a part of these symptoms—involuntary expressions without conscious feeling—did not correspond to the degree of the reflex, but that a portion were due to the action of the consciousness. Thus in coughing, a conscious sensation played a part, the tickling excited the reflex of coughing, but the giving way to it depended on the will. It was the same with vomiting. That did not take place after a purely reflex manner, but chiefly and principally by the repugnant feeling that some foods caused. Such processes the speaker designated "psycho-reflexes," since, for example, in the case of cough, the psychic force could keep back the expected irritation. On the other hand, the expected irritation could pave the way for the reflex. The sexual reflexes also were prepared by psychical impressions. The involuntary spitting out from the mouth of objectionable things that had got into it, belonged to this category. These automatic movements were very frequent, like the fidgets of neurasthenics, from any uncomfortable sensation. Further external excitants called up images and recollections, and these led to automatic movements.

This was the case of all external excitants that set up reflexes. Corresponding to this we found, in the case of internal diseases, the state of feeling that was associated with it. Normally, we felt nothing of our internal organs; every sensation, the effect of disease, caused a disagreeable sensation that called up reflexes. So the baulking movement that accompanied washing out of the stomach was not purely reflex, but partly voluntary, with a view of relieving the disagreeable sensations. The tone of feeling was accompanied by other bodily changes as in changes of respiration of the pulse of blood preparation. A series of so-called symptoms were automatic, such as coughing, eructating, &c. Internal excitations were but excesses of reflex preparation.

These considerations threw light on the powerful influence of psycho-therapeutics in bodily diseases.

At the Freie Vereinigung der Chirurgerie, Hr. Röder related some

Cases of Late Death from Chloroform.

Five cases were reported of young people who had previously been healthy, and in which the operation for which the chloroform was given was uncomplicated—four cases of operation for appendicitis, and one for nephrectomy. They all died on the fourth day following the operation. They felt well in the early part of the day after the operation, but, later on, they lost consciousness. The pulse, temperature, and character of the urine were unchanged. This condition lasted until 75 to 90 hours after the operation, when they died. In all the cases the post-mortem examination revealed fatty degeneration of the heart and kidneys. As everything else (sepsis especially) could be excluded, nothing remained to account for the condition but the action of the chloroform. These baneful consequences could not be foreseen. The speaker counselled the use of ether in place of chloroform, or, wherever possible, lumbar anæsthesia.

Hr. Bruno Wolff related a case of

Tuberculous Ulcer of the Labium.

He said that tuberculous infection of the vulva was comparatively rare, and each case still possessed a special interest. The case related was one of tuberculous ulcer of the left labium minus. Even clinically there was a suspicion of the tuberculous nature of the ulcer. It was excised, and the suspicion was confirmed by microscopical examination. Before this, the patient had had tubercle of the sheaths of the tendons of the right hand; she had also suffered from phthisis pulmonum. The speaker believed that the infection had reached the labium by the hæmogenous route. From a study of the literature of the subject he had determined that there was only the very slightest tendency of the disease, ascending to the higher parts of the genital track. In the case under notice, although it had been present six months, it had not ascended beyond the introitus vaginæ. The case supported Baumgarten's teaching, which was to the effect that tuberculosis of the female genital organs spread "as good as exclusively" in a downward direction.

AUSTRIA.

Vienna, April 14th, 1907.

Intestinaal Invagination

At the Gesellschaft, Flesch showed preparation from a child that died from the accident unrecognised during life. The whole symptoms pointed to a perforation at the appendix and the swelling diagnosed as an abscess proved on the post-mortem table to be an invagination of the bowel.

Infantile Tetany.

Escherich exhibited a child with abnormal sensitiveness to all stimuli, mechanical and electrical. For two months the child had suffered from general disturbance in the alimentary canal, vomiting, loss of appetite, and emaciation. From time to time typical croup was present, stridant inspiration with cyanosis. If the finger were drawn across the cheek the facial phenomena of spasm and paralysis would be induced. The same contractions would occur by tapping with the fingers or applying a feeble electric current to any part of the body.

Finkelstein has affirmed that if a milk diet be avoided in these cases they will immediately recover, which has not been the fortunate result in this case; on the contrary, the child was worse as soon as the milk diet was withdrawn. This is not to be wondered at, as a large number of children fed on farinaceous products have become afflicted with tetany as well as those fed on milk.

To determine whether this facial phenomenon was due to the mechanical stimulus or some morbid change in the reflex function, the face was painted with a 10 per cent. solution of cocain to anæsthetise the part, and apply a feeble current to the body; in spite of this precaution the facial phenomenon was as great as ever.

Spieler confirmed the worthlessness of the milk abstinence treatment as a barren illusion, and cast doubts on many of the authors who had obtained miraculous results from the use of phosphated cod liver oil. He always found the earliest symptom to be anod opening contraction to be greater than the anod closing contraction.

Pirquet thought the difference between the anod opening and anod closing was not so much to be relied on as the absolute amount of the anod opening below 5 milliamperes. The question arose whether the anod closing was before or after the anod opening.

Spieler replied that his experience was that the anod opening was always first, no matter how small the amount.

Neurath thought the question to decide was, what relation existed between the increased motor power and electric stimuli in these tetenoid, or spasmophile children. He had made a rough examination of a large number of children, and found 60 per cent. to 70 per cent. had this facial phenomenon produced by the current. He attributed this phenomenon to a respiratory defect, probably a respiratory poisoning. Pirquet objected to this assertion, as he had examined 500 healthy children and found the facial phenomenon present in 3.8 per cent. only.

Tick Fever.

Fraenkel showed a microscopic preparation with the spirillum of tick fever, produced in the human subject by the bite of the Ornithodorus monbatus or the Argus miniatus. The spirillum could be seen moving round the corpuscle and sometimes disappearing. The infection can be easily transferred to mice, rats, and monkeys, the latter taking ill on the second day after inoculation, and the spirillum appearing three or four times in the twenty-four hours.

Infection by Lymphatics.

Weleminsky has been experimenting with injections and contacts in the hope of discovering the path of entrance. He assures us that the infectious germ passes from gland to gland, when applied to different parts of the body and to the bronchial glands, where it enters the blood circulation and produces general infection. The whole lymphathic system is capable of taking up the poison.

It is said that the petition to the council of the Royal College of Surgeons, asking that women should be admitted to the examinations, has been signed by about 3,000 members.

CONTINENTAL HEALTH RESORTS

KREUZNACH.

Bad-Kreuznach, of far-spread and well-merited renown, and easily accessible by Flushing, Hook of Holland, and other routes, is picturesquely situated in the Nahe Valley; and in the world-wide famous neighbourhood of Bingen-on-the-Rhine, the most charming section of the Rhinelands. Its altitude above sea level is 105 metres, and it enjoys a tonic and delightful atmosphere, with a bracing air, coming over well wooded hills, from the Hunsruck Mountains, and largely impregnated with ozone from these forests, and especially from the neighbouring salt works, where the celebrated Kreuznach-salts and Mother-lye are crystalized from dripping brine-water in the Gradirhauser evaporating sheds. These ten Saline Springs are now owned by the Kreuznach Municipality, and under admirable management. There are also Thermal Springs in Kreuznach itself, of which the strongest mineralized one belongs exclusively to the popular Oranienhof Hotel, formerly the summer palace of Princess Mary of Orange. Another famous Spring is the Elizabeth-brunnen, the waters of which are drunk on an island in the extensive Kur-Park, amidst grand old forest trees. In the Kur-Gardens excellent bands play three times daily, during the summer season; the Symphony Concerts of Kreuznach ranking amongst the finest musical entertainments of Germany. During this season are also theatrical performances, balls, races, floral contests, fireworks, children's gymkana, &c. The vicinity affords a variety of excursions, hunting and fishing. So that a sojourn at Kreuznach is in many ways very enjoyable.

The Mineral Waters of Kreuznach, containing bromides, iodides, lithium, chlorides, barium, magnesium, and radium, have for many years proved highly beneficial in treatments for gout, rheumatism, obesity, tabes, chronic catarrh, heart, eye and ear affections, feminine complaints, skin troubles, cancerous growths, fibroid tumours, rickets, bone and joint diseases.

The Saline waters are conducted from the Springs to several baths and hotels. Attached to the Kurhaus is a spacious *Inhalatorium*, having ingenious apparatus for evenly diffusing the air. Carbonic acid, electro-light, mud immersions, and other approved therapeutic appliances are also used. The vapour baths here differ from the ordinary Russian and Turkish baths elsewhere, in that the hot air passing through mineral waters becomes charged with their free carbonic acid gas and other medicinal qualities The Terrain, Kefyri, Whey and the Grape "cures" are likewise in vogue at Kreuznach.

Sanitation has careful attention; and what is not so usual as might be desired at many Continental Resorts, Kreuznach gives its visitors an abundant supply of the purest drinking water.

Patients suffering from Debility after severe illness (especially after malignant Influenza), and also those suffering from Anæmia or susceptible to Apoplexy and other diseases connected with the central Nervous system, are considerably helped by a course of the Waters at Kreuznach, where they find everything conducive to convalescence and restoration to health.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Edinburgh Medical Lecturers and the Dublin University.—The following memorial, signed by all but one of the lecturers of the School of Medicine of the Royal Colleges, has been forwarded to the Chief Secretary for Ireland:—"We, lecturers in the School of Medicine of the Royal Colleges, Edinburgh, most respectfully submit that we profoundly regret the proposed legislation in connection with the University of Dublin. As teachers in a great medical school, and living in an influential centre of education, we regard the proposed compulsory incorporation of widely separated colleges under a single university as fatal to the best interests of any teaching scheme. The historic associations of Trinity College, the great men it has given to the world, its present high and liberal standard of education, command the deepest respect throughout the British Empire. We should deplore, as a national calamity, any legislation which would cancel the charter of the University of Dublin, as it would inevitably diminish the prestige which justly surrounds the degrees conferred by that University."

EDINBURGH UNIVERSITY GRADUATION CEREMONIAL.—More than ordinary interest was manifested in the spring graduation ceremonial, which took place on April 12th, on account of the presence among those on whom honorary degrees was conferred of several of the colonial Premiers—the Hon. Sir Joseph George Ward, K.C.M.G., Prime Minister of New Zealand, the Hon. Frederick Robert Moor, Prime Minister of Natal, and the Hon. Leander Starr Jameson, M.D., C.B., Prime Minister of Cape Colony. Of the last, Sir Luddon Grant said:—"As a pioneer of empire, the British South Africa Company may challenge comparison with the most famous chartered companies of yore, and this is due mainly to the genius and force of two striking personalities. The one is the late Mr. Cecil Rhodes, and the other the illustrious native of Edinburgh, who now stands in our midst. Before he turned his hand to the great work with which his name is now specially identified, Dr. Jameson, I should remind you, had risen to the summit of the medical profession in South Africa, and it is interesting to recall that amongst other distinguished patients who benefited by his skill and advice was the late President Kruger. In the late war Dr. Jameson rendered distinguished services, and though scarcely seven years have elapsed since his entry into the public life of Cape Colony, his brilliant gifts and dauntless energy have carried him again to the foremost position." Among other recipients of the degree of LL.D. were two members of the medical profession—Professor D. J. Hamilton, Aberdeen, and Sir John Tweedy, late President of the Royal College of Surgeons of England. At the conclusion of the graduation ceremony a distinguished company was entertained to luncheon in the University Union, and in replying to the toast of his health, Dr. Jameson said that judging from what he knew of the opinion of the ministers of the other South African colonies, many years would not elapse before they had one Prime Minister to respond for the whole of South Africa. He praised the University Union as a club in which students from all parts of the Empire were mingling, and said that when Mr. Rhodes conceived the idea of establishing scholarships, his hope was that the Rhodes' scholars should be missionaries of empire when they got back to their own lands, having absorbed the culture which they got in this part of the empire. That great idea really came to Mr. Rhodes from the experience of the young men from South Africa who went to Edinburgh University.

ABERDEEN GRADUATION CEREMONIAL.—On the 9th of April the University of Aberdeen held its Spring graduation ceremony, and conferred the degree of LL.D. on Dr. T. S. Clouston, Dr. Campbell Brown, University College, Liverpool; Mr. W. S. Bruce, the meterologist and explorer, Professor Hale, Chicago, and others. Dr. Clouston's name, said the promoter, was known beyond the limits of the medical profession of our country and of our language. No man had more successfully ministered to minds diseased. He had educated the profession and the public mind into juster and truer conceptions of the causes of mental disorder, of responsibility, and of their remedies, by his many writings. As a witness he inspired a confidence not always associated with the evidence of experts. It was not the least of his praise that he had set out lawyers and judges free from some errors and prejudices which rested partly on ignorance, partly on a too rigid metaphysic. As a philanthropist and reformer of the law he more than deserved the degree.

EDINBURGH INFIRMARY AND LORD LISTER.—The managers have sent to Lord Lister a memorial conveying their respectful and cordial congratulations on his attainment of his eightieth birthday. They recall with gratitude his valuable and efficient services as a member of the surgical staff, and can never forget that it was while holding the chair of clinical surgery that he carried on that famous work which has formed an epoch in the history of medicine, has revolutionized surgery, and conferred untold benefits on mankind. The managers desire to assure his Lordship of their continued interest in, and regard for him, and their earnest hope that every blessing may attend him in the time to come.

BELFAST.

THE HEALTH COMMISSION.—The sittings of the Belfast Health Commission during the past week have been chiefly devoted to the hearing of medical evidence. Four gentlemen, all ex-presidents of the Ulster Medical Society, spoke on behalf of the Society and the medical profession generally. They were Sir John Byers, Professor Lindsay, Dr. Calwell, and Dr. Dempsey. Sir John Byers occupied most of two days, and entered fully into all the health problems of the city. After dealing with the general death rate he took up that from typhoid, and infant mortality, showing how these were far too high in Belfast. He was inclined to blame the water supply for our constant typhoid, and advocated the placing of the water supply under the control of the Corporation, instead of its being under a separate board, as at present. The frequent flooding of certain parts of the city and the pollution of the Lough by sewage having been disposed of, the witness entered very fully into the question of the milk supply, with which he is specially competent to deal, as he has devoted much attention to it for years past. Briefly he advocated a very full inspection and control by the Corporation as the only way of safeguarding the people, and especially the children, from one of the most frequent sources of infection. The position of the dispensary officers, who are the medical officers of health in their districts, Sir John Byers did not consider satisfactory—that is, as regards their relation to the municipal authorities. There is at present a very defective system for transmitting to the latter particulars of the cause of deaths. On the second day Sir John Byers dealt with the effect of emigration on the death rate in Ireland generally, and then on Belfast in particular. He showed that large numbers of young people come into the city from the country, and ought to lower the death rate of the city rather than otherwise. Consumption and its relation to the textile manufactures of Belfast then came under notice. While flax spinning undoubtedly contributes to the prevalence of tubercular disease, the witness was inclined to attribute more blame to the insanitary houses of the working classes and the general want of cleanliness in them. With some remarks on the provision for the treatment of consumptives, and on the sanitary state of the schools of the city, the witness concluded his lengthy and important evidence, and was thanked by the chairman of the Commission, Colonel Harding. Professor Lindsay took up first the want of particulars of many important matters in the annual health reports of the city—a matter which has been commented on year after year for some years past in this column. No particulars are given regarding overcrowding, dairy prosecutions, flooding, the working of the main drainage, the pollution of the Lough, and many other important matters. He then entered fully into the question of phthisis, of which, he said, the main causes were undoubtedly overcrowding, bad air, and bad ventilation. The accommodation for the treatment of these cases was most insufficient, and isolation was most essential for the safety of the people. Dealing with the influence of the flax trade on tuberculosis, Professor Lindsay said that he would draw the conclusion that while the staple trade contributes to our phthisis rate, it does so probably only to a moderate extent. Dirt he believed to be an enormous factor, and one of the things needed in Ireland was a propaganda of cleanliness. Regarding the treatment of the disease, he said that an ideal method would be a threefold one—a sanatorium for incipient cases, a tubercular colony to deal with cases that were fairly advanced, and an institution for incurable cases. In the colony the patients would do some light work, such as gardening. Typhoid was then considered, and the causes were given by the witness as impure water, pollution of the soil, and dissemination of fæcal matter by careless persons. The theory of its spread by dust he thought was disproved. As regards Belfast he believed there were permanent causes at work in the state of the soil and the character of the houses, and these were reinforced by the pollution of the water supply, causing epidemics. After dealing with the inspection of schools, Professor Lindsay summed up with several recommendations, the first of which was that Dr. Bailie, the lately appointed Medical Officer of Health, should get a thoroughly trained assistant, a man who had devoted his life to public health work in some other large city. This, of course, is the type of man the medical profession urged the Corporation to appoint when the post was vacant last year. Their opinion was ignored, and Dr. Bailie, a general practitioner, lately a member of the Corporation, appointed, hence this Health Commission. The other points were clearing of insanitary areas, increased hospital accommodation, and especially further hospital and dispensary provision for phthisis. Dr. Michael Aitken gave evidence as to the sanitary condition of the working class houses in the city, as observed by him in a general practice. Dr. Dempsey, who has been in practice in Belfast for thirty-three years, and is senior physician to the Mater Hospital, said that he agreed generally with the evidence of Sir John Byers and Professor Lindsay, so would not go over the same ground. He spoke specially of the necessity for more open spaces, and of the objectionable matter often used to fill in low land for building purposes. The drain-testing he also regarded as most unsatisfactory. He urged the teaching of hygiene in schools, saying it would be more useful than French or German. When asked if he would prefer it to the teaching of Irish, he declined to commit himself. Dr. Calwell began his evidence with a quantity of statistics to prove the many and glaring deficiencies of the Belfast health reports, supplementing Professor Lindsay's evidence on this point. He then dealt with the questions of typhoid and consumption, and gave figures to compare Belfast with other cities. He agreed with Professor Lindsay as to the treatment, and said he had great hopes of the result of teaching cleanliness in the schools. He had no doubt as to the danger of typhoid infection from the Belfast water supply, but he also attributed some cases to milk and some to shellfish infection.

Cerebro-Spinal Fever.—The number of cases of this disease notified during the past week was 22, a slight falling off from the week before. The total number now reaches 263, with 177 deaths. There have been several deaths of adults, including one of a nurse who had taken a patient from his home to the fever hospital, and a police constable, who died after a few hours illness.

LETTERS TO THE EDITOR.

THE QUACK MEDICINE TRADE.

To the Editor of The Medical Press and Circular.

Sir,—The following paragraph appears in *The Times* of April 8th:—"Mr. Thomas Beecham, the founder of the well-known pill business at St. Helens, Lancashire, died at his residence at Southport, on Saturday. A native of Oxfordshire, Mr. Beecham went first to Wigan and afterwards to St. Helens where he remained for 40 years. At both place he sold pills at a stall in the market-place. Later it is estimated that the firm spent £120,000 a year in advertising. Mr. Beecham retired from business 13 years ago, and went to Southport, where he built Wychwood. He took no part in public life." This notice is printed in the largest type, and occupies the most prominent position in the leader page. The significance of this needs very little comment for the medical reader. No doubt papers which have been receiving a share of the £120,000 a year will publish complimentary obituary articles, and will explain why the distinguished deceased gentleman "took no part in public life," for which his talents, as *The Times* seems to suggest, so well fitted him. Is it not time that the medical profession took steps to expose the character of the claims to public honour which seem thus to be put forth for the proprietors of quack medicines. Does not this notice in the leading journal make it evident that it will be impossible to bring about the desired exposure save through th medium of a Royal Commission—the method which you are now persistently advocating?

I am, Sir, yours truly,

Henry Sewill.

April 8th, 1907.

THE MILK SUPPLY—MILK AND TUBERCULOSIS.

To the Editor of The Medical Press and Circular.

Sir,—As I anticipated, the writer of the article to which I called attention in my letter of the 6th inst., is unable to refer me to a solitary instance in support of his belief in the communicability of tuberculosis by means of milk. I protest against the doctrine on the following grounds:—The late Sir Richard Thorne-Thorne told us, in his Harben Lectures on "Consumption," that while tuberculosis in the adult had diminished 50 per cent. in the last quarter of a century, it still claimed a large, but also diminished, number of victims amongst children, and he attributed the latter to the fact that children are fed so much on milk.

I have very carefully looked into this question, and have already given the result in my paper on Bacteriology. But it seems to have been overlooked, and will therefore bear repetition.

In 1892 Mr. R. Henry Rew instituted an enquiry into the statistics of milk consumption in various districts. He presents the results in tabular form, which I now abbreviate in order to save space, omitting decimals. The table is drawn up on the basis of five persons in each family, and was published in the *Journal of the Royal Statistical Society*, April 26, 1892.

	gallons per annum.
West End of London (per family of 5) ..	34
North of London	29
Manchester	24
,, Middle-class District	13
,, Working-class	9
East End of London	3

"With reference to the last," he says, "it is necessary to explain that the figures are based on the fact that a gallon of milk is divided, on an average, into *thirty-seven* portions. . . . I have assumed that such family consumes one of these portions every morning and evening. It will be seen that even on this assumption, the consumption per head is infinitesimal, and it reveals, incidentally, a significant fact in connection with the dietary of the poor."

It is a fair assumption that what applies to the East End of London, applies also to all the poorer districts of London what are commonly called the "Slums."

Now I assume that no one will contest the statement that *Tabes Mesenterica*—the disease in question—occurs chiefly, if not wholly, amongst the children of the poor and indigent. At least I have never seen a case amongst those of the well-to-do. The disease is essentially one of real nutrition, and is curable by nutritious diet, of which milk, not sterilised, should form an essential part.

Why does this form of tuberculosis attack the digestive tract rather than the pulmonary? Because, said the lecturer, the tubercle bacillus gains entrance through the stomach. I venture to affirm that not a solitary case has ever been put on record in which this disease has been thus communicated. Rather, it is the *want* of milk.

I am not prepared to contest the statement of the writer of the article, in his reply, that "it is now scientifically proved that 'live' tubercle bacilli can be conveyed in milk." It is probably correct. But I cannot accept the deduction that "if milk thus infected be swallowed by children, there is a reasonable certainty that, by the law of averages, cases of tuberculosis *must* result." It is this habit of assumption that I complain of, and must resist.

In the paper referred to I have put on record a very striking case of a large tuberculous tumour of the omentum, with deposit of tubercle in the parietes, absolutely cured by abdominal section, and the subject is now the "picture" of good health. The subject, æt. 16, was the daughter of a farmer, and a thorough-going believer in the microbic theory would, no doubt, at once point to this case in support, or even proof, of his contention. But the singular fact remains that this young lady was the only one (of a healthy family) who could not be prevailed upon to take milk, *or* cream, in any form.

I am well aware "of the extreme difficulty that attends the positive identification of the agency of the conveyance of specific zymotic infection not only in 'many' but in all 'cases.'" It is because of this difficulty that I plead for less persistence in cramming this doctrine (to use homely language) "down our throats."—I am, Sir, yours truly,

GEORGE GRANVILLE BANTOCK.

14, Upper Hamilton Terrace, London, April 12th, 1907.

OBITUARY.

FERDINAND A. PURCELL, M.D., M.R.C.S.

WE regret to have to record the death of Dr. Ferdinand A. Purcell, who died at his residence, 7, Manchester Square, London, W., in his seventieth year. He was for many years Surgeon to the Cancer Hospital, Brompton, and was the first surgeon in Great Britain for perform vaginal hysterectomy for cancer of the uterus. He was a member of the Council of the Medical Defence Union, and a regular attendant at the meetings, taking a lively interest in the welfare of the Society. He was, moreover, a Foundation Fellow of the British Gynæcological Society, and contributed several papers of interest and importance at their meetings. Dr. Purcell was author of "Cancer, Its Allies and Other Tumours," and contributed several papers on cancer and allied subjects to THE MEDICAL PRESS AND CIRCULAR, and other medical periodicals.

WILLIAM SNEDDEN, M.D., L.R.C.S.

DR. SNEDDEN's death took place with tragic suddenness on the afternoon of April 11th. He had been in apparent health, and had only complained of being slightly out of sorts on the morning of his death. He participated in the spring competition of the Glasgow Medical Golf Club in the forenoon, and after lunch played a few holes against Dr. Edwards, Glasgow, when, as he reached the third green he dropped and immediately expired. Dr. Snedden was a Glasgow graduate, and had practised in Beith for over thirty years. He was a J.P. for the county, and a surgeon-colonel in the volunteers. A first-rate shot, he represented Beith Company in many of its matches. Among other appointments he was medical officer to the local authority, and had a large practice. He was greatly esteemed in the neighbourhood, and his loss is much regretted. He was a widower, and leaves two sons and two daughters.

EDWARD T. D. HARRISON, F.R.C.S., L.S.A.

WE regret to announce the death of Dr. E. T. D. Harrison, F.R.C.S., of Clifton, formerly of Welshpool. Dr. Harrison, who died in his 88th year, was descended from one of the oldest families in Montgomeryshire. He qualified as a Member of the Royal College of Surgeons as long ago as 1842, and proceeded to the Fellowship in 1883. For many years he was in busy practice at Welshpool, and he was an enthusiastic volunteer. Dr. Harrison, who retired from practice about a quarter of a century ago, and then removed to Clifton, was one of the members of the original Commission of the Peace for Welshpool, and on four occasions was mayor of the borough.

H. HOWELL PARRY, M.R.C.S.

WE regret to announce that Dr. H. H. Parry, of Bontnewydd, near Carnarvon, died with alarming suddenness on April 4th. He returned from Carnarvon in the course of the afternoon in his usual health, and a short time later a lad in his employ found Dr. Parry prostrate on the ground and wholly unconscious. Medical aid was summoned from Penygroes and Carnarvon, and examination showed that he had had a paralytic stroke. The illness proved fatal, and the sad event caused a profound sensation in the neighbourhood, where the deceased had resided for a considerable period. He was one of the oldest medical practitioners in that part of North Wales, and extremely popular among his neighbours. He had studied medicine at Queen's College, Birmingham, and qualified, M.R.C.S., in 1862. Settling at Bontnewydd, he became surgeon to the Alexandra and other slate quarries in the neighbourhood, and gained large experience in accident cases.

SPECIAL ARTICLE

PLAGUE IN NEW SOUTH WALES.

THE Board of Health of New South Wales has issued as a Government publication (*a*), a full account of the outbreaks of plague in the State in the year 1905. The various outbreaks at Sydney, at Newcastle, and on the Clarence and Richmond Rivers are dealt with respectively by Dr. Ashburton Thompson, Dr. Robert Dick, and Dr. R. J. Millard. Careful attention is given in each case to the relation of plague in man to plague in rats, and to the various epidemiological conditions which governed the outbreaks.

The most valuable part of the volume, however, is the appendix containing Dr. Ashburton Thompson's views on the epidemiology of plague, as presented in an address to the Congress of the American Medical Association held in Boston last summer. He points out that the opportunities of studying the subject have been greater in New South Wales than elsewhere, since nowhere else in modern times has there been an epidemic of plague in a community of civilised and intelligent white men.

His main conclusions he states in four propositions:—(*a*) Plague owes nothing of its epidemic form to communication with the sick; (*b*) Plague in the rat is a necessary factor in epidemic plague; (*c*) A living intermediary is necessary to communicate the infection from rat to man; (*d*) That intermediary must be the flea in one or more of its many species.

With regard to the varieties of rodent which may act as carriers of plague, Dr. Thompson found plague not only in the grey rat, but also in the black rat, the Alexandrian rat, and the grey mouse. The number of plague rats found on infected premises was usually small, from three or four to half a dozen, but in a few cases very large numbers were discovered, *e.g.*, from fifty to one hundred and eighty.

Dr. Thompson argues strongly in favour of the view that fleas are a necessary intermediary between the rat and man in the transmission of plague. Having combatted the idea that plague can be inoculated by accidental contact between an infected object and an abrasion of the skin, he goes on:—"The result of continuous examination of our rats has

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(*a*) "**Report of the Board of Health on Plague in New South Wales, 1905.**" **Sydney: W. A. Gullick. 1906. 67710. 8s.**

been to show us that rat plague always coincides in place with plague in man, and in time always precedes it; but the presence of plague rats was not always attended by plague in man. If, however, infection of the rat be a necessary condition of epidemic plague, a closer connection between plague rat and man should be traceable. Accordingly, house association between the two was often discovered. But often, on the one hand, it could not be discovered; and, on the other, often when it was discovered it was not attended by cases in man. Further, the commonly accepted observation that actual contact with the plague rat is unnecessary to infection of man was corroborated, and as a matter of observation was learned to have occurred very rarely. Moreover, such contact when it had occurred, was generally not followed by infection; and that, it will be observed, was in accord with a very extensive laboratory experience which shows that the many persons who now habitually dissect plague rats invariably escape infection, provided they do not wound themselves with their scissors and needles. The contradictory character of these several observations stands forth. The unavoidable inference from them is that if epizoötic plague is a condition precedent of epidemic plague, yet the plague rat cannot be the only factor concerned."

As regards seasonal incidence, plague has been found to be most prevalent in both man and the rat, in the autumn. This is also the season of fleas.

"It is well known that different species of fleas have their proper hosts, and prefer them to other kinds of animals. Human fleas do not *infest* rats, and rat fleas do not *infest* man; were it otherwise the rule, perhaps, would be to find multiple cases in plague-houses instead, as is the case, of finding only one person infected out of several equally exposed to the danger. Why, then, should it be supposed that rat fleas will leave the rat for man? In 1905 Liston made the suggestion that they remain with their proper host as long as it is available, and when it dies, or is withdrawn, proceeds to seek food from the next nearest animal. Rats having died of plague in a public garden at Bombay near a cage of guinea pigs, presently the latter began to die of plague; and on searching the survivors he was able to collect from them a good many specimens of *P. pallidus* (P. *Cheopis*, Roths.), which in Bombay and in Australia is the common rat flea, although guinea pigs in India (and in Australia) seldom possess any fleas at all, and when they do so harbour only one or two specimens of *Ct. serraticeps*. He observed also transfer of the common rat flea from rat to man. His attention was drawn to people who had been expelled from their house by the attacks of fleas. It appeared that on the 6th or 7th of a month the rats in the house had begun to die of plague; on the 11th fleas became so troublesome that the people had to sleep out on the verandah; on the 17th one of them fell ill with plague, and after him another. On the 20th Liston collected thirty fleas on the bodies of the remaining persons. As many as fourteen of them were of the species of *P. pallidus*; yet among 246 fleas collected by him from the clothes of various persons under ordinary conditions, but a single specimen of *P. pallidus* was found. May this indicate the reason of our observation that man takes plague only after rats have died of it?"

The Report deserves the careful attention of everyone interested in epidemiology.

BY order of Princess Christian, the president, a special general meeting of the Royal British Nurses' Association was summoned "to consider recommendations with reference to the grant of a diploma in nursing by the corporation." The meeting was held on Friday, April 12th, in the rooms of the Medical Society of London, 11, Chandos Street, Cavendish Square, W.

REVIEWS OF BOOKS.

MARSHALL ON SYPHILOLOGY AND VENEREAL DISEASE. (*a*)

WHAT have English surgeons been doing for the last twenty-five years with regard to venereal diseases? Evidently nothing; for, according to Dr. Marshall, "during that period no book has been published in England dealing in a systematic manner with syphilis and venereal diseases." Therefore he steps boldly into the breach to make up by his present work for the shortcomings of his countrymen, and so well does he do this that we cannot help feeling that we should be more interested in the book if it contained a little more of Marshall and a little less of other people. Most writers on venereal diseases (even twenty-five years ago) commence with historical notices in reference to the antiquity of syphilis. Dr. Marshall follows this lead, and gives his reader a capital peep into this nebulous subject. His second chapter, "Generalities," gives us nothing new; surely, however, alcohol cannot be the "born enemy of syphilis," but rather the "born friend," as it encourages the disease in every way. Dr. Marshall contradicts himself when he says: "Syphilis is in most cases contracted from a *sore* in the genitals . . . by kissing people with syphilitic *sores* in the mouth," as on the preceding page he rightly asserts, "the mucous patch is probably the lesion which is responsible for most syphilitic contamination." We heartily agree with Dr. Marshall when he says: "The prognosis [of syphilis] . . . depends chiefly on the duration of treatment." The chapter on the pathology of the disease is interesting, especially the few words on parasyphilis and the experimental researches for the spirochæta pallida. The next two chapters, "Chancres" and "Syphilides," add nothing to what is already known on these subjects. Many will be found to doubt the dictum in Chapter VIII. that "Syphilis is a powerful predisposing cause to tuberculosis." Sixty-five pages are taken up with two exhaustive chapters, one on syphilis of the nervous system and the other on parasyphilis or quaternary syphilis of the nervous system; both of these well repay perusal. In dealing with the general treatment of syphilis we are glad to see the author gives his own scheme of treatment, which certainly is an excellent one, though it necessitates having the patient under observation for seven years. Hereditary and congenital syphilis, in Chapter XVI., systematology of Heredo-syphilis and syphilis of the third generation, in the following chapters are all set forth in a concise and readable style. Two short chapters only at the end of the book are devoted to gonorrhœa and simple chancres. Undoubtedly a most useful work; for if Dr. Marshall has not given his readers as much of his own experience as they might desire, he has undoubtedly furnished them with a magnificent compilation of the opinions of (mostly foreign) experts, most useful for reference. The book, too, is in a very handy and suitable form, as its size is very convenient and the printing is irreproachable.

THE CHEMICAL INVESTIGATION OF GASTRIC AND INTESTINAL DISEASES (*b*).

"THE practice of medicine is becoming what it was long ago, but injustly called a true science and art." (*c*) The preface to Harley and Goodbody's book opens with a somewhat similar remark. In both statements the allegation is made that the practice of medicine in its entirety is not scientific, nor can it be said that

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(*a*) "Syphilology and Venereal Disease." By G. F. Marshall, M.D., M.Sc., F.R.C.S. Pp. vi., 495. London: Bailliere, Tindall and Cox. Price 10s 6d.

(*b*) "The Chemical Investigation of Gastric and Intestinal Diseases." By Vaughan Harley, M.D., etc., Professor of Pathological Chemistry, University College, London; and Francis W. Goodbody, M.D., etc., Assistant Professor of Pathological Chemistry, University College, London. Pp. viii., and 261. London: Edward Arnold. 8s. 6d. net.

(*c*) Simon: Clinical Diagnosis.

the accusation is without foundation. Treatment must of necessity be tentative and empirical where the cause of the disease is unknown or but imperfectly understood. It is unfair, however, to lay all the blame for lack of science in treatment at the door of the clinician. He can only be justly found fault with when he fails to take advantage of the resources which scientific investigation placed at his command.

It is the immediate province of pathology to discover causes, and of both therapeutics and pathology to find out remedies. To do either requires an accurate appreciation of the factors upon which the normal functional activity of the diseased organs depends. Thus the physiologist has also to share in the responsibility for the carrying out of rational treatment.

Nowhere in the whole range of therapeutics is an accurate knowledge of function more necessary for scientific treatment than in diseases of the alimentary canal. Consequently the question is here a very pertinent one: Have we accurate knowledge of the digestive processes in the alimentary canal in health?

Physiologists do not claim that everything concerning the functions of the organs of digestion is within their ken, but nowhere has more rapid progress been made of late years than in this field. Witness the all-important results of the investigations initiated by Ivan Petrovitch Pavlov, and carried on for the past fifteen years under his guidance in the St. Petersburgh Institute for Experimental Medicine. These are of the greatest moment in themselves, but they are not less valuable on account of the stimulus they have given to workers in other lands to labour in the same field. Of these latter none have accomplished more fruitful achievements than some in our own country, notably Starling and his fellow workers, colleagues of the authors of the book under review.

But it takes time, often long periods of time, for knowledge acquired in the laboratory to become reflected in the practise of clinical medicine and surgery. This is in part due to a certain degree of conservatism in applying the results obtained on animals to the human subject. But it is to be feared that its chief cause is a lack of sufficient inter-communication between the representatives of subjects closely inter-dependent upon one another. To take the extremes in the series just mentioned the physician is too little of the physiologist, the physiologist too little of the physician. It is the exception rather than the rule to find physicians in this country with sufficient knowledge of technique to carry out adequate laboratory investigations, particularly of a chemical nature, which would aid them in the diagnosis and treatment of disease. In consequence few of the older men particularly are fully able to appreciate or profit by the additional knowledge acquired in this way.

It is quite true that physicians as a rule have not sufficient time to carry out investigations of this nature themselves, but it is equally true that they should be carried out, and this entails upon the physician the duty of having laboratory facilities and assistance for the purpose. There can be little doubt that this will ultimately come to be generally recognised. To Dr. Vaughan Harley in this country is undoubtedly due the merit of having introduced the systematic employment of extending laboratory investigation in the diagnosis and treatment of diseases of the alimentary tract. His wide training in the methods of chemical physiology and pathology, as taught in continental schools, has been turned to daily use in the practise of his profession. A laboratory and assistance are indispensible. But Dr. Harley has been fortunate in finding amongst the pupils he trained, an assistant, now a colleague, no less enthusiastic than himself, namely, Dr. Goodbody, joint editor of the book.

The first seven chapters are devoted to descriptions of methods employed in the chemical investigation of gastric and intestinal diseases. The chapters have the merit of being short, and the methods are succinctly described. Useful practical hints are given on such points as the passage of the stomach tube, the choice of test meals, the general examination of the gastric contents after withdrawal, &c.

In dealing with qualitative chemical examination of the contents, the usual methods are described, methods which unfortunately in the vast majority of cases, constitute the beginning and the end of the investigation. By such limitation it is impossible to differentiate many of the more obscure disorders of the stomach. It is, for example, as the authors say, insufficient to determine, that an individual suffers from "acid dyspepsia," the degree and form which it assumes are of the essence of the diagnosis, and cannot be ascertained without quantitative analyses.

Following the chapters on methods, three are given to organic diseases of the stomach in which catarrh of various kinds, gastric ulcer and gastric carcinoma are treated of. In the discussion of each of these, valuable practical hints are interspersed, and in every case tables of analyses are added. These latter cannot fail to be of use for comparative purposes in future investigations. In the diagnosis of gastric carcinoma the authors place chief reliance not on the total absence of HCl, but on the absence of *free* HCl, as well as on the early and pronounced increase of lactic acid.

Functional diseases of the stomach are dealt with under disorders of secretion of motility and of sensibility. The three chapters devoted to these are amongst the most useful in the book.

It is, however, open to question whether any such condition as hyperchlorhydria exists. Hyperacidity is, of course, a common occurrence, and the table of cases of hyperchlorhydria includes striking instances of this condition, but in no case does the amount of hydrochloric acid rise above 0.48 per cent., and in only 3 is it above 0.4 per cent. These figures are well within the normal range according to recent investigations.

Relative to sensory neuroses a shrewd observation is made concerning the excessive degree of pain often produced by small quantities of bubyric and other volatile acids. It might be added that the seat of origin of the pain is nearly always the pyloric mucous membrane, and that it is generally associated with pyloric spasm.

The second part of the work treats of intestinal diseases. It is no reproach to the authors to say that it furnishes less satisfactory reading than the first. This is due to the fact that although in recent years considerable advance has been made in the chemical diagnosis and treatment of intestinal diseases, the field is comparatively unexplored. It is, however, one of paramount importance and can hardly fail to repay systematic investigation along scientific lines. There seems little doubt that ideas now prevalent regarding the general and dietetic treatment of diseases of the intestinal tract are bound in the near future to undergo radical alteration. That many intestinal diseases fall into the hands of the surgeon, whose methods are coercive and in no sense strictly curative, is evidence that much remains to be done.

The remaining chapters deal in order with motor power of the intestines, intestinal "dyspepsia" or fermentation, intestinal catarrh, colitis, intestinal atrophy, ulceration, carcinoma, sprue and intestinal concretions. The authors are quite cognisant of the limitations of their present methods in seeking to differentiate some of the conditions enumerated here, and frankly state so. Nevertheless, interesting and new matter infrequently appears.

We may add that the book is attractively got up. The type is clear, a full index is added, and we consider the work unique of its kind amongst English text-books.

WAR WITH DISEASE. (*a*)

"War with Disease" is, we believe, the first attempt made by a medical man to throw into book

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(*a*) "War With Disease." By Frederick F. Maccabe, M.B., Medical Officer, South of Ireland Imperial Yeomanry, late Civil Surgeon, H.M. Field Force, South Africa. Second Edition. London: Baillière Tindall and Cox. 1907. 1s. net.

form, for the benefit of the soldier, the elementary teachings of hygiene. This little work, therefore, does not call for too critical a handling, for the scope of the subject and the method of presentation naturally lend themselves at this stage rather to experiment than to exact treatment. So that while each man would have his own views as to the plan of such a book and the amount of information it should contain, it is not necessary to say more than that Dr. Maccabe has produced an interesting, readable, and suggestive short treatise which forms in itself an admirable basis for future endeavours of the same character. Indeed, we hope that having now attained to a second and improved edition, we shall find this book pass through many more, each better than the last. There is no reason why it should not, for not only does it contain much valuable information carefully collated and thrown into bright, simple language, but it has already gained so much favour at the hands of the authorities that many regiments are taking it as their handbook in the formation of sanitary classes and sections. Consisting as the book does of the substance of three different series of lectures delivered to military classes as widely different in intellect as the officers of the Staff College and the cavalry recruits in Ireland, there is necessarily much want of symmetry in arrangement and matter, but there is no reason why a little rearrangement and recasting should not produce a systematic and agreeable text-book, especially if the purely anatomical chapter were omitted. Dr. Maccabe throughout tackles his subject in a straightforward and workmanlike fashion, and giving just enough theory to make his directions comprehensible to the lay mind, devotes himself in laudable fashion to the practical questions of disease-prevention in the army, in camp and on service. While he is rightly dogmatic in his instruction, we do not find we can go all the way with him in several instances; for instance, we do not share his faith in the efficacy of permanganate of potassium as a preventive of gonorrhœa. But, as we have said, for a first attempt in breaking new and rather difficult ground, this book deserves warm commendation, and there would be fewer graves in South Africa at the present moment if its teachings had been known and practised during 1899-1902.

LITERARY NOTES.

That Professor Buchanan will have increased his reputation as an anatomist by the completion of his great work on the subject will be at once admitted by those qualified to pass judgment, now that the second volume is before them. His new "Manual of Anatomy, Systematic and Practical, including Embryology," in the University Series, reveals the author in the light of a great and practical teacher, who, having set before himself a task, the immensity of which can only be gauged on reference to the book, devotes, to use an idiomatic expression, "his heart and soul" to its accomplishment, giving us as the result of his labours one of the most original, complete, and best illustrated text-books on anatomy with which we are acquainted. We hope to review this work fully later on; meanwhile, we offer our congratulations to the author on the completion of his sterling work, and to the publishers on its attractive production.

⁂

The Jacksonian Prize for the year 1906, on "The Diagnosis and Treatment of those Diseases and Morbid Growths of the Vertebral Column, Spinal Cord and Canal which are Amenable to Surgical Operations," was awarded to Mr. Donald J. Armour, F.R.C.S., at the meeting of the Council of the Royal College of Surgeons, England, on Thursday last. The following subject was chosen for this prize for the year 1908: "The Pathology and Treatment of those Conditions and Diseases of the Colon which are Relievable by Operative Measures." The subject chosen for the next triennial prize was as follows: "The histological Anatomy of the Lymphatic and Hæmo-lymphatic Glands, more especially with reference to the changes which these glands undergo in acute infective processes."

⁂

Dr. Wm. Henry Drummond, the well-known Canadian poet, who died at Cobalt last week at the early age of 52, was born in Ireland and educated for the medical profession. He emigrated to Canada in early life, commenced practice in Montreal, eventually becoming Professor of Medical Jurisprudence at Bishop's University in that city. Literature, however, presented stronger claims on his tastes, and he devoted his undoubted talents to literary work and to poetry, chiefly illustrative of Canadian life in its various vicissitudes, the last of his poems being published only a few months since. He was a favourite author in the Dominion, although little known in Great Britain.

⁂

Messrs. Longmans, Green and Co. have just published a little volume entitled "The Care of Babies and Young Children" for the use of teachers, written by Miss Blanche Tucker, Inspectress of Elementary Schools under the Liverpool Education Committee. Its moderate price (1s.), and its useful information, will make it acceptable to the poor and ignorant if they can be induced to read it.

⁂

"French Law and Customs for the Anglo-Saxon," by Arthur S. Browne, the second edition of which is before us, is an uncommonly useful little book for British subjects who reside in France, either temporarily or permanently. Englishmen are, as a rule, profoundly, even contemptuously, ignorant of French laws and customs, with the inevitable result that they not infrequently find themselves in "tight corners" which a very little knowledge of local requisites would have spared them. The information here given will be found useful even by persons who only contemplate passing a season in France or its colonies.

⁂

The Editor of the *Business Man's Magazine* has sent us advance proofs of a most amusing article to appear in the present month's number. The title of the article is "The Polite Hospital Secretary's Letter Guide," and the writer presents a perfect picture of the hailstorm of letters that pours on the devoted head of a hospital secretary. The answers of that gentleman form an absolute type of the kind of ready writing in all matters that have to be argued by an official in that position. The cleverness of the article is exuberant, and will be found of interest by all interested in hospitals who possess a fund of original humour.

⁂

Last week's number of our contemporary, *The Graphic*, contains a very admirable portrait of Lord Lister, whose eightieth birthday was celebrated on Friday in all parts of the civilised world. We are indeed gratified to find the face of this illustrious surgeon in the pages of our lay contemporary, as its presence there is a tribute to the whole medical profession, which, in this particular instance, is glad to be untrammeled by ethical laws, and therefore not obliged to hide its light under a bushel. We find in the same number a beautiful reproduction of Daniel Maclise's painting of Charles Dickens. The association of these two eminent men in one issue of *The Graphic* is particularly happy.

The Hastings coroner held an inquest on April 5th on Dr. Thomas Vaux Woodifield, a retired medical man, residing at Vale-road, St. Leonards. The deceased, who was 70 years of age, had lived with a relative in St. Leonards for twelve years, being separated from his wife and family, who were legally represented at the inquest. Dr. Woodifield, who had fits of depression, was described as being very eccentric. He slept with a revolver under his pillow in the event of burglars, and ultimately shot himself with fatal effect. A verdict of "Suicide" was returned.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT PATHOLOGICAL LITERATURE.

Gumma as a Cause of Stokes-Adams Disease.—Ashton, Norris, and Lavenson (*American Journal of the Medical Sciences*, January, 1907) publish with all details the history of a case of Stokes-Adams disease due to a gumma in the interventricular septum, causing destruction of the bundle of His. The authors were able to trace the bundle both above and below its involvement in the gumma, but at the latter there was a complete solution of its continuity. In the other parts of the course of the bundle there was considerable infiltration with small round cells and a growth of young connective tissue. The association of the Stokes-Adams syndrome with syphilis has been previously noted by several observers, including Handford, Keith, Miller, and Grünbaum, and in at least three previous cases, a gumma has been demonstrated in the course of the bundle of His. It is of practical importance that such cases may be amenable to iodide treatment, and Jacquet and Erlanger have reported a case of Stokes-Adams disease apparently cured by heroic doses of potassium iodide. R.

Auricular Fibrillation a Cause of Paroxysmal Irregularity of the Heart. — Cushing and Edmunds (*American Journal of the Medical Sciences*, January, 1907) relate a case of paroxysmal arrhythmia, and make suggestions as to the cause of the condition. The arrhythmia used to occur quite suddenly, and was accompanied with nausea and vomiting, while in the intervals of the attacks the heart beat regularly, and presented nothing abnormal. There was no reason to suppose that the ventricle failed to respond to the stimuli it received; the length of the apparent intermissions was not a multiple of the time of the single beats. During the periods of irregularity, the rate was greatly accelerated, sometimes rising to 150 a minute. The authors noticed a similar form of irregularity in the dog's heart during the performance of severe operations, and they were able to produce it experimentally by the administration of poisons of the digitalis series, or by the interruption of electrical stimulation of the vagus in the neck. In all these cases the auricle was found in the condition known as "auricular delirium," an extreme and continual incoordinated contraction, each part of the auricle undergoing fibrillary contractions independent of the rest. The authors suggest that the paroxysmal arrhythmia, both in their patient and in the animals subjected to experiment, was excited by auricular fibrillation due to inhibition of the vagus centre. R.

The Spread of Cancer.—Stevens (*British Medical Journal*, February 9th, 1907) publishes some observations on the mode of spread of cancer, particularly in the case of cancer of the stomach. He has noted that the clavicular lymphatic glands on the left side are frequently involved in cases of gastric cancer, whereas those on the right are rarely affected. The most obvious explanation of this difference is that the thoracic duct is a determining factor in the mode of spread. Stevens believes that the duct may either be a carrier of infective material or may itself be affected; several cases quoted support the latter alternative. Further observations of Stevens as to the mode of spread of cancer from the stomach to the other abdominal organs support the view that the growth proceeds by direct extension along the walls of the lymphatic channels. R.

Rumination in Man.—Brockbank (*British Medical Journal*, February 23rd, 1907) gives an interesting account of a family group in which rumination was common, and at the same time he summarises our knowledge of this peculiar condition. In all, he was able to study twenty-two individuals of the group, varying in age from two years to forty-seven, while he was able to obtain information of four other near relatives also subject to the habit. Eight of the subjects were brothers and sisters, while the other fourteen were among their immediate offspring. The habit in every case appeared to start at a very early age and was regarded by the subject of it as perfectly natural. Taking a typical case, food began to return to the mouth some quarter of an hour after a meal; it was chewed, and again swallowed. This process went on for one, two, three, or more hours, the food gradually becoming more fluid. There was nothing unpleasant in the process, except near the end, when the returned fluid had an unpleasant sour taste. Rumination was more marked after a meal of meat than after lighter food. In some of the subjects the habit was under control; in others quite independent of control. Brockbank's cases were apparently of the "simple" or "physiological" type, where the habit is quite natural; many recorded cases, however, are hysterical in nature, and among neurotics the habit may be learnt by imitation. In the majority of subjects of rumination, there is no anatomical peculiarity beyond some dilatation of the stomach and possibly of the lower end of the œsophagus. Brockbank adds some interesting information taken from the literature of this curious condition. R.

Aplastic Anæmia.—Lavenson (*American Journal of the Medical Sciences*, January, 1907), in publishing a case of this peculiar form of anæmia, collects ten other cases from the literature, and discusses the pathology at some length. He concludes: (1) Aplastic anæmia is a variety of progressive pernicious anæmia. (2) Its essential features are its rapidly fatal course; the marked diminution in the number of red corpuscles together with a low colour-index; absence of megaloblasts and usually of normoblasts; leukopenia with relative lymphocytosis; and, *post mortem*, pale bone-marrow without any sign of formation of red corpuscles. (3) The essential difference between aplastic anæmia and other forms of pernicious anæmia is the absence of regenerative processes in the former. Lavenson adds that the relation of lymphocytes to total leucocytes supports the view that lymphocytes are not a product of the bone-marrow. R.

Parathyroids and Accessory Thyroids. — Forsyth *British Medical Journal*, February 16th, 1907)] publishes the results of an examination of some sixty subjects as regards parathyroid and accessory thyroid glands. The number of parathyroids is usually stated to be two on each side, but Forsyth believes it to be very variable. In some cases he found only one parathyroid on one side, while in one case he found no less than six. Their position is also inconstant, and they are rarely symmetrical. The most frequent site is on the lateral surface of the thyroid gland, near its posterior border, at the junction of the lower and middle thirds of the gland. The parathyroid cannot be identified with certainty except by microscopical examination, but its most characteristic form is an elongated, slightly flattened, ovoid body, of a pale pink hue, with smooth surface, on which ramify a few branching vessels. In some specimens thyroid or thymus tissue was found along with parathyroid, but the latter was separated by a definite sheet of connective tissue. In size, the parathyroid varies from little more than a pin-point up to nearly 2.5 c.m. in diameter. The investigator found parathyroids in greatest number in the first year of life, and from that period to old age with progressively decreasing frequency. In subjects under twenty years of age, he never failed to find them; in subjects above that age they were sometimes absent. On the other hand, accessory thyroids were rarely found in young children, but were comparatively frequent in middle-aged and elderly subjects. The disappearance of parathyroids with advancing years makes Forsyth doubt the physiological importance sometimes attributed to them.

P.

Bacteriological Examination of the Blood after Death.—Otten has made a bacteriological examination (*Virchow Archiv.*, 1906, Bd. 184, S. 284) of the blood in 200 corpses, and has only found it sterile in 84 out of that number, that is, in 42 per cent. The very numerous positive results are to be explained by the fact that he did not examine all cases, but only those in which bacteria were expected to be present. Streptococci were most often found, 69 times alone, and 13 times in company with other organisms. Staphylococci and B. coli were only occasionally found. The blood was taken in each case from the right side of the heart, and very thorough precautions were taken to avoid infection. In a large number of cases the same organisms were found postmortem as during life, except that their number was greatly increased after death.

M.

Pancreatic Changes Associated with Liver Cirrhosis.—Very few observations exist with reference to the condition of the pancreas in cases of cirrhosis of the liver, but various associated pathological changes have been recorded from time to time. Among these may be mentioned: (1) Increase in the amount of connective tissue present, with proliferation in number of the contained capillaries. (2) Thickening of the walls of the pancreatic arteries going on in many places to complete obliteration. (3) Old and new hæmorrhages scattered through the organ and giving rise to pigmentary deposits. (4) Atrophy of Langerhans islets and replacement of them by connective tissue. (5) Fatty degeneration of acini, and overgrowth of elastic tissue. Sands has recently investigated 23 cases of liver cirrhosis (*Zeitsch. f. Heilk*, Bd. 27, H. 1), and has found the above changes in some of the cases, but has been unable to establish any definite connection between these changes and the degree of liver cirrhosis. In some cases the pancreatic cirrhosis was acinar, and in some interacinar. No difference was found between the cases associated with atrophic and hypertrophic liver cirrhosis respectively.

M.

Compensation in Tricuspid Incompetence — Many writers believe that there is no compensatory mechanism in cases of failure of the tricuspid valves. Sadler has investigated the matter (*Wiener Klin. Woch.*, 1906, No. 31), both by examining the records of reported cases, and by experimentally producing tricuspid incompetence in rabbits. He points out that it is quite out of the question for any change to occur on the left side of the heart, but maintains that hypertrophy of the right ventricle is a constant feature. This hypertrophy manifests its influence most during diastole, when the increased suction power thereby given to the chamber enables it to draw the venous blood with considerable force into its cavity. Another compensatory effect depends on the liver elasticity. The liver blood vessels are distended by a regurgitant flow during systole, but during diastole, the elasticity asserts itself and helps in driving the blood back again towards the heart.

M.

Physiological Action of Blue Light. — Dr. Cavalié of Bordeaux, was the first to point out that the different spectral colours seem to produce specific impressions on animals and plants, and found that blue rays in particular exerted a sedative influence. So much is this the case that fixation of the eyes for a few seconds on blue light produces sufficient anæsthetisation of the face to permit of the performance of minor operations, such as teeth extraction. Dr. Redard has employed the method and reports the technique that he now follows (*La Quinz. Therapeut.*, March 25th, 1907). He finds that for success it is necessary to exclude all other light rays, and to keep the patient under the influence of blue rays for about three minutes. In this way local insensibility to pain is produced, and lasts for about 30 seconds. The writer has now tried it in about 40 cases and usually with success. He does not discuss the cause of the anæsthesia, but at first sight it would seem to be merely an example, and a bad one, of hypnotic insensibility.

M.

Experimental Epilepsy.—Drs. Zimmern and Dimier report their experiments on the production of epileptiform seizures in animals (*La Quinzaine Therapeutique*, March 10th, 1907). They find that when interrupted currents of low tension are employed, and the electrodes placed with one on the back and the other on the front of the head, a series of phenomena develop as the intensity of the current is increased. At first the animal falls on its back and becomes deeply comatose. Then if any change is made in the regularity of the interruptions clonic spasm of the limbs, and glottis ensue; these last giving rise to an "epileptic" cry. The best results are obtained when the negative pole is applied to the head. If after the production of coma, the current be further increased in strength, death will result from inhibition of the cardiac and respiratory centres. The resemblance to human epilepsy is increased by the fact that the temperature becomes raised during the convulsive period. These experiments were carried out in rabbits and dogs and were successful in both.

M.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons.—New Fellows and Members.

A quarterly meeting of the Council of the Royal College of Surgeons was held at the College yesterday, Mr. Henry Morris, F.R.C.S., President, in the Chair. Dr. Alex. Hill, M.A., Master of Downing College, Cambridge, and Professor Arthur Thomson, M.A., M.B., of the University Museum, Oxford, were elected Fellows of the College. The following candidates, having passed the required examinations and conformed to the bye-laws, were admitted members of the college: Robert Dixon Brown, of St. Thomas's Hospital; Charles Grange McGreer, of Queen's University, Kingston, Canada and Middlesex Hospital; and Charles Edward Waldron, of the London Hospital. At this meeting, the award of the Jacksonian Prize for 1906 was announced, Dr. Donald J. Armour, F.R.C.S., being successful.

Mr. Frederic Eve, surgeon to the London Hospital, was elected a member of the surgical section of the Board of Examiners in Dental Surgery. It was decided to add Leys School, Cambridge, and Trent College, Long Eaton, to the list of institutions recognised by the conjoint examining board for instruction in chemistry, physics, and biology.

The President stated that Professor William Wright's Hunterian Lectures on "The Prehistoric and Early Historic Inhabitants of England," which were recently postponed, would be delivered on May 6th, 8th, and 10th.

Mr. J. Ward Cousins, the representative of the college on the Central Midwives' Board, reported the proceedings of the Board during the past year, and informed the Council that, during this period, the Board have recognised 48 training schools in England, six in Scotland, and seven in Ireland, whilst the number of teachers appointed amounts to 144. The

Board have held examinations in London, Bristol, Manchester, and Newcastle-on-Tyne. 1976 candidates entered for the examinations; of this number 1,527 received their certificates, and 449 were unsuccessful. The number of certified midwives on the roll amounts to 24,549. The best thanks of the Council were given to Mr. Ward Cousins for his services as the representative of the College on the Board.

The President was elected to attend the centenary celebration of the Geological Society, which takes place in September next, as the delegate of the College.

Royal Maternity Charity.

THE annual meeting of governors of the Royal Maternity Charity of London was held at 31, Finsbury Square, E.C., on April 9th, Mr. C. Barham, C.C. (chairman), presiding. The report of the Medical Committee showed that the number of cases treated in 1906 was 2,651. The number of children born was 2,700, and the number of deaths 43—this mortality representing a rate of 15.92 per 1,000. Eight mothers had died, the rate in their case being 3.01 per 1,000. The deaths were non-preventible, and the low death-rate was a matter for congratulation as evidence of medical skill. The secretary of the society was working in touch with the Medical Department of the London County Council, and with the Central Midwives' Board. Mr. J. Whittington, in moving the adoption of the report, said the charity's midwives were highly skilled, and one of them was once engaged by the Empress of Germany. The motion having been seconded by Mr. R. J. Tasker, the Chairman said that the public had not responded to the appeal of the charity as it should have done. The festival they had held since the last meeting was not much of a success, although they thought that a hundred and fiftieth anniversary would have appealed to the public. When he was Lord Mayor they would all have a good time at the Mansion House. (Laughter.) He was very much hurt that the Lord Mayor did not invite them there last time. The reports were unanimously adopted, and the officers and committee were re-elected, with certain additions.

Inquest on a Medical Man.

ON April 5th an inquest was held before the deputy-coroner at the Turf Hotel, Winlaton, on the body of Dr. Colin Mansfield Campbell, whose death occurred at his residence, Front Street, Winlaton. Dr. Guthrie Raynes Plante, of Blaydon, to whom deceased acted as assistant, said that Dr. Campbell was about 35 years of age, and had resided at Winlaton for five years. On Sunday last witness had a long conversation with Dr. Campbell upon both professional and personal matters. Deceased was then rather depressed, although when witness had previously seen him he was all right. Deceased did not complain on Sunday, but he could not see his way clear in regard to his own personal matters. These were nothing serious—some little matters of finance. On Wednesday morning witness was called in to see Dr. Campbell at about a quarter to eight o'clock. Deceased was upstairs in bed, and was unconscious. Witness came to the conclusion that deceased was suffering from opium poisoning—an overdose of opium in the form of morphia or laudanum, or something of that. Deceased died at half-past nine o'clock on the same morning. Replying to further questions, Dr. Plante stated that he did not think Dr. Campbell was in the habit of taking opium. Deceased was not a very temperate man. He was married, but did not live with his wife. There was nothing in deceased's financial matters that could not have been put right. He enjoyed good health, and witness had never heard him threaten to do away with himself. Witness was of opinion that deceased had taken the morphia or opium to make him sleep. He was satisfied that it was a case of deceased having taken an overdose. A verdict was returned that death had resulted from the effects of an overdose of some narcotic poison, probably taken for the purpose of inducing sleep.

Poisoning by Prunes.

A REMARKABLE instance of poisoning, affecting seven members of a family, occurred in the northern district of Glasgow on April 6th. After partaking of some prunes as part of the dessert at dinner-time they suddenly became very ill. The names of the persons affected are: Jane Muir (23), Maggie Muir (19), Thomas Muir (15), Agnes Muir (10), David Muir (7), Flora Muir (6), and Mabel Muir (4). They are the family of Robert Muir, master plumber, residing at 13, Holmhead Street, Glasgow. The casualty surgeon, who examined the sick persons, stated that he was able to say they were out of danger. In his opinion they were suffering from the effects of some irritant poison, which probably existed in the dish of prunes of which they ate.

School Hygiene Congress.

A PRELIMINARY programme for the second international congress on school hygiene has been issued. The congress, of which the King is patron, is to be held at London University during the first week in August under the presidency of Sir Lauder Brunton. Delegates are to attend the congress from the United States, Austria, France, Canada, Denmark, Germany, Finland, Greece, Holland, Japan, Italy, South Africa, Sweden and Switzerland. On Sunday, August 4th, special services will be held, and on Bank Holiday there will be a reception of the delegates, followed by the President's inaugural address. Afterwards sectional meetings will be held for the discussion of various questions connected with the instruction of teachers and children in hygiene. Garden parties, entertainments, and excursions are to be held later. It was determined at the first congress, held in Nuremburg in 1904, that the educational and hygienic movement going on in the British Empire should be acknowledged by holding the next meeting in London, and probably the congress of 1910 will be held in France.

Friendly Societies' Medical Alliance Conference.

MEMBERS of the Friendly Societies' Medical Alliance deputed to attend the annual conference arrived in Exeter on March 30th. A reception was held at the Arcade Hall, where the visitors were welcomed by Mr. H. W. Loram and Mr. W. Amery (respectively chairman and vice-chairman of the Council); and Mr. C. E. Hopping, secretary. All the delegates expected, save three, were reported as having arrived.

A cordial welcome to Exeter was offered to the delegates by members of the local branch. The reception extended from half-past six to half-past nine, and at an interval in the evening refreshments were served. Members of the Alliance spent the first day as they pleased, there being no official programme. Some visited places of interest in the city, some went for the day by the seaside, and others availed themselves of inland trips. On Monday, prior to the opening of the Conference at eleven o'clock, the members of the Alliance were taken over the Cathedral by Chancellor Edmonds, and afterwards they visited the Guildhall, where the Town Clerk showed and described the civic regalia. The most contentious matter of business before the Conference was a proposal from Leeds to strengthen the defence fund. A visit was paid by the Mayor of Exeter to the Conference, which he warmly welcomed.

PASS LISTS.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

THE Quarterly Examinations of the above Board, held in Edinburgh, were concluded on the 12th inst., with the following results:—

First Examination (*Four Years' Course*).—Miss Adeline Watts passed the examination.

First Examination (*Five Years' Course*).—Of 27 candidates entered, the following 11 passed the examination: Morris Greene (with distinction), Hillary D. Brown, Joseph F. Sweeney, Alfred M. Billings, James

Mitchell, Arthur C. Price (with distinction), Francis L. Kennefick, Tiruvallur K. Jayaram, Alexander L. Gibbon, Howard A. Whitehead, and Adolph B. Kramer, and 6 passed in biology and 2 in chemistry.

Second Examination (Five Years' Course).—Of 25 candidates entered the following 12 passed the examination: Dakshina Ranjan Das Gupta, Robert W. A. Brown, Harold G. Chouler, William T. Lawrence, George N. Groves, John N. Robson, Richard Parry, John Young (with distinction), Thomas Crawford, Beatrice Coxon, Philip G. Phillips, and Charles W. Kay, and 1 passed in anatomy and 2 in physiology.

Third Examination (Five Years' Course).—Of 21 candidates entered the following 12 passed the examination: James Reid, Louis N. Robertson, William R. Mackenzie, Frederick Watson, Thomas G. Shand, Jacobus du Toit Malan, Arthur E. James, Shridhar C. Jog, William McKee, Leslie O. S. Poidevin, William F. Mitchell, and Behram S. Photographer, and 2 passed in materia medica.

Final Examination.—Of 50 candidates entered, the following 23 passed the examination, and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P.&S.G.: D. Terener de Kretser, Taylor D. Murison, George M. Williamson, Ronald M. Liddell, William McKee, Francis L. Scott, George E. Anderson, Arthur H. Bloxsome, Arthur P. O'Connell, Harold H. Babington, Wilfrid Chambers, James Ferguson, Oney M. Gericke, Arnold McMillan, Howard B. Stephenson, David Golding, John H. Simpson, Vamanrao A. Vijayakar, Douglas L. G. Radford, Sureswar Sarkar, Robert M. Jones, T. Canagasaby, and Madan Lal Puri, and 5 passed in medicine and therapeutics, 3 in surgery and surgical anatomy, 7 in midwifery, and 7 in medical jurisprudence.

University of Glasgow.

THE following have passed the Third Professional Examination for the Degrees of M.B. and Ch.B. in the subjects indicated (P., Pathology; M., Medical Jurisprudence and Public Health):—

David Anderson (P.); William Anderson (P., M.); Thomas Archibald (P.); William Barr (P., M.); Charles Bennett (P., M.); John Blakely (P.); John Lindsay Boyd (P., M.); James Nimmo Brown, M.A. (P.); William Barrie Brownlie (P.); Hector Mackay Calder (P., M.); James Carrick (P., M.); Matthew Ignatius Thornton Cassidy (P.); Donald Clark (M.); Donald James Clark (P.); James Cook, Partick (P., M.); John Cruickshank (P., M.); Neilson Davie (P.); Walter Dawson (M.); James Cowie Dick (M.); Arthur Drummond Downes, M.A. (P., M.); William Miller Fairlie (P., M.); Walter Gilmour (P., M.); Josiah Stranaghan Harbinson (P., M.); Michael Harkin (P., M.); Thomas Harkin (M.); John Mitchell Henderson (P.): Stephen John Henry (P., M.); Benjamin Hutchison (P., M.); John Lang (P., M.); Frank Crombie Macaulay (P.); Joseph Glaister M'Cutcheon (M.); Coll Macdonald (P., M.); William M'Kendrick (P.)· Murdo Duncan Mackenzie (P.); Thomas Cooper Mackenzie (M.); Francis William Mackichan (P.); William Campbell Mackie (P.); James Walter M'Leod (P., M.); John MacMillan (P., M.); Peter Russell M'Naught (P., M.); Donald Irvine M'Naughtan (P., M.); David Manton (P., M.); Frank Needham Marsh (P.); William Matheson (P., M.); Kenneth Chisholm Middlemiss (P., M.); Allan Frederick Miller (P.); Robert M'Kenzie Morison, M.A. (P., M.); James Muir (P., M.); William Aikman Muir (P.); Archibald Campbell Munro (P., M.); Charles Sutherland M'Kay Murison (P.); Albert Rutherford Paterson (P., M.); Adam Patrick, M.A. (P., M.); Ralph Montgomery Fullarton Picken, B.Sc. (P.); Murray Purvis (P., M.); Edward Quigley (P., M.); Richard Rae (P.); Henry Nimmo Rankin (P.); Nicol M'Nicoll Rankin (P., M.); Murdoch Mann Roger (P.); Neil Campbell Scott (P., M.); James Brown Sim (P.); James Alexander Stenhouse (P.): Donald Stewart (P., M.); Hugh Cochrane Storrie (P.); David Taylor (P.); John Shedden Thomson (P., M.); Robert Macnair Walker (P., M.); Thomas Charles Dalrymple Watt (P., M.); Thomas Macknight Watt (M.); Hugh White (P.); David M'Gruther Wilson (M.); William Mitchell Turner Wilson (P., M.); Hugh Young (P.). Women: —Margaret Baird Sproul Darroch (P.); Mabel Foley (P., M.); Annie M'Corrie (P.); Winifred Margaret Ross (P.); Jessie Capie Russell (P., M.).

At the recent professional examination for the degrees of M.B. and Ch.B. the following candidates passed with distinction in the subjects indicated:—

First Examination—In Zoology and Chemistry—Thomas Stewart Barrie, William M'Murray, James Eric Paterson. In Physics and Chemistry—William Larmour Anderson. In Botany—Charles Averill. In Zoology—Thomas Adam, M.A.; James Turner Brown, Charles Cameron, Kinloch Falconer, John Radcliffe Grice, M.A.; James David MacKinnon, Andrew Bruce MacLean, William Wyllie MacNaught, Farquhar Matheson James Alexander Hamilton Telfer, Alexander Stewart Wilson. In Physics—Andrew Scobie Findlay, John Mitchell. In Chemistry—Alexander Baird, John Campbell, Malcolm Sommerville, William Tudhope, Gordon Alexander Valentine.

Second Examination—In Physiology—Charles Duguid, M.A.; Donald Fisher, George Fletcher, M.A.; William M'Adam, M.A.; John Hart M'Nicol, Mary Cochrane Mitchell, Margaret Eason Robertson, Alfred Roemmele, William Wilson Rorke, Richmond Steel, David Campbell Suttie, James Lachlan Ure. In Materia Medica and Therapeutics—George Macleod, M.A.

Third Examination—In Pathology and in Medical Jurisprudence and Public Health—John Cruickshank, Robert Macnair Walker. In Pathology—Charles Bennett, William Barrie Brownlie, Peter Russell M'Naught, Ralph Montgomery Fullarton Picken, B.Sc. In Medical Jurisprudence and Public Health—Benjamin Hutchison, Archibald Campbell Munro, Adam Patrick, M.A.

London School of Tropical Medicine.

The following candidates passed the Examination in Tropical Medicine during the session January to April, 1907:—Major F. R. Ozzard, I.M.S., M.R.C.S., L.R.C.P., 1888, Capt. T. G. N. Stokes, I.M.S., M.B., B.Ch., B.A.O., Trin. Coll, Dublin, 1898, J.M. O'Brien, M.R.CS., L.R.C.P., 1902 (Colonial Service), O. Berkeley Hill, I.M.S., M.B. (Oxon.), 1906, Capt. J. W. F. Rait, I.M.S., M.B., B.S. (Lond.), 1896,.L.S.A. 1896, A. W. Atkinson, M.B., B.Ch. (Edin.), 1906 (Colonial Service), [with distinction]. M. Gamble, M.D. (Victoria), 1904, F. W. Woolrabe, M.R.C.P., F.R.C.S., (Edin.), 1895, D.P.H. (Dublin), 1900, E. G. H. Weir, M.D., C.M. (Toronto), 1899, M.R.C.S., L.R.C.P., 1903 (Colonial Service), A. Orgnieri, M.D. (Torino), 1905, C. W. McLeay, B.A. (Tor.), 1895, M.D. (West.), 1899, M.R.C.S., L.R.C.P.,1904 (Colonial Service), E. W. Wood-Mason, M.B., C.H. (Aber.), 1898 (Colonial Service), Miss A. M. Cowan, M.B., Ch.B. (Edin.), 1906, R. W. Orpen, L.R.C.S. and P. (Ireland), 1900 (Colonial Service), F. McF. W. Pollard, M.B., B.S. (Lond.), 1904, M.R.C.S., L.R.C.P., 1904 (Colonial Service), Miss A. M. Clark, M.B., B.Ch. (Glas.), 1900, B.Sc., 1898, W. N. Alexander, L.R.C.P. and S. (Edin.), 1904 (Colonial Service), H. O'Hara May, M.D. (Dublin), 1903 (Colonial Service).

Conjoint Examinations in Ireland.

The following candidates have passed the First Professional Examination held by the Royal College of Physicians and the Royal College of Surgeons:—J. S. McHugh (with Honours), C. J. Bourke, T. Buckley, F. M. J. Byrne, A. D. Clanchy, P. Daly, J. A. Dowling, F. J. Eager, J. T. Hill, N. Keating, P. Murphy, F. J. McCarthy, A. McGrath, J. Nally, C. H. Oliver, T. P. O'Reilly, D. P. H. Pearson, A. A. Russe, M. V. Sexton, J. P. Shorten, H. H. K. Sparrow, T. M. Thomson, F. W. Warren, F. Webster, P. J. Wigoder, P. O'C. White.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Graphic.—(1) On the contrary, there has been a constant decline in the death and discharge rates at lunatic asylums. Indeed, it is calculated that if the discharge rate during 1903-1905 had been the same as that of 1873-1877 the total number of the insane under care would have fallen by 1,578; instead of which it increased 7,236. (2) The increase is chiefly due to the large number of such dements as were formerly looked after at home.

ETHER IN THE GOAT.—AN AMUSING ANECDOTE.

Professor Hare is responsible for the following: When ether was first introduced, a certain Jefferson professor was of the opinion that either not enough ether could be given to produce anæsthesia, or that so much would be required that the patient's life would be threatened. He determined to conduct an experiment before the class in the old college building, and secured a pugnacious and virile billy goat as the victim. After a lengthy and vigorous argument between the goat and a number of students, the animal was placed upon the table and duly anæsthetised. In a few minutes the goat appeared to be breathing its last. The Professor dwelt upon the dangerous use of the new drug, and the class adjourned for a lecture. Hardly had they started down the stairs, which were narrow and precipitous, than the goat, which had come to, appeared in their midst and viciously butted them in all directions.—*The Jeffersonian.*

M. T.—Laborde's method of restoring animation consists in making rhythmical traction on the tongue. The organ can be held by forceps or by the fingers, and is drawn slowly in and out of the mouth. It is useful in children, and in cases of injury in which the ribs are fractured.

Motorist.—Similar symptoms have been described in a Paper in the *Lancet*, July 7th, 1906. The patient was a motor-'bus driver and complained of persistent pain in the right hip and back. The limb was spastic and the reflexes were exaggerated. At first there was hyperæsthesia, but later anæsthesia. Recovery took place in about a month under symptomatic treatment. We should be glad to have details of your case for publication, as the subject is a new and interesting one.

Tropicus.—Experiments on man have been recorded in connection with the dysentery bacillus which seem to point strongly to its specific pathogenicity. One was accidental, the experimentor contaminating his mouth with some fluid culture, and suffering shortly afterwards from a smart attack of dysentery. The other was made in the Philippine Islands on a condemned prisoner. A similar attack ensued almost immediately, and the organism was recovered from the stools.

Meetings of the Societies, Lectures, &c.

Wednesday, April 17th.

Royal Microscopical Society (20 Hanover Square, W.).—8 p.m.: Exhibition of Slides of Foraminifera by Mr. A. Earland. Paper:—Mr. E. M. Nelson: On the Podura Scale.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. L. Mummery: Clinique. (Surgical). 5.15 p.m.:—Lecture:—Dr. N. Tirard: Some Forms of Pnuemonia.

North-East London Post-Graduate College (Tottenham Hospital, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Thursday, April 18th.

Harveian Society of London (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m.: Papers:—Mr. Jaffrey: A Case of Ulcerative Colitis treated by Operation under the care of Dr. Latham and Mr. Jaffrey. Dr. L. G. Guthrie: Some Nervous Affections of Childhood.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. E. Clarke: The Fundus Oculi in Health and Disease (with lantern slides).

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

Friday, April 19th.

Society for the Study of Disease in Children (11 Chandos Street, Cavendish Square, W.).—5 p.m.: Clinical Evening for the Exhibition of Cases followed by Discussion. Patients in attendance at 4.30 p.m.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. M. Yearsley: Clinique. (Ear.)

North-East London Post-Graduate College (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Monday, April 22nd.

Odontological Society of Great Britain (20 Hanover Square, W.).—8 p.m.: Communication:—Mr. J. F. Colyer, L.R.C.P., M.R.C.S., L.D.S.Eng., on "Some Specimens recently presented to the Museum of the Society." Paper:—Mr. Harold Simms, M.D., Ch.B.Vict., L.D.S.Eng., on "Some Observations on the Bacteriology of Pyorrhœa Alveolaris." The Communication and Paper will be illustrated by lantern slides by means of the Epidiascope.

Vacancies.

West Riding Asylum, Wakefield.—Pathologist and Assistant Medical Officer. Salary £140 per annum, with board, furnished apartments, washing, and attendance. Applications to the Medical Director.

Cornwall County Asylum, Bodmin.—Third Assistant Medical Officer.—Salary £140 a year, with furnished rooms, rations, laundry, and attendance. Applications to Medical Superintendent.

Birkenhead Union.—Resident Assistant Medical Officer. Salary £120 per annum, with board, washing, and apartments. Applications to John Carter, Clerk to the Guardians, Poor-law Offices, Birkenhead.

Swansea Union.—Assistant Medical Officer. Salary £200 per annum. Applications to Llewn. Jenkins, Clerk, Union Offices, Alexandra Road, Swansea.

Fife District Asylum, Cupar-Fife.—Junior Assistant Medical Officer. Salary £120 per annum, with rooms, board, and attendance. Applications to the Medical Superintendent.

North Staffordshire Infirmary and Eye Hospital, Hartshill, Stoke-on-Trent. House Physician. Salary £100 per annum, with furnished apartments, board, and washing. Applications to the Secretary and House Governor.

Bradford Royal Infirmary.—House Surgeon. Salary £100 per annum, with board and residence. Applications to John Barron, Secretary.

Manchester Hospital for Consumption and Diseases of the Throat and Chest.—Assistant Medical Officer. Salary £100 per annum, with board, apartments, and laundry. Applications to C. W. Hunt, Secretary, Hardman Street, Deansgate, Manchester.

Lancashire County Asylum, Winwick, Warrington.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Cossham Memorial Hospital, Kingswood, Bristol.—House Surgeon and Resident Medical Officer. Salary £100 per annum, with board, apartments and laundry. Applications to John Henshaw, Secretary.

Appointments.

Angelis, A. A., M.D.Athens, L.S.A.Lond., Clinical Assistant to the Evelina Hospital for Children, Southwark.

Black, Edward Hamilton, M.B., Ch.B.Edin., Assistant House and Visiting Surgeon to the Stockport Infirmary.

Galletly, J., M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Bourne District of the county of Lincoln.

Quirke, J., L.R.C.P. and S.Irel., Certifying Surgeon under the Factory and Workshop Act for the Inistioge District of the county of Kilkenny.

Riddell, W. H., M.B., Ch.B.Edin., House Surgeon at the Staffordshire General Infirmary, Stafford.

Rose, Frank A., M.R.C.S., L.R.C.P.Lond., Assistant Surgeon to the Throat Department at St. Bartholomew's Hospital.

Births.

Drake.—On April 12th, at Chilworth, Redhill, the wife of E. C. Drake, M.R.C.S., L.R.C.P., of a daughter.

Gardner-Medwin.—On April 10th, at 22 High Street, Wavertree, Liverpool, the wife of Frank M. Gardner-Medwin, M.R.C.S., L.R.C.P. of a son.

Langley.—On April 11th, at Kiln House, Tadley, near Basingstoke, the wife of W. J. Langley, L.R.C.P., L.R.C.S., of a daughter.

Pearson.—On April 9th, at Croft House, Owston Ferry, Doncaster, the wife of Francis J. Pearson, M.R.C.S.Eng., L.R.C.P.Lond., of a son.

Steele.—On April 11th, at Sydney House, Chiswick, the wife of Charles Francis Steele, M.B.Lond., of a daughter.

Thom.—On April 5th, at Simla, India, the wife of Major G. O. St. C. Thom, R.A.M.C., of a son. (By cable.)

Marriages.

Crosbie—Crosbie.—On April 11th, at St. Finian's, Greencastle, Pierce Leslie, F.R.C.S., R.N., eldest son of Leslie Crosbie, M.D., Ardfert, county Kerry, to Winifred, fourth daughter of the late Pierce Crosbie, Esq., J.P., Greencastle, county Donegal.

Nitch—Bryden.—On April 10th, at St. Barnabas, Addison Road, Cyril A. R. Nitch, M.S., F.R.C.S., 69 Harley Street, London, son of George H. Nitch, 22 Victoria Square, S.W., to Amy Annie, elder daughter of the late Surgeon-Major J. L. Bryden, M.D., I.M.S., and of Mrs. Bryden, 8 Addison Gardens.

Phelps—Parker.—On April 11th, at Lapworth Church, John Henry Dixon Phelps, M.B., B.Ch.Oxon., of Scorton, Yorkshire, to Lucy Olive, younger daughter of Reginald Parker, of Lapworth.

White—Mason.—On April 12th, at St. Margaret Church, Stanford-le-Hope, by the Rev. J. Russell, George Fawcett White, M.D., eldest son of H. Bantry White, M.A.I., Ballinguile, Donnybrook, to Nora Dorothy, second daughter of Robert Mason, of Pitsea Hall, Essex.

Deaths.

Astley.—On April 12th, at 29 Marine Parade, Dover, Edward Farrand Astley, M.D., J.P., in his 96th year.

Lewis.—On April 8th, at Kingscliffe, Northamptonshire, of pneumonia, Thomas White Lewis, M.D.Univ.Dub., second son of the late J. M. Aylward Lewis, J.P., of Ballinagar, co. Galway, and Mrs. Lewis, 42 Morehampton Road, Dublin, aged 52 years.

Mahaffy.—On April 10th, at Maidenhead, Susan Frances Mahaffy, aged 77 years, widow of Edward Mahaffy, M.D., C.B., Surgeon-General, Indian Medical Service.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, APRIL 24, 1907. No. 17

NOTES AND COMMENTS.

Barber Midwives. THE traditional link that used to bind the barbers and the surgeons together was brought to mind in a case lately tried by the Lord Chief Justice and some of his colleagues sitting in the King's Bench Division to hear an appeal brought by a midwife, Mrs. Feldmann, against a resolution of the Central Midwives' Board removing her name from their roll. Mrs. Feldmann, it would seem, enjoyed to so large an extent the confidence of her neighbours that her services were in request too frequently for her to be able to give personal attention, and on two occasions when unable to go to cases she deputed her husband. This gentleman, it was said, in evidence, possessed a Russian medical diploma, but whether by reason of the disturbed state of his native land, or because a prophet is without honour in his own country, or through natural predilection, he decided to abandon the practise of medicine in favour of that of hair-dressing and in that capacity he not only gained an honest livelihood, but won the affections of the local midwife. What then more natural that when through the press of professional duty his wife could not fulfil all her appointments, he should act as a stop-gap? The arrangement, however, coming to the ears of the Central Midwives' Board, and Russian medical diplomas not ranking as a qualification for entry to their register, the wife was struck off the rolls and her certificate cancelled. Happily, but rather unexpectedly, the Court held that they were justified in doing so, and it may be hoped that the barber will now stick to his block. Unlike removal from the medical register, the striking of a woman off the Midwives' roll disqualifies the offender from pursuing her calling.

Caprice of the C.M.B. Now, although it is very proper that the offence of "covering" should be severely dealt with, it passes the the wit of man to deduce any sort of consistency out of the policy of the Central Midwives' Board, either as regards the exercise of disciplinary powers or of those of general administration. All sorts of grave offences are passed over with cautions and without any good reason appearing why the offenders should not be vigorously dealt with, and similar caprice marks the recognition of institutions as training schools. At a recent meeting of the Poor Law Unions Association Dr. J. M. Rhodes drew attention in a forcible manner to the utter want of method shown by the Board in sanctioning centres for instruction. He mentioned the fact that only nineteen schools had been approved for the whole of the fifty-two counties of England and Wales, and that whereas in a sparsely populated agricultural county like Gloucestershire five schools were allowed, in crowded industrial districts such as Durham and Staffordshire not a single one had been recognised. Then, too, there lurks under their actions an extraordinary jealousy of Poor Law Infirmaries which, if properly utilised, should form natural training centres. As it is, almost any voluntary institution can be approved, whilst the difficulty guardians experience in getting their infirmaries recognised is immense. The Lord President of the Council, in replying to a deputation, spoke of the Midwives' Board as an "irresponsible body." So *de jure* it is, and so *de facto* it likes to prove itself.

Midwifery Fees at Rotherham. THE question of payment of fees to medical men called in by midwives is still in a most unsatisfactory state. The Rotherham Borough Council, recognising the gross injustice of the position of affairs, lately decided to be responsible to practitioners for fees incurred in this way, as Liverpool, Manchester, and Cardiff have already made themselves responsible. There was, however, a good deal of opposition to the resolution, and it was found to be illegal in the form it passed in. Consequently the movers of a rescinding motion found no difficulty in getting the resolution nullified. One of the speakers stated that so far as he could ascertain the medical men in the town were opposed to payments being made by the Council, but probably in this instance the wish was father to the thought. But it is important that the matter should be thoroughly sifted and looked at in all its bearings before any decisive action is taken, for it must not be forgotten that if people learn to know that by employing a midwife at five shillings or seven-and-sixpence they can be assured of the services of a trained woman who, in emergency, can obtain the services of a doctor to be paid by the public authority, there is more than a danger that a large number of thrifty people who now save up a guinea to pay their own medical man for a confinement, will gradually come to fall back on the cheaper method. So that it is advisable that any fee paid by a public authority should be recoverable from the people who have incurred it, if in the opinion of the authority they are in a position to pay.

Isolation Dances. The Bristol Health Committee have been engaged in a long and anxious discussion, and considering the gravity of the matter before them it can only be remarked that they must have been been guided by an unusually high sense of public duty to have devoted so much of their time to it. The question, indeed, was none less than whether the nursing staff at their isolation hospital should be allowed to engage in the pastime of dancing once every two years. It came out that though the individual members of the committee knew that such a festivity took place, yet—heinous offence! —it had not been officially reported to the committee, and the chairman had not been asked if he approved of the list of guests! One member wished to know if this curious form of entertainment was indulged in "throughout England," and several spoke heatedly about squandering the rates in such a fashion. The burden thus untimely thrown on the rates was shown to be a matter of half a sovereign, as the nurses themselves found everything except bread and butter; and as the half sovereign was incurred once in two years, one hardly imagines that the ratepayers would groan under the load. Another great source of anxiety to the Committee was that eleven of the guests who came from a distance were given the hospitality of a bed for the night, under the supervision of the medical superintendent, and several members of the Committee learned with surprise that it was usual for dancers not to retire very early. Eventually it was solemnly determined to frame rules to regulate the conduct of this dangerous pastime, and the Committee, after sitting some three hours, adjourned. It is fair to assume that the health of Bristol is safe in the hands of such punctilious gentlemen, and that what they lack in humour is made up for by some less conspicuous qualities.

Eye Glasses for Schools. In New York, as in this country, considerable attention is being directed to the eyesight of school children, and it is estimated that 36,000 of them, representing six per cent. of pupils attending elementary schools, have defects of vision that require treatment. A committee has been working on the subject and it has now recommended that the Board of Education to incur the cost necessary for examining the children's eyes systematically. This, it is recognised will be very large, £5,000 alone being required for suitable premises, to say nothing of the salaries of the surgeons employed. But the proposal that strikes the British readers as most curious is that the Board shall provide the children with free eye-glasses! Spectacles, we could understand, and perhaps it is only the American way of putting things, but the mind rather quakes at the idea of what would happen if the happy Board School child were given the run of a stock of free eye-glasses. Even Mr. Chamberlain in all his glory would not be arrayed like one of these.

LEADING ARTICLE.

THE FRAUDULENT DRUG TRADE.

Under the above heading the *Pharmaceutical Journal* publishes an amusing tirade against the Medical Press and Circular, and what it is pleased to style our "reckless crusade against proprietary medicines." The writer of the article says that, however worthy our object may be, yet "no reasonable person can fail to see that the manner of conducting the campaign is as silly as it is useless." In support of that sweeping statement he quotes a former "difficulty" in which the Medical Press was involved with *Truth*, from which he holds we "emerged very much the worse" (*sic.*). We presume that this writer claims to be considered a "reasonable person," so that the "prophet of Covent Garden," as he calls us with easy elegance of phrase, may venture to remind him of the main issue involved in the dispute to which he refers. The Medical Press and Circular pointed out on several occasions that *Truth* had for a long time inserted in its columns an advertisement from one Mrs. Adair, offering certain "Ganesh straps," stuffed with fragrant Eastern herbs, at a guinea and a half apiece, for the cure of wrinkles. There were other "Ganesh" remedies of a kindred nature, such as "muscle oil," to which we drew the attention of our contemporary. We were favoured with many columns of fierce invective in reply by *Truth*, but from beginning to end of its articles not a single reference was made to the crucial point of the Ganesh straps and the Ganesh remedies. If that convinces the "reasonable person" of the *Pharmaceutical Journal* that our arguments were satisfactorily met and demolished, then we fear that the peculiar nature of his intellectual methods would render further argument futile. In support of his own statement that the Medical Press possesses the "blind belief" that it alone is opposed to fraud we have the following: "It" (that is, ourselves) "seems to be content with a smattering of trivial information wherewith to blunder along in its blustering campaign, sledgehammering everything and everybody that it takes into its head to hit." This sentence affords an example of the swash-bucklering style of invective that in the eyes of our contemporary clearly assumes the position of strong and sustained argument. It is of course impossible to undertake any discussion conducted on simple lines of noisy clamour. At the same time it is of interest to enquire why an attack upon fraudulent drugs should so excite the anger of a respectable journal devoted to the interests of the drug trade. So far as we can gather the writer is annoyed mainly because we have stepped in to do a work of exposure that should belong to himself and to the chemists and druggists. He may rest assured that the medical journals no less than the medical profession will hail with acclamation any help in the suppression of the nefarious trade in quack remedies, come from what quarter it may. "Chemists and druggists," he writes, " would form the most powerful ally of any properly-conducted movement which has for its object the suppression of the sale of remedies of a fraudulent character; but the policy of our contemporary seems to be to alienate the sympathy of everybody who could possibly be of service in the campaign." The direction of this charge leads us to refer to the particular paragraph which has upset the equilibrium of the *Pharmaceutical Journal.* The rock of offence is a short leader that appeared in our issue of April 10th, under the title of "The Fraudulent Drug Trade." The text was an advertisement culled from a daily newspaper of a disinfectant claiming great and unrivalled powers, but shown by a correspondent " Analyst " to be practically worthless as a disinfectant and to be foisted on the public with the help of an absolutely worthless, false and misleading chemical test. We fancy that most chemists and druggists would welcome any information that could put them on their guard against participating in a fraudulent transaction involved in the sale of such an article to the public. Why the *Pharmaceutical Journal* should be nettled by our exposure is somewhat of a mystery! It goes out of its way to attribute to us a distrust of the drug trade as a whole. It is hardly necessary to remark that the legitimate drug trade has our heartiest support and sympathy as an honourable undertaking characterised by commercial enterprise, high technical education, and sound business methods. By some obliquity of vision the *Pharmaceutical Journal* has confused our attack upon quacks and vendors of fraudulent remedies with an assault upon the members of an honourable calling. It is to be hoped that in future our attitude will be beyond misconstruction, and we welcome the intimation conveyed in the above-quoted article that "the Medical Press is not quite isolated in its aspirations, even though it is without rival." Now that so doughty a trade journal has come into the field, may we look for a general revolt of the retail chemists and druggists against the sale of remedies of a fraudulent nature? Even the want of good taste and good manners may be to a great extent condoned by honesty of purpose and purity of intention.

CURRENT TOPICS.

Diplomas for Nurses.

A very important decision was come to at a recent meeting of the Royal British Nurses' Association, namely, that it is desirable that the Association should hold examinations and grant diplomas in nursing. A scheme embodying twenty-five clauses was carried, with the addition of a further clause, to wit, one empowering the Association to deprive a nurse of her diploma for misconduct or professional incompetence. The Association propose to form centres at convenient spots, such as those possessing a university, medical school, or nurses' training school, and to hold examinations at regular intervals under the management of a committee consisting of a physician, a surgeon, a gynæcologist, and four matrons. This committee is to set the papers, and the examiners appointed are not to examine their own pupils orally. No steps are to be taken by the Association to enquire into or set any standard for preliminary general education, the function aimed at being purely that of a final examining and qualifying body. It is proposed that a fee of two guineas shall be paid by candidates, one half of which should go to the keeping of a register. This move of the Royal British Nurses' Association is a significant one, for it practically amounts to this, that if the scheme is successful and examination and registration by that body becomes the recognised *cachet* of a nurses's capability, the Association will become the governing body of the nursing profession. However well meant, such an ambition is fraught with much danger, unless it can be shown that the Association has the full confidence and support of the medical and nursing professions, and any medical men invited to become examiners will do well to weigh this point seriously. If, however, the effort of the Association stimulates a movement for the organisation of trained nurses into a thoroughly representative organisation, it may accomplish much good.

Sheffield Union Hospital.

A serious state of affairs exists at the Sheffield Union Hospital, and it is one that demands careful attention from the profession. It has become necessary for the resident medical officer and his two assistants to resign their appointments and leave the hospital under circumstances which are notorious to everyone except the Guardians, who either maintain an air of bland astonishment at the conduct of their medical officers, or seek to insinuate that the latter have been advised to do so by the Local Government Board. As a matter of fact, the trouble is the old one which occurs regularly and systematically in every improperly organised hospital, namely, whether the medical superintendent is the responsible administrative officer, or the matron. In this case it seems quite clear that the Guardians have not only not supported the claims of the medical officers, but that they have deliberately placed the management of the hospital, except for the actual treatment of patients, in the hands of the matron. We have frequently commented on similar situations before, and can now only point to this as a further instance of the short-sighted folly of attempting to run any organisation except under a recognised head, and that head in the case of a hospital a medical man. In every department of life, from the British Navy to the common lodging-house there is a single responsible head, and it remains a monument to the fatuity of Sheffield Guardians and a few similar self-important folk that they try to fight the laws on which society is founded. In the case of the present scandal there must in justice be a Local Government Board Inquiry; there are most serious allegations in question, and they must be sifted to the bottom.

Brentford Hospital "Scandal."

The last stage of the Brentford Hospital "scandal" to which reference has frequently been made in these columns was reached on the 11th of this month when a special meeting of the District Council was held to investigate the charges of negligence and want of sympathy made by Councillor G. Pearce against the matron and nursing staff of the Isolation Hospital, in connection with the illness and death of his child in that institution. At the request of the matron a searching inquiry was made and the excited councillor's grave allegations were found to be completely at fault, the medical officer himself being able to give high praise to the matron for her conduct of the case. After a long discussion the Council unanimously passed a resolution exonerating the matron, Miss Ives, and her assistant, Nurse Collins, from all blame, and expressing their confidence in them, Councillor Pearce himself supporting the motion. Then came a further surprise, for Miss Ives having had her character completely cleared promptly handed in her resignation and that of Nurse Collins, on the ground that they could not continue to serve under a council which had given them so little support in their duty. We congratulate both these ladies on the result of the enquiry and on their subsequent action. At the time, now some months ago, we expressed distrust of the accusations on *a priori* grounds, for when a "scandal" is trumpeted about in the daily press it is nearly always the work of some mischievous busybody. The Brentford Council will probably find it difficult to get any efficient substitutes for the two ladies who are leaving them. Like certain other public bodies they seem to have no notion of supporting their own servants when assailed.

An Unexpected Danger.

A correspondent draws the attention of the *Irish Times* to a danger lurking in an unexpected place. On taking his seat in the stalls of a theatre a few nights previously he suddenly felt a sharp pain near the base of the lungs. Investigation showed that a lady occupying the seat behind had pinned her hat to the back of the seat by means of two long hat-pins which protruded some four or five inches. The accident is by no means an uncommon one, and the consequences, though usually trivial, might very well be serious. It is true an ordinary puncture with a clean instrument is not likely to cause other than momentary trouble, but there is no guarantee of the surgical cleanliness of a hat-pin. Such a weapon, piercing some inches into the back, might easily be the medium for the introduction of septic material into the pleural cavity or to the lungs, and very grave conditions might arise as a result. The practice of securing hats in this way should be strictly prohibited by theatre managements. Such prohibition is advisable not merely in the interests of public safety, but may be found to protect the theatre itself, since it is quite probable that the management would be legally liable for damage done to a patron by any accident arising under present conditions.

The Tooth-brush in Schools.

One of the chief recommendations of the Royal Commission on Physical Degeneration was that immediate attention should be paid to the state of the teeth in elementary school children, and no one who knows anything of the subject will be inclined to deny that the dental condition of the rising generation is nearly as bad as it can be. It is, however, one thing to note the disease and another to find the cure, or even the method of prevention. Nearly all those medical inspectors who have investigated children's teeth have recommended the tooth-brush as a preventive, but while as an instrument of elementary cleanliness the tooth-brush is unimpeachable, it is more than questionable whether it has any profound influence on the decay of teeth. Theoretically, of course, it should, but practically we think the matter open to grave question. The children of the better-to-do classes all use their tooth-brush, and all, or nearly all, suffer from early decay, but in their case earlier and more frequent resort to the dentist complicates any fair statistical comparison. The question is whether early decay of the teeth is not due to radical developmental changes in civilised man which the tooth-brush is as powerless to avert as Mrs. Partington's mop was to deal with the waves of the Atlantic. The teeth are intimately connected in their development with that of the jaws, and owing to change of habits and food the jaws are not now of the size and power of those of prehistoric man, nor indeed of the modern savage. To preserve the teeth we must probably breed a good tooth-preserving stock, and, in the absence of such, mere cleaning the teeth will probably do as little to prevent decay as brushing the hair does to prevent premature baldness.

The Anti-Vivisectionists in Ireland.

It is probably news to many of our readers that there is a branch of the National Anti-Vivisectionist Society in Ireland. It does not, we are glad to say, make its presence felt, and it appears to spend most of its time in a condition of hibernation, so that it is on the whole rather harmless. It was perhaps in the hope of rousing it to activity that the Hon. Stephen Coleridge crossed the Channel last week to address the annual meeting. Whether it was the depressing effect of the Channel passage or infection from his somnolent audience that affected Mr. Coleridge, he was not as lively as usual. He seems to have found no fresh "platform facts" of late, and the old ones have been served up too often. He is reported, however, to have said that "vivisectors would justify the placing of two dogs in a cauldron of boiling water to see which dog would get to the other side first." We have never heard this statement before, but still it was hardly satisfying as the *piece de resistance* of the lecture. Mr. Coleridge also patted Sir Thornley Stoker on the back on account of the evidence given by him before the Commission inquiring at present into the question of experiments on animals. All this applause from the enemies of science must be more offensive to Sir Thornley Stoker than the righteous criticism to which he has been subjected from scientific investigators.

The Supply of Anatomical Material in Dublin.

We regret to notice a disposition on the part of the Guardians of the North Dublin Union to place obstacles in the way of supplying bodies to the medical schools for the purpose of anatomical study. At their last meeting the Guardians passed a resolution which may have serious effects in limiting the supply of anatomical material. Up to the present it was open to the Board to give to the schools the bodies of paupers unclaimed by friends, unless the pauper had himself expressed a desire to be buried in the usual way. In future, the question of the disposal of his body is to be brought actively before every inmate of the workhouse, and his wishes are, of course, to be respected. In addition to this, the Guardians forbid, under pain of dismissal, any official to receive any fee in respect of any bodies removed for anatomical examination. These fees, small in amount, were paid by the schools to the medical officer and master for certain certificates necessary by law. It is doubtful whether the prohibition by the Guardians can be made effective, but their expressed wish will, naturally dispose these officials to place difficulties in the way, and the supply of bodies has always been dependent to a great extent on the goodwill of the workhouse officials. The position is one of great gravity, and the efficiency of the Dublin schools of medicine is at stake. We trust that wiser counsels will prevail and that the Guardians may be brought to see that any injury to the schools of medicine is a serious injury to the prestige of the city. Anatomical study is the prime necessity of instruction in the art of medicine, and if Dublin is to maintain its position as an educational centre of importance, vexatious restrictions must not be imposed by the Guardians of the city unions.

Sanatorium Treatment at Moderate Fees.

One of the most satisfactory modern aspects of the tuberculosis question is the undoubted advantage of early sanatorium treatment. Isolation, so far as prevention goes, is clearly desirable in all stages of so infectious a malady, while the cure of the individual entails further measures that as a rule can be carried out efficiently only in a specially organised and equipped institution. Hitherto it has been found impossible to provide sufficient sanatorium accommodation for the poor of our great cities, who die either in their own homes or in poor-law institutions, as only a small proportion can obtain prolonged treatment in consumption hospitals or sanatoria. The well-to-do can obtain first-rate accommodation in abundance, both at home and abroad, and are able to fight the disease under most advantageous conditions. Between the wealthy and the poor, however, comes a large class of consumptives who are able to pay small fees, but for whom there is a lamentable lack of special accommodation. The example of Winsley Sanatorium, therefore, in this respect, deserves attention. The Sanatorium is supported by the counties of Somerset, Gloucester, and Wilts, and last week it was announced by the management that certain beds would be allocated to persons residing within those counties on payment of 35s. a week. They are also willing to receive a limited number of persons not residing within the three counties on a payment of £2 10s. per week. This certainly appears to be a move in the right direction.

PERSONAL.

At Richmond on the 15th inst., the Prince and Princess of Wales opened the Swan Memorial Ophthalmic Ward of the Royal Hospital, generously given by Mrs. Swan.

On the 23rd instant H.R.H. the Prince of Wales opened a handsome set of new buildings for the extension of Glasgow University. The buildings are for the departments of Physiology, Materia Medica, Forensic Medicine, Public Health, and of Natural Philosophy, and have cost between £70,000 and £80,000.

H.R.H. Princess Christian will formally inaugurate the completed portion of the National Sanatorium for workers suffering from Tuberculosis at Beneden, Kent, on Tuesday next. Invitations to luncheon have been issued by Sir Clifton and Lady Robinson in connection therewith.

An unusual honour has been conferred by the King upon Sir Frederick Treves and Sir Francis Laking, in consideration of their great skill and unremitting attention during His Majesty's illness in 1902. The distinction consists in an honourable augmentation to their arms, to these they are henceforth entitled to add one of the lions from the Royal Arms.

Sir Havelock R. Charles, K.C.V.O., M.D., R.U.I., Physician in Ordinary to H.R.H. the Prince of Wales, late Professor of Surgery in Calcutta Medical College, has arrived in England on leave of absence.

It is proposed to endow a Research Professorship at the Liverpool School of Tropical Medicine in memory of Dr. J. E. Dutton, who died at Kasongo, on the Congo, in 1905, from tick fever, contracted during study of the disease. Mr. A. H. Milne, Hon. Sec., Liverpool School of Tropical Medicine, will be glad to receive subscriptions to the fund.

Surgeon-Major R. J. W. Mawhinny, R.A.M.C., from Ferozepore, India, has been appointed to Belfast for duty, and Surgeon-Captain G. Baillie, R.A.M.C., from Quetta, has been posted to the Irish Command at Dublin for duty.

Dr. Thomas Wilson will deliver the Ingleby Lectures of the University of Birmingham on May 9th and 16th on the "Inflammations of the Uterine Appendages."

The Edinburgh University Club will dine at the Criterion Restaurant on Tuesday, May 7th, under the Chairmanship of the Right Hon. Lord Kingsburgh. Members intending to be present should immediately communicate with one of the Hon. Secretaries, Dr. R. Hutchison, 22 Queen Anne Street, or Mr. J. Thomson Walker, F.R.C.S., 30 Queen Anne Street, London, W.

A Clinical Lecture

ON

SOME CASES OF NERVOUS DISEASE. (a)

By WILLIAM CARTER, M.D., B.Sc.; F.R.C.P., LL.B.Lond.,

Senior Physician to the Hospital and Professor of Therapeutics at the University of Liverpool.

Gentlemen,—There are under my care at the present time a number of patients suffering from various forms of nervous disease, all of whom will well repay your careful study. Disease has been deftly and skilfully performing a series of experiments, without any of the disturbing elements often inevitably introduced by the experimental induction of such conditions as you see here, *i.e.*, there has been no trephining, no removal of a portion of the skull or vertebræ, no external violence of any kind to complicate the result. It is our business, first, to interpret, if, and as far as, we can, the cause or causes of the symptoms, which we see manifested; and, secondly, and most important to the patient, to remove those causes and bring about a restoration to health, if, and so far as, we are able.

Let us take the simplest case first, and then proceed to the more complicated.

The patient, a stalwart, powerful fellow, æt. 54, the father of thirteen children of whom twelve are married, was admitted twenty-three days ago suffering from the symptoms which I will describe to those who have not seen him. Now consider them well, and their relations to each other. One of his chief complaints was that he could not eat without biting the right side of the lower lip and cheek, the mucous membrane of which had become severely abraded, owing to this; the right cheek was flaccid, smooth, and expressionless; he had a difficulty in pronouncing some words, especially those containing labials, so that his speech was thick and slow; if he stooped to pick anything off the floor he became giddy and stumbled forward as if about to fall; pain, at first of a severe character, but not increased by pressure, was complained of at the back of the head, and over the back of the neck and right shoulder and down the right arm and leg. On testing his sense of taste, it was found that he could not distinguish salt from sugar on the anterior two-thirds of the tongue, though he recognised quinine at the tip. It was also found that the uvula, which was very long, did not respond to mechanical irritation. For nearly two years he had suffered from what he spoke of as "rheumatics," by which he means pain; and also from occasional slight tinnitus in the right ear. That was ail. The eyes could be closed and opened as in health. The pupils were normal, and vision good. Hearing was practically unaffected—a little less acute in the right than in the left ear. The grasp was very powerful, and equal in each hand; so powerful was it that neither of our dynamometers could register its force, the index being driven instantly in each case to the extremity of the arc. He could stand steadily with the feet close together and the eyes shut. There was no discoverable impairment of sensation, except that of the special sense of taste. I tested the skin of the face in a variety of ways—pinching, pin-prick, &c., and his statement invariably was that he could feel as well on the one side as the other, and as well as he could before the illness commenced.

Now the very simplicity and fewness of the symptoms make the case somewhat puzzling, and its interpretation difficult. If sensation had been impaired on the parts supplied by the fifth nerve—for it was obvious that it was that nerve which was affected and not the seventh; if the eye had been inflamed; if there had been diminished sense of smell, &c., the clinical picture would have been deemed more complete, and the causes of the various lights and shadows entering into its composition more comprehensible. But we must accept facts just as they are presented to us without adding to or subtracting from them for the sake of supposed scientific completeness. Is there any portion of the great fifth nerve which seems to have been specially picked out by the morbid process, whatever that may have been? Certain facts stand out markedly; first, the gustatory or lingual branch of the fifth nerve must have been rendered functionless, or there would not have been the inability to taste salt and sugar or to discriminate between them. Let us trace this nerve and see if there is anything in its course, connections, and distribution which will help us to understand the case. It lies at first beneath the external pterygoid muscle, where it is joined by the chorda tympani, and immediately afterwards beneath the internal pterygoid to which it sends branches; then, pursuing its way, it reaches the side of the tongue over the upper constrictor of the pharynx, where the muscle is attached to the maxillary bone, and, lastly, runs along the side of the tongue to its tip, distributing branches in its course, and ends by joining in a sort of partnership with the hypoglossal nerve. Suppose now that this single branch—the gustatory division of the fifth—could have been deftly picked out by an accomplished experimenter and divided or so squeezed as to be rendered functionless, would not the great majority of this patient's symptoms have followed? I think they would, and that there must in this case have been a singular limitation of the disease-process to this branch, and almost to it alone. But is this possible? Why not? The experimenter often directs his attention to one small nerve and elucidates symptoms by injuring or destroying it; only in such a case as ours, where the nerve lies deeply throughout its whole course, he could not have attained his purpose without complicating the experiment with much injury to more superficial parts, and inducing reflex phenomena which such injury often causes. But are all the symptoms explained on the hypothesis of a disease-experiment on the gustatory nerve near its origin and on it alone? No, I do not think they are. The pain in the occipital region of the skull, and in other parts, as well as the giddiness on stooping, cannot thus be accounted for, and need the involvement of other sensory nerves or their centres. But these had been of long duration, while the other symptoms were comparatively sudden in their onset. What kind of lesion might have attacked this gustatory nerve and the other nerves? Remember the patient's occupation, and the time of the year. He superintended the working of a stationary engine, from the heat of which he was obliged to absent himself, by passing into extreme cold, where perspiration was at once checked. Are such sudden changes liable to be followed by inflammatory or sub-inflammatory deposits? I think that common experience will say that they are. But, if so, is it not curious that a single branch of a single nerve should be picked out for special attention? It may be curious, but even if this branch had alone been attacked it would be by no means unique.

If our vision could be so enlarged as to enable us to see the thickening (and its resulting pressure or irritation indicated by the symptoms) of the gustatory nerve, and possibly other nerves at the posterior part of the head, could we do anything to remove it?

(a) Delivered at the Liverpool Royal Southern Hospital on Feb. 12th, 1907.

There is one remedy which it would be well always to try. Mercury causes the rapid absorption of lowly inflammatory deposits and mercury is too much neglected in modern therapeutics, possibly because it is believed by many to influence only those caused by syphilis. I do not believe for a moment that this man had ever been syphilised, yet we rubbed mercurial ointment into his axillæ, and in a fortnight all his symptoms had disappeared, and he begged to be allowed to go back to his work. He has only consented to stop till to-day in order that you might for yourselves see the results of the treatment employed, if I am correct in judging that the treatment and his restoration to health have any connection with each other.

The next case—and the only other of the five cases of nervous disease that I shall have time to describe to-day—is by no means so simple. Like the last it is that of a powerful healthy-looking man, who also, like the last, is a fireman. But he had better repeat his own story as it was written down from his lips when given to us on January 26th of the present year. It was to the effect that he had never had a day's illness till the evening of the preceding day, January 25th, when he felt pain in the back of the neck, and the back of the left shoulder. He went to bed at midnight, slept well until five the next morning, when, as he says, he awoke with a "creepy" feeling all down his left side, and almost complete loss of power in the right arm and leg. With the aid of two friends, who supported and partly carried him, he was just able to reach the hospital from an adjacent street, when it was found that besides the right motor paralysis, there was great impairment of sensation on the left side extending from the fourth rib in front and the fifth dorsal spine behind, down to and including the feet. Over the whole of this surface from the middle line in front to the dorsal spines behind on the trunk, and over the whole of the left lower limb, he was quite unable to distinguish heat from cold, or the deep prick of a pin from an ordinary touch; the arm, forearm, and hand were not affected. His own idea was that the illness was caused by his sudden passage from an overheated stoke-hole, while he was perspiring, into the intensely cold atmosphere of January 25th, when the temperature was much below freezing. He was quite certain that he had suffered from no accident, and that he had always been well able to do his work up to the morning of admission. On carefully continuing our examination, it became obvious that there was a more extensive disease-process than in the last patient, and, moreover, that it affected only the spinal cord. Thus on the motor side this powerful-looking man, with every effort could only move the index of the dynamometer to 3 with his right hand, while it ran round at once to 43 when grasped with the left hand. The pectorals, rhomboids, and all the muscles of the right upper and forearm were obviously much weakened. When he was carefully got out of bed and made to stand with his feet together and eyes closed, there was but little if any swaying, but the gait on his attempting when supported to move forward, was very unsteady, and on the right side seemed to be spastic. Co-ordination of the muscles of both legs was good, but that of the right hand and arm poor. So much for motor changes. Turning now to the sensory side, there was a curiously mixed distribution. Thus, the merest touch on the right side of the neck and right shoulder caused the intensest pain; while on the left there was the diminished sensation that I have mentioned to you.

The knee and Achilles reflexes were exaggerated. There was plantar left-side extension on irritation, while on the right side there was no reaction. The biceps jerks were active and equal. The circulatory, respiratory, and alimentary systems were normal. Turning now to the cranial nerves, it seemed at first as if one of these at least had been affected, until we learned from him that the defective sight in the left eye had existed unchanged for many years. All when carefully tested, were found to be normal. Sight in the right eye, hearing, smell, and taste were unaffected, his mind and memory were clear, and there had been apparently no passing disturbance of consciousness. What interpretation can be put upon these curiously distributed nervous symptoms? In trying to understand their causation, I think we must bear in mind the comparative, but by no means absolute suddenness of their onset, and the peculiar circumstances immediately preceding this. He had suddenly passed from extreme heat into extreme cold. He went to bed at bedtime, as he believed, quite well, except that there was some pain, though not enough to interfere with the sleep, which for five hours was unbroken and complete. Then he awoke with intense pain and apparently more sudden loss of power over the right half of the body below the neck, and of sensation over a considerable though not quite equal area on the left. I should think that in all probability the parts were affected almost if not simultaneously, but that being in bed and asleep he was not conscious at first either of the loss of power or of sensation. I think we may conclude that the affection was exclusively spinal, *i.e.*, that the cord alone and not the cerebrum was involved in the morbid change. What *was* the change, then, that had in so short a time transformed this powerful, healthy fellow into the weak, shattered creature that you have seen? If you refer to the systematically arranged diseases of the nervous system, the affections which seem to be most nearly reflected in our patient are syringomyelia and hydromyelus; but there are circumstances which compel us to exclude these. Firstly there is the comparative suddenness of onset. Then, again, in both of these cases, the patients were well until they passed suddenly from extreme heat to extreme cold; and the question naturally arises whether the chilling of the surface and its consequent contraction of superficial blood-vessels caused dangerous internal vascular distension, with possibly small hæmorrhages in, or inflammation of, the pia mater. That there was something more than a passing congestion of the membranes of the cord is, I think, pretty certain, as this condition is generally characterised by symptoms from which our patient did not suffer. In it there are fibrillary tremors, and as well oscillatory movements of the fingers, owing to the irregular action of the interossei and lumbricales muscles, and easily seen when the hands are extended and the fingers separated from each other. There are also strange disturbances of sensation—paræsthesiæ—experienced over different portions of the skin and likened by the patient to the hot feeling produced by holding an overheated metallic plate near the surface, &c., &c. Moreover, this condition is often speedily benefited by the use of constrictors of the spinal vessels and counter-irritation on either side of the spine. Thus I have seen the greatest relief afforded by large doses (ʒj) of the liquid extract of ergot, and the application of Brown Sequard's white-hot cautery along either side of the dorsal vertebræ.

But things were different here. If we are correct, as I think we are, in concluding that the spinal cord and its membranes are alone disordered, what affections can explain symptoms so anomalous—almost complete loss of motion on one side and greatly impaired sensation over a large portion of the other? We could more easily have understood them if, the lesion being spinal and not cerebral, the impaired sensation had been on the same side as the motor paralysis, as this association often occurs in the case of lesions, whether experimental or pathological, involving a transverse half. And the pain immediately above the level of the motor paralysis is a common symptom also. But to have *no* diminution of sensation on the side of the motor paralysis, and *great* diminution of it on the opposite side, must be regarded as very unusual.

Then what is the cause of these symptoms, and has it acted on the sensory track or roots on the one side and the motor on the other? I am afraid it would be impossible to decide with certainty. What *is* certain is that the body, when healthy but overheated and with its superficial vessels dilated, was suddenly subjected to intense cold. Was there a dilatation of the vessels of the cord, caused by the constriction of those of the surface of the body? This, I think, is not unlikely. Nor is it unlikely that different areas of the pia mater were affected with different degrees of congestion, nor that where the distension was greatest exudation followed. It was the fear of this which dictated the practice adopted, for I know that such quick and intense beginnings as we had here often have very slow and very painful endings, owing to inflammatory exudations, which subsequently, like cicatricial tissue, contract, press on nerve cells, and cause permanent mischief, unless they are absorbed while in an absorbable condition. Mercury, as ointment, was therefore rubbed in freely morning and night, while the intense pain was allayed by the local application of aconite and belladonna. What has been the result thus far? Sensation has become normal on the left side; he can walk alone fairly well; with the right hand he can send the dynamometric pointer to 13 instead of 3; and the severe pain on the right side of the neck and shoulder is much subdued. We shall therefore persevere for the present, and if necessary later on, call in the aid of electricity, massage, and the hypodermic injection of strychnine, all of which, either together or separately, are of great use where muscular weakness remains for any length of time.

Note.—Electricity and massage were used, as well as the inunction, and the patient left the hospital well in a few weeks.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Arthur Hy. Benson, M.A., M.B. Dub., F.R C.S., Surgeon to the Royal Victoria Eye and Ear Hospital, Ophthalmic Surgeon to the Royal City of Dublin Hospital. Subject: "Glaucoma."*

CLINICAL LECTURES.

In addition to the twelve Clinical Lectures acknowledged as in hand in our issue of the 3rd inst., we have since received, and hereby acknowledge with thanks, the following:—

Bland-Sutton, J., F.R.C.S., Surgeon to the Middlesex Hospital, and Senior Surgeon to the Chelsea Hospital for Women. Subject: "The Value and Fate of Belated Ovaries."

Horrocks, Peter, M.D.Lond., F.R.C.P., Senior Obstetric Physician to, and Lecturer on, Obstetrics and Diseases of Women in Guy's Hospital. Subject: "Disorders of Micturition."

Pringle, Seton, M.B., B.Ch. (Univ., Dub.), F.R.C.S., Surgeon to Mercer's Hospital, Dublin. Subject—"The Treatment of Carcinoma of the Great Intestine."

West, Samuel, M.D.Oxon., F.R.C.P.Lond., Physician to, and Lecturer on, the Principles and Practice of Medicine at St. Bartholomew's Hospital. Subject: "Foods and Feeding in Certain Conditions."

Van Dwellers Stricken with Diphtheria.—An outbreak of diphtheria is reported from Carmarthen district, a family named Jones, who travel about the country in vans, having been affected by the disease. When in camp near Mydrim a child died, and the other children of the family being ill, the authorities removed the Joneses to Carmarthen, their van being taken to an isolated place in the borough for disinfection. The family were also isolated, and their bedding and clothing were either disinfected or burned. The patients, who have almost recovered, will shortly return to their vans.

ORIGINAL PAPERS.

ON THE PRESENT POSITION OF THE TREATMENT OF TUBERCULOSIS BY MARINE CLIMATES. (a)

By WILLIAM EWART, M.D.Cantab., F.R.C.P.
Senior Physician to St. George's Hospital and to the Belgrave Hospital for Children.

Part I.

Mr. President, and Fellows,—The honour conferred upon me by your Council's invitation to open this debate will be best acknowledged by an endeavour to assist you in clearing up the situation, if, as it almost appears from the selection of the title, any doubts should prevail as to where we stand. To that end I may venture to dwell upon principles rather than details, and also to refer briefly to the nature and requirements of the affections to be treated.

Novelty in meteorological facts or in therapeutic methods is hardly to be expected of this address, neither can it provide a complete panorama of the subject. But its freedom from any seaside bias is assured as it has been entrusted to a critic rather than an expert, almost more familiar, after upwards of a score of winter visits to the Alps, with the climate of the altitude than with that of the coast. On that score alone his conclusions would be debatable; and as the practical conclusions are the only essential part of an address, they may be at once briefly enumerated as a basis for the discussion of the suitability of cases for marine treatment:—(1) All cases of *surgical tuberculosis* and scrofula are suitable. (2) All *latent* or *threatened* cases of tuberculosis pulmonalis are suitable. (3) Early cases of *declared tuberculosis* or of "declared phthisis pulmonalis" are debatable, and the responsibility of advice is great, for climatic treatment may turn the scales. They are all fit to try the mountain cure. But failing this not all of them will benefit most at the sea-side; and more equable climates may be indicated. (4) The suitability of cases of *advanced phthisis* can only be decided in relation to the existing prognosis and to personal toleration and preference in regard to climate. Well sheltered marine stations are available, provided the patient's inclination favours them. But in a smaller group, some chances of improvement may still remain which doubtful climatic influences should not be allowed to mar, if on fair trial they should have proved unsatisfactory. (5) The excellent progress maintained at chosen spots along the coast by some cases of *chronic quiescent phthisis* reveals the fact that there are temperaments for which sea-side air is specially favourable, and may be of positive advantage even at the later stages.

The meteorological conditions are a relatively easy study, but their uneven influence upon individuals are as various as the nervous systems which react to them; and these differences are greatly intensified in disease. The sensitiveness of the rheumatic is proverbial. For the majority the approach of rain or of snow is a discomfort, and the fall a relief; but there are exceptions. Again the exhilarating effect of dry frost is not shared by all, but there are those of intense electric susceptibility to whom frost is pain because of its dryness, and who are exhilarated by the change to a damp atmosphere. But in addition to this nervous response to weather, some effect is exerted upon the tissues themselves in health and in disease. These are some of the physiological details which complicate the apparent simplicity of our enquiry.

The mental factor must not be forgotten. For children the sea has boundless charms, and for older minds instruction. We are all as children when gazing upon our terrestial limits with the great unknown beyond; but some invalids might resent the solemn monotony of the scene.

(a) Opening Address to the Debate at the Hastings Meeting of the Balneological and Climatological Society on March 16th, 1907.

The effect upon the nervous system oscillates with the weather and the sky. There may be individual intolerance for the glare, or for the rhythm of the wave. These obvious instances serve to illustrate those more subtle nerve responses which are apt to influence our results.

"*Reaction*"—there is a volume in that significant word which symbolises much of the purpose and of the mode of action of our climatic treatment. The nervous system, and particularly the vasomotor system, appears to furnish the working mechanism of reaction; and its sphere extends widely in two directions that of a stimulation of the general metabolism, and that of the local effects upon skin and mucous membrane, and of the reflected effects upon functions, viscera, and tissues.

Sea Air and Sea Water; and Thalassotherapy.

Sea Water.—The immense ocean, our earth's greater surface, is still, for many purposes, a blank, its wondrous powers and its inexhaustible treasure hidden—except from the vision of the poet. It is true that it has yielded us iodide of potassium and cod liver oil, but other great remedies for our terrestrial ills may yet arise from the deep. For, although two of the branches of "sea treatment"—our sea air and our sea bathing—are as old as the race, the latest branch of "Thalassotherapy," the practical pharmacology of the sea, is still in its infancy.

If there is any special virtue in sea air it must have been derived from sea water. Quinton, of Arcachon, has written a large book on the constitution of the latter, and of its diffused organic contents which, together with its high saline charge, raise it to the value of a serum, and to a strength which has to be diluted more than half (3 parts of distilled water to 2 of sea water) before it is isotonic with our own. In that proportion it has been extensively used, after simple filtration, in moderate sized subcutaneous injections, of which he describes the remarkable results.

As to its other uses, the ancient recipe of sea water as an *internal medicine* has never been much patronised. The chief mode of employment is external. *Sea bathing* is not appropriate for consumptives; but the modified sea bath or *sea-water rubbing* belongs to the daily routine of a marine treatment. It is singular that, whilst inland mineral springs impregnated with the buried residue of former oceans are used for *inhalation* with considerable success, nothing is attempted at our marine stations by way of pulverising the living briny serum for throat-sprays or vapourized inhalations. The method may prove inapplicable in phthisis but it might be tried in other affections.

Sea Air.—The breathing of sea air is apt to get the credit for results not entirely its own. If we bring it to rest, dry it, and warm it, is there still any specific virtue left in it distinctive of the sea? This question cannot be answered off-hand. *Ocean air* is free from microbes and from the coarser particles of which dust is made up; and this purity is reinforced, as it were, by ozone and possibly by radiobes. Are there not, however, some finer and more characteristic constituents analogous to those emanations from soil and vegetation which occupied so large a place in the old etiology of endemics, and still claim consideration in connection with asthma. Asthmatics are acutely conscious of a "closure of the chest" by given atmospheres, and sometimes by that of the sea. We, too, are familiar with the delightful sense of a freer and deeper breath on approaching the coast. Both forms of respiratory reaction suggest an atmospheric cause. And as to their mechanism, this might be a mere intensification of those normal activities with which Watson Williams credits the bronchial muscles in healthy respiration. We *do* know that organic matter is contained in the spray swept up from the wave, and that for every falling crystal which contributes to the saline incrustation of the vegetation, and of every exposed surface on shore, there remains in suspension until oxidised away, a minute quantity of organic matter made up of the lower forms of animal life and of the nutrient basis diffused through the ocean, which must be so fine as to resemble an exhalation, although not comparable to the full-flavoured effluvia arising from the beach. The important question for your discussion is whether sea air is in itself, and apart from added influences, a respiratory stimulant.

The other atmospheric peculiarities are physical rather than chemical and biological. They possess nothing specific, though there is something characteristic in their grouping. Ocean air is always more or less *moist*. But relatively dry air may be blown across narrow seas, as exemplified in our own East winds so discomforting to the soft hydrated nerve endings of a fog-bred race.

The Marine Climates of the Ocean and the Coast.

We must not imagine that the curative virtues of climates are to be judged according to a mere scale of comfort. The open air hardships of pre-historic cave-dwellers may have surpassed in real value some of our climatic refinements. Our ideals must vary with the objects of treatment: and these furnish us with two great climatic types—*the protective and the active, or stimulating*.

There are distant southern shores which offer us close approximations to perfect protection varied with each turn of the French and Italian Riviera and of the African Coast; Mediterranean and Atlantic Islands, too, Corsica, Capri, and Sicily, Madeira, Teneriffe, and the Canaries; besides the more remote West Indian and Californian resorts. In their number are to be found instances of the more bracing type, though sometimes marred by a liability to treacherous winds from mountain or valley. But in general they are unsuitable in summer; and this explains the absence of any systematic national sanatorial enterprise in the Riviera. Our own protecting climates though not so exquisite as those of the cœrulean type, are no less varied, and they are available in summer as well as in winter. Moreover, as we possess a graduated series of bracing stations, we are practically independent as regards marine climates; and this is some compensation for our complete lack of any available altitude.

The Ocean Climate.—An open air life on some small mid-ocean island would give us the unadulterated advantages of a climate which may also be obtained in a modified form and with some drawbacks on any "liner" or in a "floating sanatorium." Sea air from every point of the compass, sea air always, and sea air only, laden with salt and gluey sea stuff, always moist and never freezing, with steady breezes and long dead calms or passing storms, not varying immoderately in temperature from day to night, or even from season to season, clouded at times, but more often glittering with a thousand mirrored suns—radiant, temperate, equable, and moist—this is the marine climate in the fulness of the term. Its characteristic is "equability."

The Sea Coast Climate.—How different the climate of the coast with its ever renewed atmospheric conflicts, and its daily balancing of the temperature-account by breezes from the land and breezes from the sea. Thanks to the latter, sea air is never long absent from shore; but strong winds and long winds may blow from the land, and we then realise that this is not a "climate," but a "mixture" of two climates, a *tertium quid, varium et mutabile semper*. In our latitude it may get frost from the land, but seldom from the sea, which keeps the atmosphere warmer and moister than that inland, relatively temperate, equable and moist, but not in any of these respects equal to the ocean climate, and in none of them constant. Ever astir, the searching damp air keeps things moving, and when it comes from the sea it is "strong air," though it is often only land air possessed of very different qualities; but whether from the sea or from the land, it is apt to rush into fitful disturbing winds: truly a climate of vicissitudes, a school for ever ready reaction: its name is "variability."

In reality each station has a climate of its own which partakes more or less of the marine type according to the extent of its shelter from inland influences and of its open exposure to the sea. Thus sometimes the sea element of the climate may happen to be considerably mitigated. There are indeed those less frankly marine climates in which, far from being eliminated, the land features of configuration, vegetation, and soil are the more essential part.

The variability common to all local climates becomes a drawback or a boon according to the therapeutic requirements. In short, sea-coast climates can seldom boast of being ideal, but they have a wider range of selection and of adaptability to individual cases, if only these opportunities were to be utilized.

Catarrh and the Influence of Wind.

This is the topic of the day; but it is really only a new phase in the old question as to the bracing and the relaxing quality of winds. The chilling influence which they all exercise varies with their strength and temperature. But their varying moisture also largely governs the rates at which heat and electricity are conducted away from the surface; and it accounts for the diverging effects of the south-westerly and of the north-easterly winds which of all others provide us with the most instructive contrast. Dr. Wm. Gordon's laborious investigations have led him to the conclusion that, whatever the effect may be upon the clinical course of the affection, a south-westerly exposure distinctly favours a higher prevalence of pulmonary tuberculosis. The demonstrable fact that moisture is one of the conditions of existence and of activity of the bacillus, tends to support the results of his statistics. An experimental study of the behaviour of the mucous membrane would be a much more difficult matter. But clinically there is no doubt that any sudden transition from cold and dry to mild and muggy weather heralds the onset or the recrudescence of catarrhs. A similar conclusion was pointed out in my article on bronchitis in Clifford Allbutt's System of Medicine on the basis of the Registrar-General's statistics which showed a lower rate of mortality from bronchial affections in the Eastern than in the South-Western Counties. If these conjunctions are not to be regarded as fortuitous they should be capable of some rational explanation in the future. The facts before us read thus—that whilst moisture of air definitely favours bacterial life, it also appears to foster a liability to catarrh, and to lessen the resistance of the organism to the causal factors of the latter. It would thus seem as though wet winds might be conducive not only, as urged by Gordon, to an increased frequency of consumption, but also to an aggravation of its catarrhal tendencies a point of primary importance for our present enquiry in these islands, swept on the one side by the moist Atlantic gales, and on the other by the winds which have yielded their moisture to the intense refrigeration of the polar ice-fields and of the Siberian steppes. Great Britain has lost its evil name as the home of phthisis mainly thanks to the drainage of its damp soil. Perhaps you will bear with some brief remarks upon some of the other factors of catarrh.

The natural history of pulmonary catarrhs would be a simpler one to trace if we possessed evidence that their causation was exclusively microbic. But whilst recognising the probability of an active infective factor, particularly in the more acute febrile colds, which has recently been ably urged by Dr. Prosser White we must still assume that the physical stress of violent oscillations of pressure, of temperature, of moisture, and of electricity, plays no mean part in their etiology. The wonder is that in the integrity of the physiological state we should rise superior to the strain. Between the fulness of health on the one hand, and its pathological disablement on the other, there is no common measure. The mysterious gulf between them cannot be explained, but it is graphically represented by the expression, "collapse of the mechanisms of adaptation," which implies some nervous failure.

A stoker will think nothing of facing, immediately after the fierce heat of the furnace, the coldest wind on deck; but when prostrated by catarrh a slight draught may chill him to the bone and the radiation from an ordinary fire may lead to a profuse coryza. Undue sensitiveness of the surface is with some an innate delicacy; or it may be acquired from injudicious coddling. Little or much of it is invariably induced by the depressing influences of phthisis. Where it exists this individual predisposition to catarrh adds serious responsibility to our climatic selection as even in those free from tubercle it impedes recovery and favours relapse. Such subjects, too, are specially difficult to train up to a toleration for damp or cold air. The contingent which they contribute to the ranks of phthisis is accountable for a large proportion of failures or long delayed recoveries in the "open air" of tnis country or of the Alps. They need an ideal climate of their own; in brief, *the most perfect climate, with a personal correction.* For want of this they are apt to run through the triple series (*a*) of common and influenzal catarrhs, (*b*) of bacillary bronchial catarrhs, and (*c*) of irritative *vomical catarrh* with suppuration generally incurable and disastrous, unless the atmospheric severities be tempered to the irritable membrane.

The intense sensitiveness of the cutaneous surface of many invalids to the slightest impressions conducted by damp air, and the excessive response of the mucous mechanisms are but too genuine; but there is also *the chill "on the mind"* which intensifies the evil. These are poor subjects for our average marine climates in winter; but the initial catarrh, if slight and quite early, may benefit in some warm bracing shelter.

In the absence of any tuberculosis catarrh often finds its natural remedy at the sea; and I believe that the degree of suitability of the particular local climate is reflected in the varying time required. Careful selection will be specially needed in cases where the catarrh is inveterate and its perpetuation fraught with organic consequences, as in bronchiectasis.

The Forms of Tuberculosis.

This is not the place for any pathological discussions, but we may refer to Dr. Nathan Raw's recently published views as they suggest an entirely novel basis for our classification. He believes that the human subject is liable to be attacked by two types of bacillus —the *human* and the *bovine*—and that these two types of infection are not only strictly distinct, but in a sense mutually immunising, so that one infection may be successfully combated by the tuberculin from the other variety. The bacilli of bovine type are supposed to be conveyed by milk through the intestine. Those of human type being inhaled, would thus be almost exclusively responsible for our pulmonary tuberculosis; whilst practically all other forms of tuberculosis would be due to infection of the bovine type.

Whatever eventually may prove to be the fate of this theory, it emphasizes a distinction previously manifest. From our own special standpoint, pulmonary tuberculosis is known to differ much from all other forms in its behaviour under the influence of climate. It is indeed mainly in connection with the pulmonary cases that the value of the marine climate becomes a difficult question. They constitute a separate category, whilst for our climatic purpose all other forms may be grouped together.

Tuberculosis Other than Pulmonary.—We need not dwell long upon this large and varied collection, which includes "surgical" tuberculosis of skin, of bones, of joints and of glands, genito-urinary tuberculosis, abdominal tuberculosis, and the tuberculosis of serous membranes. Happily it may be said of nearly all these that they stand the marine climate wel land tend to benefit from it. The other group cannot be so briefly dismissed.

Pulmonary Tuberculosis and Its Varieties.—The many anatomical and clinical varieties of lung disease really defy classification, as they are the outcome of endlessly various individual proclivities as regards tissue-reaction and function. For our practical therapeutics we shall look only to the broadest features as our guides: but we cannot ignore *predisposition* in its three aspects—the *constitutional* liability to infection, the *localised individual vulnerabilities* of *organs*, and their *functional inadequacies or instabilities*. The individual evolution of tuberculosis pulmonalis is largely determined by the inherited weakness of the lung with tendency to catarrh, combined in the worst cases with a feeble heart. In the large group of lymphatic tuberculosis the defect is not in the lungs; the liability resides in specially vulnerable serous membranes, or in intensely irritable glands. And similar lines of predisposition run through the other varieties.

Happily in many cases of accidental infection the subjects are free from any strong predisposition, and the tendency of the early lesions to a spontaneous cure is evidenced by the frequency with which their vestiges are recognised in the lungs of those who have met with a sudden or violent death in the midst of perfect health, the proportion being 20 per cent. according to the statistics of the Morgue quoted in W. Huggard's excellent Handbook of "Climatic Treatment."

It would be straining the common uses of language to describe as "consumptives" these bearers of "latent" tubercles which may never give occasion either for suspicion or treatment. "Tuberculosis," on the other hand, is an inadequate statement of the multiple miseries which make up the pathological and clinical record of the dying consumptive. As a fact his tubercle was complicated by catarrh, by pneumonia, by necrosis and by sepsis; and in our ministrations none of these could we afford to ignore. There may be then something to be said for the old-fashioned distinction between phthisis and tuberculosis. Only we are now aware that tubercle is the primary event; and we have to reverse Niemeyer's famous dictum and to say: "The worst that can befall the patient infected with tubercle is that he should develop phthisis." The onset of phthisis is the disaster which all our efforts are bent upon warding off; and one of our chief weapons is climate.

The necessity of an adequate definition of cases and stages for purposes of consultation and of treatment is my excuse for the much-abbreviated and incomplete classification, reduced to the ultimate factors of clinical requirement which I now submit.

CLINICAL TYPES OF PULMONARY TUBERCULOSIS.

Mainly Tubercle (*Dry, Grey*).—I. Early, "Local," and often Latent; Healing. III. Late and Declared; "Spreading." IV. Terminal "General" Infective Tuberculosis (Acute or Subacute).

Tubercle with Catarrhal Pneumonia.—II*a*. Acute Caseous Phthisis (mainly pneumonic). II*b*. Common Subacute Phthisis (mainly catarrhal). II*c*. Chronic Excavating Phthisis with catarrh. II*d*. The same without persistent catarrh.

The groups I. and IV. require no comment. Group II., with its sub-groups, shows the varying results arising from different degrees of predisposition to the catarrhal and pneumonic process, *e.g.*, "Galloping Consumption" (II*a*) from its major degree, and "Quiescent Late Phthisis" (II*d*.) from its minor degree. Group III. contrasts with the preceding in the absence of predisposition. It is made up of adults originally of strong constitution, but broken down in their resistance by privation, syphilis, or alcohol.

BY LORD ALLENDALE'S will published last week St. George's Hospital benefits to the extent of £5,000.

DEATH from anthrax was the verdict at Liverpool last week on John McHugh, æt. 37, who had been employed in connection with Glasgow boats at the docks. No hides, however, had been in the cargoes with which he dealt, and the medical man who was called in said that the man must have contracted the disease by inhaling the dust about the docks.

ABDOMINAL COLPOPEXY, PROLAPSUS UTERI (a).

BY PROFESSOR JACOBS, M.D.,
Brussels.

I SHOULD like to detain you for a few minutes in order to consider the radical cure of the severest cases of uterine prolapse—I mean the total hernia of the uterus out of the pelvic cavity, which is ordinarily designated by the name of "complete prolapse of the uterus," accompanied by prolapse of the vagina, or, to be more explicit, the total prolapse of the vagina and the hypertrophic elongation of the vaginal mucosa, which is often covered with excoriations and, sometimes, by very large and deep ulcerations of the external os and of the vagina. All these lesions constitute for a woman one of the most painful infirmities. She is condemned to keep quiet, and to have complete rest; briefly, it is absolute invalidism for the patient. One will readily admit the justification, even the necessity, for such a radical and severe operation as hysterectomy, so much the more as in such cases the different colporraphies, and any other kind of plastic operation, which gives good results in less severe ones, yield only transient and illusory results.

Seeing the numerous recurrences which I had noted, and the continual complaints of patients, I performed for the first time, in 1894, abdominal hysterectomy with the ablation of a large vaginal ring. I finished the operation by the fixation of the vagina to the ligamentary stumps.

This operation I called *abdominal colpopexy*. From 1894 to January, 1907, I performed 77 operations of this kind on patients whose age varied from 43 to 71; I have had one death after operation, which was due to stomachic complications of specific origin. This death has thus no direct relation to the operation. Of the 77 cases I have recorded there have been three cases of slight recurrence, consisting in a certain amount of cystocele due to a small degree of prolapse. Considering these results I am induced to invite your attention to an operation which is indeed very radical, but as a fact not dangerous, and the results of which have been very encouraging during the thirteen years that I have performed it.

Technique of the Operation.—Abdominal section, —the incision reaching to the pubis. The uterus strongly drawn upwards so as to well stretch the vaginal walls is freed on the right and on the left from its ligamentary attachments by the incision of the broad ligaments outside the appendages, and the hæmostasis of the ovarian arteries being secured, the round ligaments are cut, and the section is continued to the supra-vaginal portion of the cervix. Two small forceps are placed on the uterine arteries which are divided. I next divide the utero-sacral ligaments behind, which allows of the immediate withdrawal from the abdomen of the total mass of the uterus and appendages.

By scraping with a small piece of gauze, I detach in front the peritoneum, the bladder and the neighbouring cellular tissue, in this way freeing as far as possible the anterior vaginal wall. Posteriorly I pull back the peritoneum as well as the cellular tissue, so as to strip off the posterior vaginal wall; in the same way the stumps of the broad ligaments close to the cervix, which contain the uterine arteries are drawn back. Here there is slight arterial hæmorrhage, coming from the division of small branches of the uterine artery which run to the cervix, easily controlled by small forceps. The uterus remains attached to the vagina through the insertions of the latter to the cervix. With the finger one can readily locate the vaginal portion of the cervix.

(a) Read before the British Gynæcological Society, April 11th, 1907.

Section of the Vagina.—The section of the vagina must be made so much lower in proportion as the prolapse is pronounced. The section must be such as to remove the hypertrophy of the vaginal mucosa, that is to say, the superabundance of tissue which is always present in old cases of external genital prolapse. Instead of cutting the vaginal canal transversely, I continue the section in a V shape, widely opened towards the top on a level with the vaginal insertion on the cervix, the section being made at first on the anterior, and afterwards on the posterior vaginal wall. Generally this latter section is less important than the first, the posterior prolapse being nearly always less thickened than the anetrior. The two V.V. shaped sections join each other by their branches on the lateral wall of the cervix. The uterus is thus removed with a portion of the vagina, which latter is proportionate to the vaginal prolapse.

I perform then anterior and posterior colporraphies from above, placing my sutures in such a way that the knots disappear within the vagina; that is to say, the stitches cross the vaginal mucosa on one side of the incision, the sub-mucous tissue of the same side, then the submucous tissue of the opposite side and the vaginal mucosa of the other lip of the incision. The stitches are placed from below upwards and tied as soon as they are placed. When the last two stitches are put in, the vagina is shrunk and shortened proportionally to the amount of the excised portion. A few other stitches bring the anterior and posterior walls together and close the vagina.

Lastly, I reconstruct the pelvic floor. An overwhipping suture, beginning from one end of the broad ligament, brings together the two parts of the incised peritoneum, which hide the stumps of the ovarian artery, the round ligament and the uterine artery. A second overwhipping suture is made on the opposite side; these two sutures join each other above the new vaginal vault, which is thus largely covered by the portion of the peritoneum in front. To avoid any possible recurrence of vaginal prolapse, I bind together with two strong silk ligatures, the round ligaments to the vagina; the sutures pass in the following way. They cross the vesical part of the detached peritoneum, the sub-mucous tissues of the anterior wall just about the middle of the new vaginal vault and the posteror wall of the vagina, the utero-sacral ligaments, and finally the peritoneum of the posterior pouch. The round ligament of the corresponding side is drawn in the direction of the vagina, the ends of the silk ligatures, before mentioned, hanging in front and backwards, are then tied forcibly, so as to catch the round ligament in the knot of the suture.

The vagina is thus suspended in the pelvis proportionately to the length of the stump of the round ligament. A similar suture is placed on the opposite side, bringing together the round ligament, the vagina and the utero-sacral ligament of the corresponding side. When the operation is finished, there are in the middle line from the front to the back: the bladder, a vesico-vaginal *cul-de-sac*, the vagina, the posterior peritoneal pouch, the rectum. On the sides: the broad ligaments, which are enforced by the round ligaments stretched between the vagina and the lateral wall of the pelvis.

This operation, which is rather difficult to describe, will as a fact be very easy for any surgeon to perform who is accustomed to abdominal hysterectomies. I think that it does not present as much danger as vaginal hysterectomy, which in these cases of old exterior vaginal prolapsus, is always very difficult. I have never met during the course of the operation the slightest occurrence which could not be foreseen. All the different stages of the operation are as well controlled as in abdominal hysterectomy for fibroma or cancer.

Post-operative Dressing.—Immediately after the operation an antiseptic vaginal dressing is made and renewed every two days till the vagina is healed; when the vaginal sutures of the colporraphies may be removed. The patients are kept for two or three weeks in bed, and subsequently for a few weeks they are advised to refrain from any muscular effort.

The vaginal plastic operations are not absolutely necessary, in more than half of my operated cases I did not have recourse to them, notwithstanding very old and deep tears of the perineum and the vagina. It cannot of course be said that vagino-perineal plastic operations would complete successfully the abdominal operation. The experience I have thus obtained during several years in a total number of 75 patients enables me to say in the most emphatic way that the results of this operation are integrally maintained, notwithstanding prolonged and very tiring labour. For instance: My first patient, a washerwoman, has continued her business for thirteen years, and up to the present there is not the slightest appearance of recurrence. I want especially to point out, that the most delicate point of the operation consists in the avoidance of any lesion of the vaginal mucosa while placing the suspending suture, so as to prevent their slow separation through suppuration.

CLINICAL RECORD.

EXTRA-UTERINE PREGNANCY. (*a*)

Under the care of FREDK. BOWREMAN JESSETT, F.R.C.S.,

Senior Surgeon, Cancer Hospital.

E. S., æt. 30, married, was sent me by Dr. Smyth, Islington, on February 5th, 1907, with a lump in the left side of the abdomen, which she had noticed getting larger during the previous three or four months. Menstruation regular up to five months ago. No children, although married for four years. Has never been pregnant.

History.—Menstruation occurred first week in September, and after that she saw nothing for three months, and began to think herself pregnant, but had no symptoms such as morning sickness or enlargement of the breasts. At this time she changed her residence, and while doing so one morning felt very ill, and went to bed. While in bed she began to lose very copiously, accompanied with pain in the lower part of abdomen. She kept her bed for six weeks,

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(*a*) Read before the British Gynæcological Society, April 11th, 1907.

losing on and off all the while. At the beginning of this time she had pain in micturition. At the end of the six weeks the bleeding ceased, but she had hardly been able to get out of bed owing to pain. About this time she became conscious that a lump was growing in the left side of the abdomen. This has continued to increase until the time of her admission.

Present State.—On examination of the abdomen, there is a hard irregular mass to be felt in the left iliac fossa, extending above pubes and to the left of umbilicus, somewhat irregular and bossy on surface, moveable from side to side to a limited extent, but this occasions some pain. It is tender on pressure, especially at a point midway between umbilicus and left ant.-sup. spine of ilium. The mass is divided into two portions, a small boss above the pubes, which proved to be the fundus of uterus and tumour. There is no fluctuation, and the mass gives the impression of being solid. It has a smooth rounded edge above; below it dips into the pelvis.

Per Vag.—The uterus has only a limited movement, the fundus is indistinctly felt behind the pubes. In the vaginal fornices the abdominal swelling can be felt by deep pressure. There is no depression or bulging of the fornices.

Operation (February 5th).—The patient being anæsthetised, I opened the abdomen in the middle line between the pubis and umbilicus. The parietal peritoneum was adherent to a rounded dark tumour underneath, which was found to be an extra-uterine gestation sac between the layers of the left broad ligament, with extensive adhesions to the sigmoid flexure, rectum and small intestine. The sac was opened and a dead fœtus (5 or 6 months) and placenta extracted. This was followed by free oozing from the interior of the sac, which was controlled by ligature and pressure. An attempt was now made to separate the sac from its adhesions to parts of the intestine, but it was only found possible to do so to a limited extent owing to bleeding and risk of injury to the bowel. As much, therefore, as could be was ligatured off and removed. The remainder was brought up into the wound and stitched there by a continuous catgut suture passing through the peritoneum, muscle, and the edges of the sac. The sac was now plugged with iodoform gauze, and the rest of the abdominal wound closed in layers.

The patient was rather collapsed on leaving the table, and was given an injection of strychnine.

February 6th.—She rallied well after the operation. General conditions good. The plug was changed on the third day and re-plugged. Ten days after the operation the gauze plug was replaced by a rubber drainage tube, a good deal of discharge escaping. She steadily improved, and the depth of sac rapidly decreased and is now nearly closed, the patient's general condition being excellent.

[I am indebted to my House Surgeon, Mr. Hortop, for these notes.]

OPERATING THEATRES.

GREAT NORTHERN CENTRAL HOSPITAL.

EPITHELIOMA OF THE FLOOR OF THE MOUTH, TONGUE AND FAUCES, WITH EXTENSIVE GLANDULAR INVOLVEMENT—FISTULA, PLASTIC OPERATION TEN MONTHS LATER FOR ITS CLOSURE.—MR. ARTHUR EDMUNDS operated on a man æt. 50, who was suffering from a discharge of saliva from a fistula under the left lower jaw. The patient had presented himself ten months previously with an extensive epithelioma. This involved the left side of the tongue, forming a mass the deeper parts of which extended into the middle line, but the ulceration had only just reached the dorsum of the tongue opposite the front two molar teeth. It extended on the floor of the mouth, and had become adherent to the lower jaws; posteriorly it had involved the root of the anterior pillar of the fauces. Glandular infection was confined to the left side, but was pretty extensive, not only the submaxillary group being affected, but also the glands along the internal jugular. Fortunately the glands were neither very large nor very adherent. The case thus presented a clinical picture, representing about the limit of operative possibility, but the faucial involvement was such that it was thought advisable to attempt an operation. Operation in these instances, Mr. Edmunds said, was not very hopeful, as there are few cases which are permanently cured, but there are many cases which receive considerable benefit from operative interference; it is often possible to completely and permanently extirpate the primary growth, although recurrence takes place in the glands, saving the patient the pain and discomfort of having a sloughing ulcer in his mouth. It was always rather difficult to make up one's mind whether to attack the glands or the growth first, or if both should be removed at one operation. It should be remembered that these patients die of sepsis rather than shock, and no effort should be spared to minimise the severity of the infection. In the present case where the whole of the side of the neck had to be exposed and glands removed almost down to the clavicle, communication between the oral cavity and the cellular tissue of the neck would have been extremely serious, and accordingly operation was performed in two stages. An incision was made with a slight curve upwards parallel to the lower jaw about the level of the hyoid bone extending backwards to the sterno-mastoid muscle, along the anterior border of which the incision was prolonged for about four inches; a flap was thus raised and turned forwards; an extensive dissection of the fat fascia and lymphatic glands of the anterior triangles of the neck was performed and the wound sutured. At the upper part of the incision, where the wound was crossed by the posterior belly of the digastric, an attempt was made to separate the wound of the neck into two portions by stitching this muscle to the deep surface of the overlying skin flap; the advantage of this procedure was well seen in the subsequent stage of the operation, when it became necessary to throw the wound of the neck into communication with the mouth; the whole of the tissues of the neck below the line of the posterior belly of the digastric remained completely shut off, although the upper part above this level became infected. The wound healed normally. A fortnight later an incision was made extending through the middle line of the lower lip to reach the upper limb of the former incision. This was re-opened and a thick flap consisting of the cheek and the tissues over the lower was reflected backwards exposing the bone as far as the coronoid process. Two saw cuts were made through the bone in front and behind the spot to which the growth was adherent, and after division of a few muscular fibres, it was possible to retract the jaw forcibly towards the unaffected side, thus obtaining perfect access to the growth. There was probably, Mr. Edmunds remarked, no incision which gives the surgeon so free an access to growths at the back of the tongue and allows one to keep the respiratory passages so free. In his opinion tracheotomy should never be performed if it can be avoided as this operation prevents the patient coughing properly and prevents the expulsion of any purulent discharge which may have run into the trachea. He was strongly of opinion that the infective pneumonia which was such a dreaded complication of these cases was produced not so much by the insufflation of blood at the operation as by the entry into the bronchi of the purulent discharges from the wound. The growth being thus exposed, it was first seared with a thermo-cautery, to avoid implanting cancer cells in the raw wound. The whole of the tongue with the exception of the tip and the mucous membrane of its right half was freed with scissors and a blunt dissector, practically the whole of the muscles attached to the hyoid bone being removed. An incision was carried into the soft palate and the whole of the anterior pillar of the fauces on the left side turned down. It was now possible with very little dissection to sever the remaining connections of the tumour and to remove it. It was very often possible, he pointed out, to save a considerable portion of the mucous membrane of the tongue, although the surgeon must be careful not to get too close to the ulcer and when possible this should be done as it enables one to stitch up the wound in the floor of the mouth to a much greater extent. In the present case he was able to suture the wound in the soft palate to the mucous membrane at the root of the tongue and to close by catgut sutures the posterior half of the wound in the mouth, and also by sewing together the mucous membrane of the front of the tongue to make a sort of tip for the remains of this organ. In extensive wounds of the mouth it was, he said, very important to unite the mucous membrane as far as possible. This diminishes the granulating surface and consequently the amount of discharge; many of the sutures will, of course give way, but even when this occurs one has often succeeded in converting a wide gap into a narrow cleft. Where possible also some sort of a tip should be made to the tongue in order to prevent adhesion of the front of the stump to the floor of the mouth, a condition which very materially impedes articulation. The wound was sutured and a drainage tube put in at the front angle. The after-history was uneventful and the patient was quite comfortable in about two days. The anterior part of the wound did not heal, and a fistula remained; the object of the present operation was to close this fistula. The whole of the rest of the wound was soundly healed, the patient's general health was extremely good, and there was no sign of recurrence of the growth. He had been back at his work, a carpenter, for several months, and could articulate intelligibly. The patient was anæsthetised, and an incision made around the cutaneous opening of the fistula, a fusiform piece of skin and the epithelium of the fistula were removed. The skin was then dissected up for a short distance, around the wound and its edges united with a few points of silkworm gut. This was successful in closing the fistula, the wound having now completely healed.

TRANSACTIONS OF SOCIETIES.

BRITISH GYNÆCOLOGICAL SOCIETY

Meeting held April 11th, 1907

The President, Mr. W. D. Spanton, in the Chair.

Mr. **Bowreman Jessett** proposed that a vote of condolence be sent to the daughter of their late friend, Dr. Purcell, who was a Foundation Fellow of the Society.

The resolution was carried in silence.

Mr. **Bowreman Jessett** showed the specimen and read notes of a

CASE OF EXTRA-UTERINE PREGNANCY AT THE SIXTH MONTH,

which will be found fully reported on page 450.

The **President** desired to make an apology on behalf of Professor Jacobs, who found it impossible at the last moment, to be present to read the paper he had promised, but had sent a copy of his paper, which Dr. Macnaughton-Jones read, on

THE RADICAL CURE OF PROLAPSUS UTERI,

which will be found fully reported on page 449.

The **President** said the subject was interesting, and although it opened up one particular operation for the relief and cure of prolapse, he took it that on the present occasion it would be agreeable to the Fellows to broaden the discussion, so as to embrace the general aspects of the subject.

Sir **William Smyly** said he was surprised at the successful results which Professor Jacobs had obtained from the operation. He would not have imagined that removal of the uterus and part of the vagina, even with colporrhaphy, in extreme cases of prolapse, would have resulted in such a large proportion of cures—*i.e.*, 70 cases out of 75. The operative treatment of very bad cases of prolapse was one of the most unsatisfactory in gynæcology, in his opinion. In cases where the pelvic diaphragm was completely torn through and destroyed, and where there was complete procidentia of the uterus through the vagina, any operation which gave such good results should be hailed with the greatest pleasure by gynæcologists. As to the general subject of prolapse, he believed that the vast majority of cases of prolapse could be divided, as Hegar had said, into two groups—those which depended upon relaxation of the peritoneum—vaginal enteroptosis, and those which depended on injury to the pelvic floor, especially to the pelvic diaphragm. Those were two absolutely different classes, and required different treatment. The paper which had been read would apply to both those forms, and would help gynæcologists in the treatment of them. But the second form, that in which the prolapse depended upon injury to the pelvic floor, he had no doubt was in the majority of cases the results of bad midwifery—that is to say, the result of the improper use of forceps. He felt certain that women who had their pelvic floors torn through with the forceps, if they had been allowed to deliver themselves, would have escaped procidentia. The next important point in the treatment of prolapse, he thought, was that the cases must be operated upon early. The women who had prolapse were generally old, and were shy of operations, and it was common for them to ask whether something else short of operation could not be done, such as treatment by means of a pessary. His usual reply to such patients was that he could put off the operation for a few years, but it would be increased in risk, and the ultimate result would be less successful than if the operation were done now. He thought it was most important that in the first place the physician should make a diagnosis as to the exact form of prolapse. But in the case of any woman who had a tendency to prolapse, to retroversion with descent and injury to the pelvic floor, his opinion was that the sooner she was operated upon the better the results would be.

Mr. **Christopher Martin** said his practice was to treat all cases with Sir James Simpson's pessary, and he did not operate on cases unless he found that the prolapse would not keep up with this pessary. In the majority of cases—perhaps in 9 out of 10—that was all that was necessary. There were some cases in which it would not keep back the prolapse, but then he was sure no Hodge or ring pessary would do so either. In such cases ventro-fixation combined with an extensive colpo-perineorrhaphy was sufficient. He believed that most cases of bad prolapse should be looked upon as similar to an ordinary hernia, either umbilical or inguinal, and in doing a radical cure of hernia the essential part of the operation was to reconstruct the fascial structures. Therefore any extensive cutting away of the mucous membrane in the vagina only was futile. The uterus was not suspended by the mucous membrane of the vagina, nor by the peritoneum. The essential thing in an extensive operation for prolapse was to restore, as far as possible, the pelvic fascia, and if it were possible to reconstruct the pelvic fascia and bring back the condition to that which obtained in the virgin, the operation would be a perfect one. A year or two ago he read a paper before the Society on radical cure for prolapse, and the operation recommended was removal of the uterus and of the vaginal mucous membrane, and—what was the essential part of the operation—the bringing together of the pelvic fascia from side to side. In that way the diaphragm was made of pelvic fascia between the rectum behind and below, and the bladder in front and above. In that way the fault caused by the vagina was done away with, and one segment of the pelvic floor did not slide over the other, but a hammock of membrane passed across and supported the viscera. It was a severe operation, but if it did not kill the patient it cured her. He had operated upon four cases in that way, and they had all recovered. Still, they all had a serious convalescence, and at one stage it was doubtful in each case whether they would get well He feared there would be cases in which this operation described would fail. Certainly he had seen extensive ventro-fixation and colpo-perineorrhaphy fail. He was surprised that there had been such a large proportion of cases of cure.

Dr. **Macnaughton-Jones** said that there could be no question that this operation offered many advantages in the treatment of exceptionally severe cases of prolapse. An important point was that in enclosing in all the structures forming the vault of the vagina after the hysterectomy, the round ligaments, and the utero-sacral ligaments were included. As had been said, the suspension of the vagina was in proportion to the length of the stumps of the round ligament. As an abdominal operation, it appeared to be as complete and radical as could be desired. He thought that in operative gynæcological work, if an operative procedure entailed greater risks to life than those involved in the condition which it was proposed to remove, it was rarely justifiable; and, no matter how successful an operator might be, this in itself might not justify the step. This operation no one could deny was a serious one. He quite agreed that the important point in treating these cases of prolapse of the uterus was early rectification of the original anatomical defects. Relaxation of the vaginal outlet, retroversion of the uterus, with descent of the vagina, associated with commencing cystocœle or rectocœle, were usually dealt with successfully by free colpoperineorrhaphy with colporrhaphy, and, if necessary, suspension of the uterus. He had gradually grown to look on all pessaries as necessary evils, and avoided their employment whenever it was possible. They frequently did more harm than good, often by reducing the tone of the vaginal wall, their after-effects tending to increase rather than to cure the evil they were meant to rectify. This necessarily applied more particularly to pessaries of a large size. The question was also raised in Professor Jacob's paper as to the relative advantages of abdominal and vaginal coeliotomy in these cases. To illustrate his meaning, Dr. Macnaughton-Jones showed the uterus of a patient, now aged 84, from whom nine years ago he removed it for a prolapse of twenty-five years duration, and it could be seen that the bladder and rectum were adherent to the greater part of the uterine surfaces, all three being contained in the procident sac. A large portion of the vaginal canal was removed at the same time, and the whole structures were united to form a new vault. The second uterus shown, removed also by the vaginal route, was even a worse case than this. In the sac was a myomatous uterus with mucoid degeneration of its canal. The sac contained the bladder, adherent to three-fourths of the anterior surface of the uterus, and the rectum to its posterior. The same operation was performed, and the patient had no trouble subsequently. In both cases there were severe ulcerations on the exterior of the mass. This, he thought, proved that, though he did not doubt that the abdominal route was the best, extreme prolapse could be successfully dealt with by the vagina. Dr. Macnaughton-Jones showed four models of sections of the pelvic viscera prepared at the *Medizinisch Warenhaus*, Berlin. The sections were made by Professor Freund, of Berlin, and V. Rosthorn, of Heidelberg. They showed beautifully the various organs, with the muscles and fascia of the pelvis and its walls, by frontal, sagittal and horizontal sections.

Mr. **Bowreman Jessett** said the first point of interest in connection with the paper was the large number of cases in which the operation had been performed. The cases were those of complete prolapse, in which the uterus came through the vulva. In these severe cases the only means of cure was to remove the uterus, and he thought that exactly the same result would be attained by removing it by the vagina as by an abdominal operation. He agreed that after removal of the uterus it was necessary to stitch across the pelvic fascia and include the round ligaments in the first line of sutures, and then do an extensive anterior and posterior colporrhaphy. In that way considerable shrinking of the vagina was produced, with a sound vault. His experience had extended to about 23 cases. He thought the simpler the operation the better, and he could not see the object of opening the abdomen and pushing the uterus, which was protruding through the thighs, up through the abdominal wall before removing it.

Miss **Garrett Anderson** said the extremely bad cases of prolapse which had been described were not very common The operation which had been carried out at the New Hospital for Women during the last few years was intra-peritoneal shortening of the round ligaments, which she believed was a successful procedure, though it was necessary for a longer time to elapse before a proper test of the value of the operation could be made. For the bad cases vaginal hysterectomy had been done, combined with closure by a plastic procedure.

Dr. **Ethel Vaughan** said in those cases of complete prolapse of the uterus one should make a distinction between those which occurred in younger women and those taking place after the climacteric. She did not say that hysterectomy was justifiable for a procidentia of the uterus in young women, but after the climacteric the uterus had done its special work and become a more or less useless appendage, so that the reasons against its removal were much less valid than in a younger patient, and in such a case, if it was convenient to remove the uterus, she thought there should be no hesitation in doing so. Just before Christmas she had such a case, where the vagina was enormously hypertrophied and elongated, and after removing about three inches of it, as well as the uterus, she closed the upper end of the vagina with catgut and suspended it to the peritoneum and subperitoneal fat above the bladder, as one would do in suspension of the uterus. The patient had done very well, and had been completely relieved of her trouble. She united the pelvic peritoneum before tying the silkworm gut stitches which suspended the vagina to the abdominal wall. She thought that in younger women an operation which was very useful was a posterior suspension of the uterus done by Kelly's method. Among the causes of procidentia which should be mentioned, as well as lesions in the floor and those due to intra-abdominal tension, were those due to dragging down of the uterus, either by a fibroid or from a bulky elongated cervix, because in the last class of cases supra-vaginal amputation of the cervix very often completely relieved the patient. With regard to palliative measures, she wished to mention a pessary which had been designed by Miss Aldrich Blake, and which she thought a great improvement on the cup and stem pessary. It consited of a vulcanite ring on a slightly curved stem, so that all pressure on the cervix itself was avoided.

Mr. **Furneaux Jordan** said he thought the worst cases of prolapse occurred mostly after the climacteric. He believe all the cases mentioned in the paper were between the ages of 41 and 75, so that there were very few of the patients under the climacteric age. He agreed that the plastic operation, with the addition of ventro-fixation or suspension, was quite enough. But cases did occur which defied all methods of suspension or any plastic operation. Although he saw large numbers of out-patients every week, he had seen only two cases in which he had found it necessary to remove the uterus, and in those two he performed vaginal hysterectomy. It struck him at the time that there was no certainty of being able to support the vaginal vault, and in those extreme cases the operation described in the paper would probably be successful. It was stated in the paper that it was not a difficult operation, but it seemed from the description as if it were a serious procedure, and was likely to be rarely justifiable. Still, it was clearly justifiable in cases of cancer, and in the last six months he had removed the uterus and the broad ligaments and the appendages and the vault of the vagina in four cases of cancer of the cervix. That was a tedious and serious operation, though it was not very difficult to carry out, and it would be far easier to do in a case of prolapse than in one of cancer of the cervix. Each time he had performed that operation he had fastened the stump of the round ligament and the broad ligament to the posterior vaginal wall below the fixation, and he could bear witness to the fact that in those cases which had been examined afterwards the vagina seemed taut or strung up to some extent by the attachment to the abdominal wall by the round ligament. He cordially agreed with the view that in extreme cases the operation would be necessary. He did not think it was an operation which would be often justifiable.

Dr. C. H. F. ROUTH said in his early days he remembered two cases which were very remarkable. In those days, when the uterus was prolapsed and projecting completely out of the vagina, the cause was some violent effort made at delivery in the case of a very large child, and the treatment of that day was remarkable—namely, to procure a very large ball, almost as large as the internal diameter of a cocoanut, and push that up the vagina as far as it would go. On different dates he was called to see two ladies who each had one of those balls inside the vagina. That kept the uterus up so that it never came down afterwards. But of course such a body was very uncomfortable. Had he not seen what was described he would have regarded it as an invention on the part of somebody who wanted to talk of matters of which he knew nothing. In both those cases he was obliged to use forceps, with the patient under chloroform, and it required much pulling to get it away. The odour from it was very repulsive. Yet some patients had such a ball in the abdomen for five years. After removal, astringent injections were used, and the patients kept quiet, and sometimes water which was almost boiling was employed, and also hot irons. In the end both patients got perfectly well, the vagina contracted, and no further untoward result ensued. Of course he did not recommend that procedure, but he thought it worth while to remind Fellows that such procedures were once practised, and yet, as far as he knew, perfect cures resulted.

Mr. MANSELL MOULLIN said he had been rather astonished to hear remarks from different speakers as to the scarcity of those cases of prolapse. Looking back on his experience of many years he could remember hundreds of them, and he did not feel at all astonished at the numbers mentioned in the paper. Every effort was made in the out-patient departments to relieve patients by means of pessaries, etc., and the cases were regarded as more or less hopeless for operation. He agreed that any palliative measures for the relief of prolapse was absolutely futile. In some of the cases in which the condition was in the early stage, colporrhaphy might be of some use, but for a bad case such a procedure he regarded as absolutely useless. He was certain that the union of the fascia was the one point which offered the only scientific and reasonable hope for the relief of cases of prolapse.

Dr. HEYWOOD SMITH said that patience was a virtue which operators sometimes lacked, as sufficient time was not allowed to see what a prolonged course of treatment might do. If patients suffering from prolapse were placed on their backs, or even tilted up on a bed which enabled that to be done, with some weeks' rest, it would be possible, with the application of some proper pessary, to keep the uterus in fair position. In young patients a rest and astringent injections toned up the vaginal wall, and a pessary which was large enough rested on the side of the walls and the bony part of the pelvis, and so kept up the uterus. Professor Simpson's pessary was perfect.

Dr. NEATBY said when he began operating he tried colporrhaphy and perineorrhaphy combined. Then he tried ventral suspension. But what he found most useful was that those should be done together, as by suspension alone the heavy redundant vaginal walls were sure to pull down the uterus and stretch the adhesions; while with colporrhaphy alone the heavy uterus was sure to force down the vagina. Some patients would bear the two procedures at the same sitting.

Dr. S. J. AARONS said he thought prolapse was practically a hernia, and there was no real way of reducing such a hernia radically except by operation. Some form of pessary was certainly an advantage. The one which Dr. Ethel Vaughan had referred to had been in use in Soho Hospital for many years, or one very similar, consisting of a ring with a stem and a sacral curve in it, which had a strap passing over the nates. In the out-patient department we learnt to try and cure cases without sending them into the hospital. Many cases were treated and made quite comfortable with pessaries. For some the ring and stem were used, and in others the pessary with the shelf, while others had the simple ring; the cases were also seen where there had been ventral suspension with fixation, and had returned with a large cystocele and rectocele. Therefore, the results of those operations required watching for many years before it was possible to say a cure had been effected. In those cases of prolapse where there were cystocœle and rectocœle he thought a pessary would do as much good for the patient as any operation.

Dr. C. H. BENNETT said he had had some experience in the matters under discussion. On two particular occasions a perfect cure was brought about by using pessaries, and at the same time giving the patient cold Sitz baths half an hour at a time three times a day. Those patients got perfectly well and remained so. With regard to the use of forceps, his experience was that forceps were employed for the convenience of the medical man, and not for the benefit of the patient in many cases. He said deliberately that the medical attendant was in many instances directly answerable for prolapse of the uterus when it occurred, and for the trouble which many patients suffered in confinement. Though he had been in practice for a good many years, he had never lost a case of midwifery in his life. He attributed that largely to the patience he exercised in allowing Nature to do her work without hurrying it.

Dr. H. HODGSON said he hoped, when the discussion opened, that something would be said about the cause of prolapse of the uterus. So far all that had been said on the matter was what Fellows had heard many times before, namely, that prolapse was due to an insufficiency of the ligaments and to their giving way. Consideration of the anatomy of the parts would show that it was nothing to do with the ligaments; it would be clear that the ligaments were stretched and injured by he prolapse, and not that the prolapse came as a consequence of the ligamentous failure. It would be seen that the ends of the ligaments which were attached to the uterus formed a band round the uterus where the internal os was. Then the prolapse commenced, with elongation of the cervix, which in itself was fairly clear evidence that there was pressure on the fundus, driving down the conical uterus through the resisting ring, that ring being formed by the ends of the ligaments. Even if those ligaments were made of steel he thought prolapse would still occur. The cause appeared to be some alteration of intra-abdominal pressure plus a flaccid condition of the parts, or some growth. Normally, the abdominal pressure should be neutral, but many things would cause it to be plus, and it was one of those causes which first started the downward progress of the uterus. The uterus formed a cone or wedge, and only a little movement sufficed to drive it through the ring.

The PRESIDENT said it was quite clear that in speaking of prolapse of the uterus many different conditions were discussed. Pure prolapse was one thing, but it assumed so many different forms, and arose from so many different causes, that to deal with it in debate from one point alone was misleading. It was necessary to take the out-patient department view of it, and also the in-patient department view. The out-patient department gentleman had stated that evening, and he thought very properly, that many cases were amenable to treatment by pessaries—at any rate to the extent of permitting the patient who applied for relief, to go about her duties again. That was the important point which must be considered in the matter. It was not every case of prolapse which demanded severe and grave operations, and such operations should only be undertaken when the patient expressed a strong wish to have the operation done. If an operation of a grave and complete character was to be carried out, that of Professor Jacobs commended itself as the most effective which could be devised. But, short of that, he was inclined to share the views of those who thought that in the majority of cases it was clear that in young patients if the cervix were removed it was often sufficient, because the vagina contracted up and the prolapse was cured. Then there was a class of case which occurred in elderly women, where the vagina was very patulous, and had lost the whole of its tone, for which nothing short of an extensive operation would be effective. The operation which had been described that evening must be attempted in such a case, or else a large vaginal operation. His own experience had been mainly in treating through the vagina, and, having had a large number of such cases, he was able to say that the results on the whole had been satisfactory. The old operations, such as Emmet's, were altogether failures, and always gave way sooner or later. But if one excised a large portion of the vaginal wall, taking away the whole of the cervix, and restored the perineal body, in many cases the woman would be able to go about with perfect comfort, and she would probably be able to resume her usual active work. It had been very properly stated that a patient should not have an operation performed which subjected her to greater risks than did the condition for which the operation was to be done. He noticed that no mention had been made that evening of the Alexander operation. Some time ago Dr. Alexander read a very interesting paper before the Society, and many people appeared to carry it out, and still found it effective. But he feared that many surgeons did not find it as effective a procedure as some of their Fellows did, or as the author himself did. The discussion had been a most interesting one, and the thanks of the Society would be sent to Professor Jacobs and also to Dr. Macnaughton-Jones for having made the translation and brought the matter before the Society.

The meeting then terminated.

ROYAL ACADEMY OF MEDICINE IN IRELAND

Section of Medicine.

Meeting held Friday, April 5th, 1907.

The President, J. M. Redmond, in the Chair.

UNUSUAL NERVOUS SYMPTOMS.

Dr. Dempsey exhibited a case showing unusual nervous symptoms, which he regarded as the result of multiple spinal sclerosis. The case was discussed by Dr. Craig.

ANEURYSM OF THE THORACIC AORTA.

Dr. **Winter** showed a man suffering from the above. The man suffered from loss of voice, owing to paralysis of his right vocal cord. There were no physical signs, other than a limited area of dulness on percussion and some difficulty in deglutition. On examination with X-rays a definite pulsating tumour could be seen on the left of the sternum.

PSEUDO-RENAL COLIC.

Dr. **Parsons** read a paper on the above, which was an account of a case which had long defied diagnosis, but had ultimately been correctly diagnosed as an aortic aneurysm. The specimen was exhibited.

ADDISON'S DISEASE.

Dr. **Dempsey** read an account of a case of Addison's disease of unusually short duration.

CEREBRO-SPINAL FEVER OCCCURRING IN A CHILD THE SUBJECT OF LYMPHATISM.

Dr. **George Peacocke** read a paper on the above subject in a girl, æt. five years, which ended fatally eleven hours after the onset of symptoms. The chief symptom was repeated attacks of convulsions. There was only slight retraction of the head. Kernig's sign was absent. There were several purpuric spots of irregular size present on the legs and arms. The *post-mortem* revealed the presence of lymphatism, enlarged and bulky thymus, enlarged mesenteric glands, hypertrophied Peyer's patches and solitary follicles, prominence of the Malpighian corpuscles on section of the spleen. Cerebro-spinal fluid removed by lumbar puncture, shown after death, was turbid, the turbidity being due to leucocytes. Weichselbaum's meningococcus was found.

Dr. **Harvey** explained the microscopic slides.

Dr. **Kirkpatrick** asked if a diagnosis of the condition of lymphatism had been made before death, and if there was any way by which it could be recognised. The condition had been found in a number of cases in which sudden death had occurred during the administration of anæsthethics for operations, and the diagnosis of lymphatism before death was a matter of practical importance.

Professor **White** thought it possible that the condition of lymphatism had a good deal to say to the question of infection. Most of the cases that died of cerebro-spinal meningitis had had trouble with adenoids, and a good deal of lymphoid tissue at the back of the nose, and it was possible that they became infected in that way. The organisms existed in some healthy people. At the back of the nose there were many kinds of diplococci, many difficult to distinguish from the organism in cerebro-spinal fever. The only case in which he saw a *post-mortem* in the present outbreak had the condition which Dr. Peacocke called lymphatism.

Dr. **Peacocke**, in reply, said the idea of lymphatism did not occur to him during the patient's life. The symptoms before death were, unfortunately, practically nil, and the only physical sign likely to be detected would be the presence of a very large thymus showing dulness.

LARYNGOLOGICAL SOCIETY OF LONDON.

Meeting held April 5th, 1907.

The President, Dr. J. B. Ball, in the Chair.

Dr. St. Clair Thomson exhibited a man, æt. 29, who had been shown at the previous meeting on account of a "malignant endo-laryngeal growth." Since then an operation had been performed for its removal, and a section of the growth was exhibited. As some of the members were unable to satisfy themselves that the growth was of a malignant nature, it was decided to refer it to the Morbid Growths Committee for a further opinion. The interest of the case rested in the early age of the patient.

Dr. **St. Clair Thomson** also exhibited a woman æt. 50, with prolapse of the ventricle of Morgagni. This patient had also been exhibited at a previous meeting, and since then the prolapse had been removed. A microscopic section presented mainly œdematous tissue.

Dr. **H. J. Davis** exhibited, a boy, æt. 12, who, according to his mother's statement, had never spoken. The boy was unable to protrude his tongue. He was very intelligent, and he heard and understood perfectly. He could hum songs in tune, but could not speak a word (aphemia). At the age of three, it was stated, he had right hemiplegia. Opinions were invited as to suitable treatment.

Dr. **James Donelan** cited a similar case in which improvement followed education in a deaf and dumb institution.

Dr. **Dundas Grant** considered that there was much mechanical defect through weakness in the muscles of articulation.

Dr. **Watson Williams** considered that there was a lesion in the neighbourhood of Broca's convolution, and that there might have been an injury at birth. He agreed with Dr. Donelan's suggestion.

Dr. **de Havilland Hall** considered the case to be one which should be trained, and pointed out that the mother should be informed that the treatment would be a matter of years.

Mr. C. A. **Parker** also considered that the patient would do well under training, unless the disuse of his tongue had rendered articulation impossible.

Dr. **Davis** in reply considered that the boy could not speak owing to the paralysis of the tongue, and on that account he would not derive much benefit from being trained.

Dr. **Donelan** exhibited a patient with destruction of the columella of the nose occasioned either by syphilis or by lupus. Various suggestions were made for overcoming the resulting defect, opinions being divided between a plastic operation and the use of a mechanical appliance. In view of there being some evidence of active disease, Dr. Donelan decided to observe the case a little longer before doing anything of a surgical nature.

Dr. **Dundas Grant** exhibited a case of

PHARYNGO-KERATOSIS (MYCOSIS)

improving under the application of salicylic acid in sulpho-ricinate of soda. The patient had been under this treatment for twelve months. When first seen by Dr. Grant various applications were made, first a saturated solution of salicylic acid in alcohol to the spots on the right tonsil, the galvano-cautery to the left one, then pure formalin to the left one and a 10 per cent. solution of sulpho-ricinate of soda to the right. Next a one per cent. solution of formalin in glycerine was applied for a month, at the end of which time comparatively no change had taken place. She then commenced a daily application of a 10 per cent. solution of salicylic acid in sulpho-ricinate of soda, first to the right tonsil, and then to both. The patient complained at times of the application producing a dry feeling in the throat at night, but eventually scarcely a vestige of the disease remained.

The **President** said that he had tried salicylic acid for mycosis, but that he did not have much faith in the treatment.

Dr. **de Havilland Hall** commented on the way that keratosis, like warts elsewhere, would sometimes clear up in an astonishing way.

Sir **Felix Semon** enquired why keratosis should be treated locally at all, inasmuch as it always got well of itself. He considered that there was no real remedy for the condition, constant applications to the throat rendered the patient needlessly nervous, and greater importance was attributed to the malady than it deserved. Moreover, the man who treated such a trifling condition for a long time exposed himself to recrimination.

Sir **Felix Semon** hoped the profession would recognise that keratosis occurred when the patient was run down, and that it would disappear under a change of air and tonic treatment, and that no local treatment was necessary.

Dr. **Fitzgerald Powell** had found that cases generally got well after the application of a cautery.

Mr. **Herbert Tilley** also spoke of spontaneous disappearance of the condition without local treatment.

Dr. **Dundas Grant**, in reply, expressed himself in agreement with Sir Felix Semon. He had put before the patient the fact that the appearance of the throat was of no significance. and thought the discomfort that the patient had gone through in using the remedy was out of proportion to the result. He would not recommend the treatment in every case of the kind.

Dr. **Jobson Horne** exhibited a macroscopic specimen of lympho-sarcoma of the mediastinum. The growth had caused extensive obstruction, almost obliteration, of the œsophagus without any breach of the mucous membrane. The larynx presented œdema localised to the right arytenoid region; immediately below the œdema in the fold passing down between the cartilages of Santorini and Wrisberg was a small ulcer. The points of interest were the unusual extent of the œsophageal obstruction, and also whether the localised œdema of the larynx was occasioned by local infection, or was secondary to obstruction caused by the mediastinal growth.

THE THERAPEUTICAL SOCIETY.

Meeting held in the Apothecaries' Hall on April 16th, 1907.

Dr. J. E. **Burton Brown**, President, in the Chair.

Dr. **George Oliver** read some notes on the

CONTROL OF A SUPERNORMAL ARTERIAL PRESSURE.

He gave the leading results of his clinical observations on the management of a persistent rise in the arterial pressure by diet, baths, electricity, and remedies. He pointed out the value of a non-stimulating diet, and especially of a lacto-vegetarian and salt-free diet in the high pressure cases; a minimum proportion of calcium salts in drinking water; warm massage douchings; saline and carbonic acid baths; D'arsonvalization and the electric light and ozone baths; warm equable climates (Jamaica, India, and Egypt); evacuant treatment; asepsis of the bowels; and apressor remedies. He indicated some practical suggestions furnished by physiology in the selection of apressor remedies for less or more continuous use, and stated his further favourable experience of the benzine derivatives at the same time, showing that our control over persistent increments of arterial pressure is limited to the cases in which the pressure rise is moderate and the vaso-motor play of the peripheral arteries is not seriously impaired.

Sir **Lauder Brunton** considered Dr. Oliver's paper very valuable. He thought that in cases of very high tension absolute rest in bed with quiet of body and mind was indispensable. With perfect rest, vegetarian diet, and the steady use of nitrites even cases of exceedingly high tension might be successfully treated. A salt-free diet might be useful in cases of very high tension, but it could not be continued for a length of time as it is so irksome. Salt might be to a considerable extent replaced by sugar in the dietary. The modern treatment of high tension by nitrites and nitrates had been recommended by Lord Bacon in the time of Elizabeth, as the two remedies he recommended for prolongation of life were nitre and blood letting. The nitre he employed probably contained a quantity of nitrates, and blood letting was a remedy which had fallen too much into disuse, and in cases of high tension might be employed again with advantage. He showed Von Basch's instrument as modified by Potain for estimating blood pressure, and also a combination of this instrument with Riva Rocci's armlet.

Dr. **Herbert French** reminded the Society that cases of very high blood pressure occurred even amongst those who were at the same time vegetarians, non-smokers, and life-long abstainers.

In his reply Dr. **Oliver** agreed that rest in bed would diminish the high blood pressure even in the worst cases, but this was owing to a diminished call upon the cardiac end of the circulation. In those who were obliged to work, the ventricle factor could not be diminished, and such cases seldom reacted to apressor drugs so long as they remained up and about. He thoroughly approved of the revival of venesection for such cases.

Dr. Pallow, of Maesteg, died suddenly last week. He became unconscious, and Dr. Sheen, Cardiff, was called in for consultation. The patient, however, failed to recover, death being due to meningitis.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY.

MEETING HELD WEDNESDAY, APRIL 10TH, 1907.

DR. FREDERIC BAGSHAWE (St. Leonards-on-Sea) in the Chair.

THE adjourned discussion on

"THE PRESENT POSITION OF THE TREATMENT OF TUBERCULOSIS IN MARINE CLIMATES,"

which was introduced by Dr. William Ewart at Hastings on March 16th, was resumed by Dr. Alfred Street (Westgate-on-Sea). He said that the weight of evidence was on the side of those who contend that pulmonary catarrh is essentially microbic in origin, and that it always owns a factor other than mere cold. The humidity of marine climates was usually a tolerable humidity, for humidity must always be considered in relation with temperature, the really important point being the amount of moisture which can still be absorbed before saturation is reached. The climate of the north coast of the Isle of Thanet has long been recognised for its favourable influence in cases of tuberculosis, especially those amenable to surgery, but its precise factors are not yet discovered. Cases of locally originated tuberculosis are rare there. Hæmoptysis may be relatively more frequent at the seaside than inland, and there is need for abundant open air shelter. As maintained by the opener of the discussion, the more extensive and more systematic use of our marine climates is strongly indicated.

Dr. SOLLY (Harrogate) alluded to the beneficial influence of variety of scene to all who were obliged to seek health under the necessarily restricted conditions of a sanatorium life, and in this respect a "sea view" with the eternal contrasts of light and shade, and variety of colour and movement, offered advantages which no inland station could afford; and he had often wondered why so many sanatoria were founded inland to the comparative neglect of the sea coast.

Dr. CLIPPINGDALE expressed the view that a case of phthisis, in any stage of the disease, did better in a bracing climate than in a relaxing one.

Dr. LEONARD WILLIAMS said that it was necessary to draw distinctions between various kinds of marine climates. The climate of the north coast of the Isle of Thanet was as different, for example, from the south coast of Devonshire as the climate of high altitudes was different from the climate of the plains. It depended upon the type of tuberculous person which of these climates should be recommended.

Dr. EWART, in reply, explained that the bacilli could not be directly influenced by such slight oscillations of temperature or such moderate variations of climate as occurred within the temperate zones. But to their host these influences made all the difference. He entirely agreed with Dr. Street and other speakers as to the unequalled value of the bracing climate of Thanet; but it was apt to be too "strong" for the more advanced cases of phthisis, although invaluable in the early stage and in surgical tuberculosis.

THE CENTRAL MIDWIVES BOARD.

MEETING HELD THURSDAY, APRIL 18TH.

The President, Dr. CHAMPNEYS, in the Chair.

THE proceedings opened with the unanimous re-election of Dr. Champneys as president for another year.

THE PRIVY COUNCIL AND POOR-LAW INSTITUTIONS.

A letter was read from the Secretary of Privy Council stating that the rules as drawn up would be approved save that part of II. dealing with poor-law institutions as training schools.

Miss PAGET moved that this exception be accepted under protest, and only as *pro tem.* seeing that the old rule (C1) to continue had been found unsatisfactory in its working.

Dr. PARKER YOUNG said that it was merely a question of accepting the amendments or resigning their posts.

Sir WM. SINCLAIR remarked that to send a protest which would simply be shelved would be waste of time. Let the objections simply be entered for the benefit of the medical profession.

Mr. WARD COUSINS added that after the way the last resolution sent up was treated he agreed with Sir Wm. Sinclair that it would be more dignified to pass the matter over.

It was finally agreed to send a protest against exempting poor-law institutions from the supervision of the Board.

Miss PAGET moved that the name of Dr. Stanley Atkinson be added to the Penal Committee, and this was done.

THE IGNORANCE OF MIDWIVES AND PUERPERAL FEVER.

SIR WM. SINCLAIR after the reading of the report of the Penal Cases Committee remarked that a great many cases reported shewed slackness all round. There ought to be a rule that the temperature be constantly taken *and recorded*, as this was one of the best preventatives against puerperal fever.

Miss WILSON objected. There were, she said, some 12,000 midwives of whom 8,000 were incapable of doing this duty, and if the local authority had to report a lapse in its performance, it would give endless trouble.

Dr. PARKER YOUNG remarked, Sir Wm. Sinclair had expressed exactly what he was always urging. If these women could neither read nor write they had no right to be on the roll.

Sir WM. SINCLAIR added that it was not a case of the convenience of midwives, but one of life and death to patients. He did not mean the matter to rest. There were 3,000 deaths from puerperal fever alone. They could not take the responsibility of letting so many lives be lost.

Dr. PARKER YOUNG seconded Sir Wm. Sinclair, but the voting was against the motion.

Miss WILSON adding, that although she sympathized with Sir Wm. Sinclair, she must urge the cause of the poorer women in rural districts where midwives were hard to obtain.

Sir WM. SINCLAIR expressed a wish that his motion and the names of voters for and against be duly entered on the minutes. He also urged that in the appointment of a sub-committee the medical faculty be more largely represented. They were doing their medical colleagues an injustice by not so doing. He would like Dr. Parker Young's name added to the names of the President, Miss Paget, and Mr. Fordham (treasurer), who were soon to prepare a statement on the amendment of rules. Dr. Parker Young expressed willingness to meet them if his professional engagements allowed.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Apri 18th, 1907

TINEA CAPITIS.

Is tinea, or ringworm of the scalp, contagious? For a long time, tinea of the head was considered as a parasitic and contagious affection, more or less analogous to trichophyton. This theory was first set forth by Bazin (1862), and up to these last years unanimously accepted, the arguments being based on clinical, experimental, and bacteriological observations.

The bacteriologists affirmed the existence of specific germs in the tinea patches—bacteria, bacilli, &c. Unfortunately none of these germs have proved to be very virulent. The parasite discovered by Malassez

Eichhorst, was only a common saprophyte of the skin, while the micro-bacilli discovered by Sabourand never provoked ringworm by inoculation (Hallopean).

Experimental research was not more fortunate in proving the contagiousness of the disease. Each time an attempt was made, by inoculation, to transmit the malady to a healthy subject it failed (Jacquet). Only one case of positive inoculation is known (Blaschko), but this case was contested by the colleagues of Blaschko himself, and it can be said that up to the present every experimental effort has been unsuccessful.

As to clinical observations, they carry certain weight, but none of them were sufficiently precise to warrant discussion.

Some time ago, two Paris dermatologists published a case of ringworm epidemic observed in the police force. Four men, it was said, belonging to the same squad, were constantly together. Every second day they had to mount guard and relieve each other at fixed hours. In the interval of their turn to go on guard, they stretched themselves on a camp bed covered with a mattress and a pillow. In a short time all of them were found to be affected with ringworm of the scalp.

Here was positive proof of contagion, but a minute inquiry put everything in its place. The men affected were not constantly together, their turn to mount guard did not come every day but at long intervals, and in lying down they took particular precautions not to contaminate each other. If, then, they were affected with ringworm, it was by no means proved that contagion was the determining cause.

The theory of the anti-contagionists reposes on facts that may be divided into two classes—those of positive order and those of negative order.

To the first class belongs the success obtained in treating the ringworm according to the ideas of M. Jacquet, for whom tinea is but an ordinary lesion, a symptom caused by some irritation. Any local irritation, of no matter what nature, can provoke ringworm, on the condition that it attacks a pre-disposed individual; the *role* of this pre-disposition is considerable. Here it appears in the course of a well-defined malady (frequent in syphilis); there, on the contrary, it seems to develop independently of any disturbance of the general health, but the appearance is illusory. For when the patients are examined with care, it will be almost always found that the disease is associated with some morbid elements—troubles of the circulation, polyuria, hypophosphituria, albuminuria, seborrhœa, hyperhydrosis, or, on the contrary, anhydrosis, &c. However, none of these would be sufficient of themselves to provoke ringworm. Some cause of local irritation is necessary, and this is frequently due to dental lesion or the abnormal cutting of a tooth.

If this theory is exact, it is not necessary in order to cure the patients, to apply to the ringworm patch one or other of the famous antiseptic lotions or ointments; it suffices to stimulate the general condition of the patient and to treat the local irritation which provoked the malady.

It is thus, in fact, that M. Jacquet has treated systematically for several years the affection with almost invariable success. He asserts that this treatment cures more rapidly and more surely than any other method. He pleads consequently in favour of the neurotrophic theory of ringworm.

As to the negative facts, M. Jacquet made over one thousand attempts at inoculation under the most favourable conditions, without succeeding in provoking one case of the disease. Consequently he concluded that ringworm was not contagious and that there was no danger in allowing a person affected with the malady to mix with others.

His views have been adopted by many others, among whom may be mentioned, Besnier, Brocq, Daulos, Jeanseline, and Leredde. Professor Besnier, the well-known dermatologist of the St. Louis Hospital, was formerly an ardent partisan of the contagion theory, but to-day he has changed opinion. Professor Brocq is said to have sought during the last ten years, for cases of contagion, and was unable to find one authentic example. Jeanseline says: "For the ringworm is not contagious;" and Leredde, "Ringworm cannot be communicated."

The opinion, consequently, of the majority of contemporaneous dermatologists is that tinea is neither a parasitic, contagious, or epidemic affection. In accordance with these views, the Paris Board of Health has advised the Prefect of the Seine to remove the interdict touching affected school children; they are no longer isolated from their companions.

Ascites.

Calomel, grs. 2
Sugar, dr. 1

Divide into 20 powders. One every three hours. Each evening a tablespoonful of castor oil to expel the calomel. The treatment should not exceed four or five days.

Acne Rosacea.

Flowers of sulphur, dr. 6
Spirits of camphor, dr. 6

Paint on the face every evening with a pencil. The alcohol volatilises, leaving on the skin a layer of camphor and sulphur which can be washed off in the morning.

GERMANY.

Berlin, April 20th, 1907.

At the Verein für Innere Medizin Hr. Ewald showed A Spindle-Shaped Dilatation of the Œsophagus that had been diagnosed during life. Such a diagnosis was not often made with certainty. The patient was a man æt. 30, and the diagnosis had been made three years before. About a year and a half before his admission into the Augusta Hospital he had been suddenly attacked with vomiting in the night; after every meal he had had regurgitation, that now and then amounted to actual vomiting. Then one day he suddenly brought up a bright red mass of tissue that the medical man who attended him said came from an ulcer in the œsophagus. From that time the patient's condition changed, sometimes he could take food without any trouble, sometimes not; frequently he brought up remnants of food that he had taken days before. As carcinoma and organic stricture could be excluded there remained only either a diverticulum or a spindle-shaped dilatation of the œsophagus. The speaker then tried the various tests given by Rumpel, and the results were always in favour of the latter eventuality. By the constancy of the results obtained all the possible sources of error that attached to the experiment were eliminated. From the fact that the patient could sometimes swallow well and sometimes not at all and also from the circumstance that he could introduce the tube into the stomach himself it was clear that beyond the spasm there was no organic stricture. The size of the sac could be reckoned at about 400 cc.m., the food mass remaining in it, 250 cc.m. No products of digestion were found in this; in the stomach were some chlorides, but no free acid. The patient got gradually weaker, and at last died. The diagnosis in the determination of which œsophagoscopy by Glückmann's instrument and Röntgen illumination were made use of, was confirmed at the autopsy. The circumference of the unopened œsophagus was, below the bifurcation 5–6 cm., above 5 cm., the width of the opened gullet was above the cardiac end 4 cm., below the bifurcation 10 cm., above it 9 cm. The muscular coat of the walls was thickened to 3 cm. As regards ætiology the case confirmed the view that in idiopathic dilatation of the œsophagus two factors were necessary, first, spasm of the cardiac end; second, atony of the walls of the œsophagus.

Hr. Benda observed that some years ago he had examined the body of a man who had dilatation of the œsophagus that was diagnosed during life. He found then that there was an attachment of the œsophageal branch of the vagus to a lymph gland, which Kraus had noted as of ætiological moment.

Hr. Ewald replied that he had not overlooked that well-known point.

Hr. Schusler showed two patients who had been sent to him on account of eye symptoms. The first case was that of a man æt. 61, who four weeks before had found that he was blind in one eye. Examination showed atrophy of the optic nerve and rigidity of the pupil. He had suffered for about three years from nerve troubles, shown especially by trembling of the hands and feet. Ataxic symptoms were also present. The case was one of combination of paralysis agitans with locomotor ataxy. The second patient, æt. 33, had during the last few months become completely amaurotic, before then having hemianopsia. He had remarked lately that his gloves had become too small for him, and his rings would no longer go over his fingers. The nose was thickened and the facial expression had become peculiarly fixed. The case was one of acromegaly and the X-ray image plainly showed a good sized tumour of the hypophysis.

Hr. Ewald doubted whether there was any paralysis agitans in the first case as the tremor was an "intention" tremor, while the tremor of paralysis agitans ceased when intentional movements were made.

Dr. Schusler replied that Gerhardt, Junr., had published some cases of paralysis agitans with "intention" tremor.

At the Laryngological Society Hr. E. Meyer showed a child on whom tracheotomy had been performed for diphtheria. As the disease subsided there had been great difficulty with the "decanülement." The degree of stenosis and the winding of the canal and especially the fact that the retention of the intubattion cannula for twenty-four hours set up a sharp attack of bronchitis rendered all measures vain. Success was first obtained with Fischer's modification of O'Dwyer's tube of hard gum with a metal core, which could be retained for a fortnight without setting up any ulcer. The child even breathed well and spoke with a low voice.

At the Medizinisch Gesellschaft Hr. F. Friedlander spoke on

Antidotes to Poisoning by Lysol.

From the affinity of oil for kresol as observed by Blumenthal he had given lysol along with oil and other fats to rabbits. If he gave these soon enough, *i.e.*, before the onset of spasms they did not come on. He got the same effects from giving albumen. If the administration of the antidotes was delayed fifteen minutes or beyond it no longer did any good. For the antidote to be successful, five times as much of it as of the poison taken must be given.

At present there was no theoretical explanation of the paralysing of the kresol. Albumen coagulated with kresol, the coagulated mass was digested by pepsine-hydrochloric acid. Kresol taken internally was excreted mainly in the urine, but little by the bowel. In animals to whom the antidote had been given the excretion was much slower than in others.

In practise by far the best thing after lysol poisoning was to wash out the stomach as speedily as possible. Until this can be done oil in white of egg should be given, *in any case water should not be given.* After the washing out, oil or egg albumen should be given.

Hr. F. Blumenthal said that he could confirm what had been said. In treatment washing out was the first line from which success was sometimes obtainable, even when the patient was pulseless. After that the oil or egg albumen should follow.

Hr. Weinberg has used an oily mixture externally, and the skin bore lysol up to 60 to 80 per cent. without harm, so long as the part to which it was applied had been carefully dried. The moist skin was cauterized. Very much weaker solution of lysol in water acted as a caustic. Lysol-oil mixtures could be used on the skin when otherwise carbolic acid would be used.

AUSTRIA.

Vienna, April 20th, 1907.

Cerebro-Spinal Fluid.

Lehndorff and Baumgarten presented a report to the Gesellschaft on their examinations of twenty-five cases of cerebro-spinal fluid. It was alleged at a former meeting that the cause of meningitis was due to an accumulation of lactic acid in or about the nerve centres. To confirm or deny this opinion of Uffelmann the present report was desired. It now confirms the presence of lactic acid in every one of the cases, but refrains from saying this is the cause.

Zack added to this report by saying that he had obtained an ether extract of lactic acid from the cerebro-spinal fluid taken from cases of tubercular meningitis.

Leucocytosis and Serum Injection.

Bienenfeld next gave the results of his experiments with serum and albumen. After injecting a quantity of foreign albumen a pause of eight to twelve days occurs, when a typical rash, efflorescence, fever, swelling of the lymphatic glands, œdema, swelling of the joints, albumen in the urine, and general disturbance appears. In four of the cases daily numeration of the leucocytes was taken and the blood found to be in a state of leucopenia. This is the term used by Lowits where the white corpuscles have undergone leucolysis or destruction of the leucocyte, as was the case in his experiments after abnormally lowering the temperature. Goldschmidt obtained the same results by injecting the extracts of the spleen, thymus, and marrow of bone—a destruction of the leucocytes as opposed to the function of manufacture of the leucocyte. Bienenfeld found the leucocyte curve fall after giving this artificial serum of albumen he had prepared, and concluded that this lowered in some way the specific gravity of the leucocyte, and thus destroyed some constituent of the blood. In order to test this hypothesis he selected nine cases of scarlet fever and injected 100 to 200 centimetres of Mosers' Polyvalent Scarlatina Serum; also others with tetanus were injected with Behring's Tetanus Antitoxin for three or four weeks, and the leucocytes enumerated daily. Dried preparations were preserved for confirmation. The results of large doses were two-fold on the number of the leucocytes. First, immediately after the injection leucopenia, followed later by lecocytosis; secondly, there is also an increase of the leucocyte curve in the prodromal period of the serum, which sinks after six days with a serum eruption. From this point the number of leucocytes descends till an absolute leucopenia is produced, numbering 5,000 only in four days later. After all the serum phenomena have passed off the leucocytes return to the original number.

Bienenfeld agrees with Löwits that the leucopenia is the direct result of destruction in the blood by the serum, and not by nitrogen as affirmed by others. There is also a connection between this leucopenia and swelling of the glands, spleen, &c., as well as the formation of precipitine.

Schlesinger thought this an important question, and asked if we had this leucopenia in typhoid fever. For example, he had several cases under his own observation where the white corpuscles were only 3,000. He injected 130 cubic centimetres of serum, and four days later found the white corpuscles to be 14,000, which gradually rose later to 24,000. During this period all the phenomena of "serum disease" were present, viz., urticaria, articular swelling, albuminuria, and elevation of temperature.

Escherich believed there was a change in the blood after an injection of serum which could be demonstrated with the Röntgen Rays, but whether it was due to the serum checking the function of manufacture of white corpuscles or their destruction he would not like to say.

Bienenfeld remarked that there was a similarity between the serum injection and the action of the Röntgen Rays, as both produced leucopenia and an increase of the mononuclear leucocytes. He suggested the possibility of a degenerative change having been produced in this bone marrow.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

SERIOUS SHOOTING ASSAULT ON DR. JOHN CARSEWELL, GLASGOW.

It may be remembered that about two years ago, Dr. Carsewell, along with Dr. Marion Gilchrist, successfully, though at very great annoyance and financial loss, defended an action brought against them by a Clyde pilot, named Purvis, for erroneous detention in an asylum. Much sympathy was expressed for both Dr. Carsewell and Dr. Gilchrist at the time, and expressed itself in the substantial form of a fund to pay off part of their law expenses. Much regret will therefore be felt that Dr. Carsewell has again become a victim of the animus of the pursuer, who, on April 16, assaulted him in a most deliberate manner. About three o'clock, Dr. Carsewell left the Parish Hospital in Duke Street and proceeded westward to his residence. As he was stepping on to a car near Moore Street, he heard three sharp explosions and felt two sharp twinges in his left thigh. He fell helpless to the ground, and just as he did so saw a man with a smoking revolver in his hand. Duke Street was thronged at the time, but so suddenly was the outrage perpetrated that the first intimation anyone received was the sound of the revolver. The man was at once arrested, and was in a perfectly collected frame of mind. He gave his name as William Purvis, retired Clyde pilot, and on his way to prison talked quite freely. "I am guilty," he said. "My intention was to get the doctor into the witness-box again and to squeeze the truth out of him. I have lost £400 over him. He has ruined me." He added that he expected to get six or eight months for the affair. One version of the affair is that as Purvis fired at the doctor from a few yards' distance and saw him fall, he exclaimed, "Take that fool to the hospital." Happily it is thought that Dr. Carsewell's injuries are not serious. He has three wounds, one over the left buttock, one in the front of the left thigh and one in the right thigh. The bullet which struck the left thigh passed completely through, narrowly escaping the femoral artery. He passed a fairly easy day, and at the time of writing (April 18th) his condition is satisfactory. He is under the case of Sir William MacEwen. Purvis was brought before the magistrates on the 17th inst. and remanded. At a meeting of the Daily Relief Committee of the Glasgow Parish Council it was agreed to send a message of sympathy. The chairman said that the unfortunate occurrence opened their eyes to the fact that Dr. Carsewell, in the course of his duties, had disagreeable, and even dangerous, tasks to perform.

Milk Supply of Edinburgh.—A very important report on the milk supply of the city has been issued by the chief sanitary inspector, Dr. Williamson. The bacteriological work was carried out in the Usher Institute, and the organisms specially looked for were B. coli, B. enteritidis sporogenes, streptococci, and acrofast bacilli. A very large number of samples, representing many sources of supply, both in town and country, were submitted to examination. B. coli and B. enteritidis sporogenes indicate pollution during milking. The former increases rapidly in the milk, the latter does not, so that it may be taken as a measure of the original contamination. Streptococci are found in the dung of cows, and in various diseases of the udder; they are important as giving rise to sore throats, &c. Among the acrofast bacilli, B. tuberculosis is, of course, that which must be sought; other members of the group are found in grass, manure, &c. When acrofast bacilli were detected they were inoculated into guinea-pigs to ascertain their true nature. The average percentage of fat in these samples was: Railway milk (evening), 3.38; country milk (morning), 3.22; town milk (morning), 3.19, centrifuged sediment. The total solid contamination was greater than in Dr. Houston's specially collected London milk, in which no sample showed more than 25 parts per million. In town milk there were less than 25 parts per million in 66 per cent.; in country milks in 52 per cent., and in railway milks in 56 per cent. B. coli was found in all the samples examined; it was present in only 40 per cent. of Dr. Houston's specially collected London specimens. B. enteritidis was found in 47 per cent. of town milk, 28 per cent. of country milk, and 37 per cent. of railway milk. Streptococci were found in 30, 19, and 14 per cent. respectively. The most satisfactory result is the entire absence of tuberculosis in connection with any of the milks examined. The organisms found are those which are associated with dirt and manurial origin, and in the absence of efficient inspection it is not likely that greater freedom from contamination than is represented by these figures can be attained. Dr. Williamson makes the following recommendations to ensure greater purity: (1) At present milking is done in the byres in which the cows stand all day and night for months at a time. Milking ought only to be allowed in a separate milking shed apart from the byres. (2) The milk of recently calved cows should not be allowed to be sold. (3) The following regulations require revision—(*a*) The rule that no "direct" communication is allowed between a milkshop and dwelling-house is interpreted to mean that if there is a passage between the two it is permissible. This, of course, is wrong. (*b*) There is much confusion at present as to what articles the regulations allow to be sold in milk shops; many at present obtainable in such places contaminate the milk supply. (*c*) It ought no longer to be compulsory to register as milksellers all applicants, irrespective of their personal suitability or that of their premises. (4) The storage of manure in byres for fourteen days is allowed. It would perhaps be an ideal, but it ought to be removed every twenty-four hours. (5) The existing legislation is insufficient to ensure the seizure of tuberculous cows discovered in byres. Tuberculous milk is much more dangerous than tuberculous meat, which local authorities are empowered to destroy; yet under the existing regulations it is possible for the owner of a tuberculous cow to remove the animal from the district where it has been detected, and to transfer it to another locality, where it may legally be used for milk giving purposes until the condition has been detected by the officers of the district to which it has been transferred.

BELFAST.

Cerebro-spinal Meningitis.—During the last week, 30 new cases of cerebro-spinal meningitis were notified to the Public Health Office, and 23 deaths were notified to the Registrar-General, bringing the mortality up to 200. Apart from this epidemic there is less infectious disease than usual in the city. It is reported that Professor Symmers is doing some interesting work at the bacteriology of the infection in his laboratory at Queen's College, and has succeeded in cultivating the meningococcus for many generations. This has not been done hitherto, and is the first necessity for the preparation of a serum or antitoxin. At the forthcoming meeting of the Ulster Branch of the British Medical Association, which is to be held in Londonderry on Saturday, the 27th inst., there is to be a discussion on cerebro-spinal meningitis, in which Professor Symmers is to take part, so some information on his recent work may shortly be expected.

Holywood Water Supply.—The Urban Council of the little town of Holywood, in Co. Down, is constantly in trouble with the ratepayers over the water supply. Last week one indignant inhabitant reported to the authorities that he had found frogs, fish, and blood in his tap water. It sounded as though some modern Moses had been at work in the neighbourhood, reproducing the plagues of Egypt, but the matter appears to be no joke, for the sanitary sub-officer, when questioned about it, said that frogs and fish must have got into the main when the water-basin was cleared. Perhaps when a few of their first-born have died the Urban Council may take the matter vigorously in hand, and alter what is a disgrace to any civilised community in these days.

Belfast Health Commission.—The Commission has not sat during the past week, but is to sit again about the 24th, when it is expected that expert evidence will be taken on the water supply. Professor Symmers will give evidence as to its present character, while his predecessor, Professor Lorrain Smith will give evidence as to what he found during the severe typhoid epidemic of a few years ago. The Water Commissioners have had three experts busy for some time past making examinations and analyses, and they also will give evidence, so an interesting week may be anticipated.

LETTERS TO THE EDITOR.

MILK AND TUBERCULOSIS.

To the Editor of The Medical Press and Circular.

Sir,—Dr. Granville Bantock's statements and arguments in the letter in the Medical Press of April 17th are, like all his writings, interesting and even amusing. but they do not seem to take us much further—regarded from a practical point of view. He agrees that "it is probably correct that 'live' tubercle bacilli can be conveyed in milk," but seems to suggest that, although milk thus infected may be partaken of in any quantity, the danger of setting up tuberculosis in those fed upon it is never to be regarded seriously. Does he hold the same opinion with regard to milk containing the contagium of typhoid fever, for example? There are always a certain number of persons immune, and in cases where a typhoid outbreak is clearly demonstrated as due to milk infection, it always happens that a large percentage of those consuming the milk escape. No doubt the same thing occurs in tuberculosis, and the fact that this disease in every form attacks by preference the children of the poor is to be accounted for on many grounds. They live in surroundings of darkness, dampness and filth, strongly predisposing to the disease; whilst starvation from lack of food or from improper feeding increases their susceptibility. Surely we ought not to wait for a scientific demonstration of the entire sequence of contributory causes and of the mode of attack in tuberculosis, or any disease due to a specific contagium, but ought to set about to prevent the dissemination of the poison by every possible means. Until we shall have gained the means to stamp out tuberculosis in cattle we are surely bound, in light of our present knowledge, to do all that may lie in our power to prevent the consumption of infected meat, and of milk reasonably to be suspected of holding the specific poison. This, as I understand it, is all that you, Sir, are contending for; it is certainly that which will be striven for by most of us until better ways are indicated.

I am, Sir, yours truly,
A Family Doctor.

Bristol, April 18th, 1907.

OBITUARY.

WILLIAM HENRY RANSOM, M.D.Lond., F.R.C.P., F.R.S.

With regret we record the death of a well-known member of the medical profession in the person of Dr. W. H. Ransom, of Nottingham. Deceased, who was one of the oldest practitioners in the Kingdom, had been ailing for some months, although his end from heart failure came somewhat suddenly. He died at the age of 83, having graduated in 1850 M.D. of London, from University College, which he entered in 1843. He took the Fellowship of the London College of Physicians in 1869. Born at Cromer in 1823 he was educated at Nottingham, in which town he started practice in 1850. He engaged in some natural history research, which was published in the Transactions of the Royal Society, of which body he was made a Fellow in 1870. In 1854 he was elected physician to the Nottingham General Hospital, and he was connected with many other local medical institutions. In 1892 he was President of the British Medical Association. From his earliest days he opposed the popular view that cold was the cause of many maladies, and in this connection he was an early and consistent advocate of the open air treatment of consumption. Dr. Ransom lived a strenuous life professionally and socially. Space will not permit us to record his many spheres of usefulness and activity, which included volunteering, education, and local and general politics. He has left three sons, of whom one, Dr. W. B. Ransom, succeeded his father in practice on the retirement of the latter some eight or ten years ago. Among his friends Dr. Ransom numbered such men as Herbert Spencer and Huxley. His loss will be felt by a wide circle of friends and acquaintances, both within and without the medical profession.

JOHN LACY COLLISON-MORLEY, M.D., Brux.

The death, which occurred on April 10th, of Dr. John Lacy Collison-Morley, deprives St. Paul's School of one of its best friends. Dr. Collison-Morley acted as medical officer to the school, and practised in the neighbourhood for many years. He was an indefatigable collector of prints and engravings, and earned the gratitude of the school by his gift of a valuable collection of portraits of distinguished *alumni* of the school. To his original gift he made frequent additions, and it is largely due to his generosity that the school is able to maintain a sense of continuity with the old City school of Milton, Pepys, and Marlborough. Dr. Collison-Morley, who was formerly a lieutenant in the 20th Regiment, qualified from Guy's Hospital in 1872 and held the degree of M.D. of Brussels.

BEATTIE BAIN, M.D.Edin.

We regret to record the death of Dr. Beattie Bain, at Dundee on the 9th instant. He was born at Montrose, and after graduating at Edinburgh University, became Superintendent of Craiglockhart Hospital, Edinburgh. After a year he became assistant to Dr. Low, at Sandringham, where he came much into contact with members of the Royal Household. He then left for Bristol, where he held an extensive practice for ten years. Twenty-five years ago he settled down finally in Dundee where he took much interest in local educational and social matters. His death at the age of 68, removes an engaging and distinguished figure from his native town.

SPECIAL ARTICLE

THE UNIVERSITY QUESTION IN IRELAND

During the past week there have been the usual budget of protests against, and approval of, the supposed scheme of the Government for the improvement of University Education in Ireland. On Tuesday a quarterly meeting of the Standing Committee of the Roman Catholic Church in Ireland was held in Dublin, at which a long declaration and resolution were adopted and ordered to be published. The following paragraphs taken from it will give a fair general idea of the opinions expressed in it:—

"On the supposition, then, that the Government gives us an adequate and worthy scheme on any one of the three plans which we put before the recent Royal Commission, we, for our part, shall be prepared to accept it as final, and as the settlement, in our time, of the Irish University question. Of course, neither we nor anyone else can foresee what the natural development of institutions may bring with it, but on the condition just stated, as far as we are concerned, we shall consider the Catholic grievance as removed, and the whole question closed.

"At the present stage, as is obvious, we cannot go farther than this expression in general terms of our approval of the Government plan of a National University as the basis of a settlement. When a scheme, worked out in full detail, and showing its positive provisions both for the general interests of education, and for the special interests which it is our first duty to protect, has been formulated, we shall be in a position to pronounce a definite opinion upon its merits."

On the same day, in the House of Commons, Mr. Birrell, in answer to Viscount Castlereagh, said that the proposals of his Majesty's Government will proceed upon the lines indicated by Mr. Bryce, subject, it may be, as, indeed, he intimated, to modifications if found necessary, and that he was not yet in a position to name a date for placing before Parliament the Government proposals for dealing with Irish University Education.

A protest has been sent to the Government from members of the Galway Alumni Association protesting against "the attempt to place out Alma Mater in a position inferior to that of the other Queen's Colleges in the new University scheme of the Government."

Lastly, protests against the "Government Scheme" have been sent from Sheffield University and from St. David's College, Lampeter, whilst a resolution approving in general terms of the scheme have been adopted by the Irish County Councils General Council, a body which is representative of the Nationalist Councils throughout Ireland.

A memorial has also been sent to Mr. Birrell by eight hundred Ulster graduates, amongst whom are represented the Universities of Dublin, Oxford, Cambridge, London, Durham, Edinburgh, Glasgow, Aberdeen, and Freiburg, in Baden, also the Queen's University and the Royal University of Ireland. The memorial is also signed by Archbishops, Bishops, Peers, Baronets, Deputy-Lieutenants, military and naval officers, doctors, lawyers, and many influential representatives of the trade and industry of Ulster. The memorial protests against a scheme which will "inevitably lead to the ruin of the principal representative and exponent of modern thought and research in this country."

THE QUALIFICATION OF "MIDWIVES."

WE have commented in these columns over and over again on the extraordinary ideas which seem to be present in the minds of certain members of the Central Midwives' Board on the object of the Midwives' Act and of their duties as members of the Board. It may be trite, but it is none the less true, that the object of passing the Act was to secure the better training of Midwives, and to regulate their practice, in order that they might be a benefit instead of a curse to their patients. Consequently, it follows that the Act was not passed in order to promote the welfare of, no doubt, well-meaning, but dangerous, old and illiterate women. At the last meeting of the Central Midwives' Board, as reported in our columns to-day, Miss Wilson objected to a rule that the temperature of the patient should be regularly taken and recorded because there were some eight thousand registered women who were incapable of doing so! We speak subject to correction, but are we not right in thinking that this is the same lady who expostulated vehemently at the Central Midwives' Board on a previous occasion because certain members of the Board desired to make illiteracy a bar to registration? If we are correct, then it appears that Miss Wilson having secured the admission to the register of illiterate women now desires to make these women's capacities the standard by which rules "for the better training of midwives and to regulate their practice" are to be drawn up! The Central Midwives' Board is receiving scant courtesy at the hands of the Privy Council, although on the point involved it is acting in accordance with the principles on which it was created. How can it, however, persuade a body of eminent laymen that it is doing so, when over and over again it is hopelessly and publicly stultified itself. We fear that, in its conflict with the Privy Council, the legitimate aspirations of the Board will suffer because of its absurd conduct in the past.

REVIEWS OF BOOKS.

THE CLINICAL SOCIETY'S TRANSACTIONS.(a)

THESE transactions are always most readable and full of interest, and the present volume, which represents the work done in the year 1905–1906, is no exception to this statement. It contains thirty-five papers of varying length on clinical cases, and in addition fifty-two short records of cases shown at the meetings of the Society. Its papers, taken as a group, are illustrated by twelve plates, and twenty-six other illustrations. The general character of the volume is unchanged, the paper, printing, and general binding being, as usual, everything that is to be desired. Out of so many articles of merit it is difficult to select any deserving special comment more than others, and so we must content ourselves by referring to a few, while premising the fact that many not mentioned are equally excellent. Amongst the purely medical papers, that by French and Ticehurst on "The Relation of Traumatic Diabetes Insipidus to Glycosuria" throws some light on the general pathology of diabetes. The case was that of a man who received a severe head injury in 1901, and thereupon developed extreme polyuria, without glycosuria. Attempts were made to produce alimentary glycosuria by feeding with large quantities of carbohydrates, but without success. The patient then left hospital, but returned three years later with extreme glycosuria and almost complete carbohydrate intolerance. Treatment had very little effect on the glycosuria; but the condition again disappeared spontaneously a year later, the polyuria and polydipsia, however, persisting. As the writers point out this type of case is very rare, and they have only been able to find one similar one recorded. Dr. Samuel West has contributed two short papers—one on "Periostic Respiration" as distinct from Cheyne-Stokes breathing, a condition which, he believes to be of much less prognostic importance than Cheyne-Stokes breathing, and which he believes to be only found in cases of basal meningitis; the other on a peculiar pleural effusion. A paper by Dr. Bax entitled "A Series of Cases in which Pulmonary Embolism appeared to be due to the Displacement of a Thrombus in the Main Trunk of the Pulmonary Artery" is more entertaining than convincing, though we have no doubt that pulmonary thrombosis and subsequent embolism does occasionally occur. The surgical papers are this year more numerous than usual, and considerable attention seems to have been drawn to cases of unusual varieties of hernia, as four out of the thirty-five articles deal with the subject. Peritonitis in typhoid fever, apart from perforation, seems also to have attracted attention, and judging from the cases published in this volume and elsewhere would seem to be more common than is usually believed. Another interesting intra-abdominal condition on which a paper appears is "Suppurative Pylephlebitis" secondary to suppuration within a mesenteric gland. Amongst the most interesting of the cases exhibited we may mention the following:—Adiposis Dolorosa; Extreme Obesity with Precocious Puberty in a girl æt. 3; Mediastinal Dermoid; and Myasthenia Gravis. The volume well repays perusal, and is an interesting exposition of the current of medical thought during the last twelve months.

(a) "Transactions of the Clinical Society of London." Vol. xxxix. London: Longmans, Green and Co. 1906.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

Acute Dilatation of Stomach and Intestines in Peripheral Neuritis.—Dr. Parkes Weber reports a case of the above (*Edin. Med. Journ.*, April 1907, page 315). The patient, a man, æt. 50, was admitted to hospital with the typical signs of peripheral neutritis, probably alcoholic in origin. At first he did not present any serious symptoms, but after he had been under observation for a couple of days, he began to suffer from severe abdominal pain and had an attack of vomiting. The abdomen soon became distended, and the pulse rapid and feeble, so that it was thought advisable to perform a laparotomy on the supposition that acute pancreatitis was present. The patient however died suddenly under the anæsthetic (ether) before the operation was commenced. At the autopsy practically nothing abnormal was found except gaseous distension of the stomach and intestines, more especially the latter. The writer suggests that this distension may have been due to neuritis of the vagus nerve, leading to a sort of paralytic atony of the bowel wall. He points out that section of the vagi in the dog leads to intestinal dilatation and thinks that both it and the condition found in the present case is similar to paralytic distension without peritonitis, so often found after severe abdominal operation. M.

Obscure Renal Hæmaturia.—An interesting paper with the above title is contributed to the *International Clinics* (Vol. IV., 16th Series, page 122), by Elliott. He points out that it has been the experience of most surgeons to cut down more than once on kidneys for the relief of hæmaturia, and to find nothing abnormal. Various names have been applied to such cases, such as "renal hæmophilia," and "essential renal hæmaturia," but the present writer prefers the above individual title. Various theories also have been advanced to explain the occurrence, but none entirely satisfactory, although at one time considerable credence was given to Klemperer's view, that the bleeding was the result of paralysis of the vasoconstrictor nerves of the kidney, resulting in vasodilatation and consequent diapedesis of the blood elements. The aim of the present paper is to show, by allusion to cases, that in almost every instance some local renal lesion is really present. Among the local lesions he most frequently found chronic nephritis, which may be unilateral, or may even involve a part only of one kidney. Another lesion occasionally found is an angiomatous condition of the capillary blood vessels in the pelvis of the kidney; while occasionally simple movable kidney may prove the cause of intermittent hæmaturia. Till every case is thoroughly investigated, the existance of a purely functional hæmaturia should be regarded as non-proven. M.

An Unusual Form of Tabes Dorsalis.—Lapinsky (*Deutsche. Zeits. fur Nerven Zeilk.* Bd. 30, 3-4) describes a rare form of locomotor ataxia, which he has met with in five cases, and in which in the early stages pain, paræsthesia, and in fact, all sensory disturbances are absent. The first complaint is in fact of weakness, sometimes felt all over the body, but more especially in the legs, and frequently the weakened parts show some atrophy. The weakness may be present in all the muscles of the extremities or special nerve muscle groups may be picked out. Ataxia is not a very prominent symptom, but is present more or less in all movements. In the later stage of the disease all the typical phenomena of tabes dorsalis develop. The writer first thought that the primary weakness signified some disease of the anterior cornual cells, but microscopical examination in some instances proved these cells to be normal and, in consequence, the conclusion is drawn that the paralysis is centripetal in origin and due to a loss of muscle tone. M.

Neuronal as an Hypnotic.—Gerlach and Dreyfus report their clinical experience with neuronal (*Munich Med. Woch*, 1906, No. 21, and *Therap. Monat.*, May, 1906). They find that in cases of simple insomnia this drug, the chemical nature of which is expressed by the name bromid-ethylacetamid, is most useful in doses of ½ to 1 gramme, while in cases of nervous excitement doses of from ½ to 2½ grammes almost invariably produced quietude. Occasionally untoward results follow its use, more especially headache and acceleration of the pulse. Gerlach experimented with it in cases of epilepsy and found the fits diminished in number during its use. The diminution, however, seemed to be due, rather to the hypnotic effect of the drug than to any specific effect. M.

The Diaphragmatic Reflex.—Hess (*Münch. Med. Woch*, 1906, No. 36) understands by the term "diaphragmatic reflex" a slight contraction of the sternal part of the diaphragm leading to sucking in of the ensiform cartilage, and induced by stroking and tapping lightly the nipple. It appears to the observer as a very rapid but slight sinking in of the upper portion of the epigastrium, and resembles in consequence the epigastric reflex. It must, however, be distinguished from this last named, which can be induced by stroking the skin at the side of the thorax between the third and the sixth rib, and which is due to contraction of the rectus abdominis and external oblique muscles. Hess believes that the reflex path for the diaphragmatic reflex is not through the phrenic nerve, but is through the fifth intercostal, and he maintains that the phrenic nerve only supplies the posterior part of the diaphragm, the anterior part receiving its nerve supply from the lower intercostals. M.

Trypsin in Cancer. — W. Carter ("Therapeutic Notes") (*Liverpool Med. Chirurg. Jour.*, March, 1907), by way of reply to an oft-repeated question, "Do you consider trypsin of any value in the treatment of cancer?" gives the following case in which in consultation with Dr. MacAfee, he advised the use of trypsin owing to the beneficial effects reported to him in two apparently similar cases of uterine cancer:—"Patient æt. 51, unmarried had panhysterectomy performed for adenocarcinoma of the uterus. The left ovary was found to be seriously involved, considerable infiltration had taken place into the tissues around and from soon after the time of operation—in July, 1900—up till the beginning of 1905, it was evident that the disease was making progress in the pelvic region; a considerable mass could be felt in the left groin, and a large ulcer formed in the posterior wall of the rectum. This soon necessitated colotomy, which was performed in March, 1905. The patient was much relieved by this operation till August, when several alarming syncopal attacks occurred, and there was much exhaustion; pain in the pelvis was intense, and frequent discharges from the rectum took place with symptoms of septicæmia. The patient became steadily worse; increasing weakness, with symptoms of absorption and constant distress from the activity of the rectum, notwithstanding the injection of local sedatives, pointed to a rapidly fatal termination. On February 19th the use of trypsin was commenced. Two drachms of the liquid trypsin co. (Allen and Hanbury's) made up to one ounce, with water, were injected (into the rectum) daily, and one drachm three times a day administered by the mouth. There was an immediate improvement in both the local and general condition. The sense of urgent pressure ceased and the general increase of comfort was most gratifying. Sleep returned, the digestion improved and wasting was checked. The abdomen became less tender, and a marked diminution of the resistance in the left groin became evident; and in a month the patient was able to get out of a bed to a chair, and several times during the summer she has been able to take drives of considerable length. Such is Dr. MacAfee's report, and in order to learn whether the improvement continued, I telephoned to him for information, as these notes were being prepared for the press. The reply was in the affirmative. When it is remembered that the act of sitting up in her bedroom even, much less of going downstairs, and less still of driving out of doors, would not have been thought possible ten months previously, and, moreover, that a microscopic examination had determined beyond question that the growth was an adenocarcinoma, this case seems to point to the possible power that may be possessed by trypsin of differentiating between one form of cancer and another. It may perhaps be added that the matter discharged (from the colotomy entrance) after the injection of trypsin (into rectum) was alkaline in reaction, very albuminous and contained trypsin; but as 20 fl. oz. were sometimes discharged while only 1 fl. oz. of the trypsin solution was injected, it obviously contained very much more. Whether the additional fluid discharged was the result of any solvent action produced by the drug upon the cellular or other elements of the growth, must be matter of conjecture. What is not matter of conjecture, however, is the very great improvement in the patient's condition which followed, and, as we think, was caused by the treatment."

Lobar Pneumonia.—Affleck (*The Scottish Med. and Surg. Journ.*, April, 1907) discusses the question as to whether this disease has assumed a graver character of recent years, and whether the mortality rate is rising. From his clinical experience extending over some forty years he is inclined to answer the question in the affirmative, He is unable to recall that his teachers regarded pneumonia with the anxiety with which it is now looked upon, and finds from the returns of the Registrar-General of Scotland that the death-rate has been steadily rising since 1880. In that year the rate was 86 per 100,000, in 1890 it was 123, in 1900 it was 141, and in 1902 reached 155. Some interesting figures are also given from the Annual Reports of the Medical Registrar of the Edinburgh Royal Infirmary to show the high rate of mortality of pneumonia among alcoholics. Thus in 1899–1900 of 19 alcoholic pneumonias 17 died; in 1900–1901 of 5 all died, and in 1901–1902 of 22 cases 18 died. K.

The Nature of Diabetes Insipidus—Seiler (*Zeit f. Klin. Med.*, Berlin, 1907) concludes from his clinical and experimental experiences that diabetes insipidus is the result of an anomaly in kidney functioning which consists in the fact that the kidneys are no longer able to secrete urine of a normal concentration. The concentration is always below normal. If sufficient fluid is not ingested, then the elements of the urine are retained and trouble follows. To obtain sufficient fluid for the purpose Nature calls for increased intake of fluid by increased thirst, and satisfying the thirst leads to the polyuria. This may possibly be the cause also of the polyuria observed with contracted kidney. It might be possible, he suggests, to influence the diabetes favourably by diuretics to improve the secreting conditions in the kidneys. D.

Multiple Neuritis Simulating Progressive Muscular Atrophy.—Grinker (*Journal of the Am. Med. Assoc.*, March 9th, 1907) reports three cases, one of alcoholic polyneuritis, one of lead paralysis, and one of progressive muscular atrophy, illustrating the futility of attempting to differentiate these conditions by objective symptoms alone, without study of the etiology and course of the disease. Grinker holds, nevertheless, to the advisability of clinically separating the cornual from the peripheral lower neuron disorders. His conclusions are given as follows:—(1) Clinically, multiple neuritis may simulate a spinal atrophy as regards distribution of paralysis, absence of sensory symptoms and protracted course. (2) Progressive spinal muscular atrophy may resemble neuritis in the presence of pain, remission of symptoms and subacute course. (3) Etiology and course are still the best guides in the clinical diagnosis of the various muscle atrophies. D.

Leukæmic Blood Picture in a Case of Fracture of the Ankle.—Simon (*Am. Journal of Med. Science*, March, 1907) reports a case in which after fracture of the ankle the blood had the characteristics of that of myelogenous leukæmia. Six months later the blood had returned to normal condition. D.

Salt-Free Diet in Nephritis.—Peabody (*Med. Record*, March 9th, 1907) emphasizes the importance of the dechloridation treatment in cases of general anasarca from chronic parenchymatous nephritis with failing heart power. He says that its effect is perhaps enhanced by the simultaneous administration of heart tonics, such as digitalis and theobronim—preferably the latter. Peabody says that while clonic irrigations with hot sodium bicarbonate solution and catharsis are of value in some cases, the most important agent is the negative one referred to. After complete removal of the edema he administers progressively increasing daily quantities of salt, carefully watching for any recurrence of the edema, the endeavour being to ascertain the exact salt equilibrium for each patient. He is not yet prepared to report results. D.

Epidemic of Acute Anterior Poliomyelitis Occurring in Sweden During 1905.—Lundgven (*Hygiea, Stockholm*) traces the clinical picture of the disease as observed in 147 cases in the Växjö district. There were 403 cases in the entire epidemic which commenced in April, and reached its highest point in August and September; no case has been known since the beginning of 1906. The incubation seemed to be about 8 or 10 days, and a prodromal period followed, lasting from 1 to 3 days, with headache, vomiting, stiffness in the back of the neck, pains in the back, fever, and somnolence in the smaller children, with convulsions in some cases. The symptoms subsided after a few days, leaving a certain weakness in the arms or legs, and a staggering gait in some cases. In the majority, however, as the initial symptoms subsided, a gradual paralysis was observed, with paresis of the bladder, and in one case, disturbances in sight and in another of hearing, with loss of speech in a number. The mortality was about 10 per cent. Permanent paralysis was left in about 25 per cent. of the cases. D.

Ferments for Disinfection of the Intestines.—Fournier (*Presse Medicale, Paris*, 1907) says that the ideal disinfectant for the intestines would be an anaërobic ferment able to transform sugar into formic acid, but nothing of the kind is known. Brewers yeast answers some, but not all of the desired conditions for a disinfectant, and it frequently fails to exert any action, while the generation of alcohol is not always desirable, and the yeast is not resistant enough to act along the entire length of the digestive tract. The only ferment known to date which adapts itself anaërobic conditions and acts directly on the carbohydrates, while very resistant to external influences, is the lactic ferment. The combination of the lactic streptococcus and the lactic streptobacillus in symbiosis is proving an efficient and reliable means of disinfecting the intestine. D.

Medical News in Brief.

The London Hospitals' Saturday Fund.

The annual meeting of this Fund was held on Saturday last at the Mansion House, the Lord Mayor of London presiding over a crowded attendance, which included the medical officers of several of the London boroughs. The report of the council showed that the income of the fund in 1906 was £26,460, as against £25,930 in 1905, an increase of £530. The board of delegates had sanctioned the distribution of the sum of £23,898 among 205 institutions as follows:—General and special hospitals, £16,241; convalescent homes, £1,469; dispensaries, £911; Distribution Committee, £2,550; Surgical Appliance Committee, £1 500; Ambulance Committee, £111; miscellaneous institutions, £1,116. This was the largest sum ever distributed in one year, and exceeded that distributed in the previous year by £267.

The Lord Mayor having briefly alluded to the work of the fund, the adoption of the report was moved by the Right Hon. Sir Savile Crossley, Bart., president of the fund, and seconded by Archdeacon Sinclair, and carried, after which the Lady Mayoress presented a number of medallions and diplomas of merit awarded for efficient first-aid work during the year, and Dr. Wynter Blyth read an interesting address on "Sanitation."

The Medical Attendants to the Royal Irish Constabulary.

In the House of Commons on Wednesday last, Mr. Sloan asked the Chief Secretary for Ireland whether he was aware that the staff of medical attendants in Belfast was reduced from five to four, while the strength of the Belfast constabulary had substantially increased; would he state how many of the four medical attendants resided within their districts; whether he was aware that in Cork city the police medical attendant for the northern portion of the city lived on the south side, and the medical attendant for the south side lived on the north side; would he say if the surgeon to the force exercised any supervision over the medical attendants to the Royal Irish Constabulary all over Ireland; and, seeing that the police themselves paid these attendants a gross sum of about £10,000 a year out of their salaries, whether he would arrange that they should have some voice in their selection.—Mr. Birrell replied: In 1904 the number of medical attendants upon the police in Belfast was reduced from five to four upon a redistribution of stations in the city. Formerly there were but two medical attendants in Belfast. Three out of the four reside within their districts. In the remaining case this is not possible. The fact as to the places of residence of the medical attendants for Cork is as stated in the question. The surgeon to the force who is attached to the depot does not exercise supervision over the medical attendants throughout the country. The cost of medical attendance on the constabulary is not provided by the men but is borne on the votes. In the circumstances there do not appear to be any grounds for giving the men a voice in the selection of their medical attendants.

Society for the Relief of Widows and Orphans of Medical Men.

At a Quarterly Court of the above Society on Wednesday, April 10, Sir Thos. Smith, Bart., vice-president, in the chair, proposals for membership of the Society were read from three candidates, and they were duly elected. Since the last Court two members have died. Applications for relief were received from two widows of deceased members, and grants at the rate of £50 per annum each voted. One widow, who was left in very indigent circumstances, received an immediate grant of £10 10s. over and above the annual one. Eight letters had been received from the widows of medical men, during the past three months, asking for relief, but this had in each instance to be refused as their husbands had not been members of the Society. Any registered medical practitioner, residing at the time of his election, within a 20-mile radius of Charing Cross, is eligible for membership, full particulars and proposal forms may be obtained from the Secretary, at the offices of the Society, 11, Chandos Street, Cavendish Square. The date of the Annual General Meeting was fixed for Thursday, May 9th.

Philip Walker Studentship in Pathology.

The Professor of Pathology, Oxford University, announces that an election to this Studentship will take place in October next. The Studentship was founded "for the furtherance of original research in Pathology." It is of the annual value of £200 (payable quarterly in advance), and is tenable for three years. The Student may be of either sex and need not necessarily be a Member of the University of Oxford, nor be legally qualified to practise the profession of medicine. While holding office the time of the Student must be devoted to original Pathological research, and if the work done be of exceptional promise, the Studentship may be extended for a second period not exceeding two years. Intending candidates are requested to send letters of application, along with three testimonials (one of which should vouch for the candidate's personal character and general education), so that these shall be delivered to "The Registrar of the University, Oxford," on or before September 14th. The full text of the regulations relating to the Studentship will be found in the *Oxford University Gazette* for February 2nd, 1904, and copies of these Regulations can be had on application to the Registrar.

PASS LISTS.

University of Aberdeen.

The degree of Doctor of Medicine (M.D.) has been conferred on the following:—Alex. Callam, M.B., Ch.B., Burnley, Lancs. Thesis—"A Clinical Investigation of the Relative Efficacy of the so-called 'Organic' Iron Compounds in the treatment of Anæmia" (with commendation); John Conry, M.B., C.M., Fort Beaufort, Cape Colony (thesis for M.B. under old regulations); Arthur W. Falconer, M.B., Ch.B., Stonehaven. Thesis—"The Etiology and Symptoms of Gastric Ulcer" (with honours); Alex. Thomson, M.B., C.M., Fochabers. Thesis—"Rickets." (Under old regulations.)

Degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.).—With Second Class Honours.—*Norman Stephen Gilchrist, M.A., Newseat, Rothienorman; *Robert Williamson Asher Salmond, 469, Union Street, Aberdeen; Williamina Abel, David Anderson, M.A., William Angus, James William Barnett, Agnes Valentine Baxter, M.A., B.Sc., John Stott Beedie, B.Sc., James Alex. Clark, Andrew Coleman, James Alex. Davidson, James Donaldson, Robert Philip, Herbert W. Glashan, Leighton Hill Hay, James Hunter, Adam Hutton, Harry Middleton, George Mitchell, James E. Mitchell, John P. Mitchell, John Hay Moir, Alfred James Pirie, James Robertson, M.A., Alex. Hugh Skinner, M.A., John Paton Stuart, Frank Pearce Sturm, James E. G. Thomson, James I. P. Wilson. *Passed Final Professional Examination "With Distinction."

Diploma in Public Health.—Alexander Grant Anderson, M.A., B.Sc. (Aberd.), M.B., Ch.B. (Edin.), Aberdeen; Frederick Arthur Foy, M.B., C.M. (Aberd.), India; John Jenkins, M.A., M.B., Ch.B. (Aberd.), Burghead; Arthur Kellas, M.B., Ch.B. (Aberd.), Aberdeen; Forbes Jackson Stuart, M.B., Ch.B. (Aberd.), Aberdeen.

Royal College of Physicians of Ireland.

At a stated meeting of the President and Fellows of the Royal College of Physicians of Ireland, held on Friday, April 5th, Dr. William Roche, L. and L.M., K.Q.C.P.I., 1867, was admitted to the Membership of the College.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

MILK AND TUBERCULOSIS—A CORRECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I shall be much obliged if you will be good enough to correct a misprint in my letter of the 12th inst. Thus, for "real nutrition" substitute "mal-nutrition."—I am, Sir, yours truly,

GEO. GRANVILLE BANTOCK.

14 Upper Hamilton Terrace, N.W.
April 19, 1907.

BUTH.—Adhesion of a persistent pupillary membrane to the cornea is, of course, very rare, but you will find it described as having occurred in the eye of a cat in the Report of the Ophthalmological Society published in Dec. 26th number of THE MEDICAL PRESS AND CIRCULAR last year.

LEX.—Yes, it is a way Lord Chancellors have, but we hope better things of Lord Loreburn. As to dates, a deputation of the London County Council, asking for amendments of the law of Death Certification and of the Coroners' Act, waited on Lord Herschell in February, 1895, the speakers being Sir E. Harris and Dr. Job Collins. Another deputation of the Council waited on Lord Halsbury in November, 1896, but that gentleman is known to have regarded this as such a good world that it needs little amending, and he not only did not take the opportunity presented by nine years of office, but he took very little notice of other representations made directly to him by the medical practitioners of London.

CLIMATO-THERAPY AT BUXTON.

THE following extract from the annual report of the Devonshire Hospital, Buxton, suggests some new principles in climato-therapy :—

The air of Buxton, resting on the large area of the mountain limestone and millstone grit formations, at an elevation of 1,000 feet and upwards above the sea level, must be an important factor in enhancing the health advantages of the situation of the hospital; and the sanitary position that has been secured by the efficient drainage and sewerage of Buxton, and its conveyance to a distance from the town; and complete chemical defœcation, and the destruction of all remaining refuse in a powerful furnace, must have completed the sanitary advantages, and lessened beyond calculation the risks of zymotic or epidemic disease.

DR. DAVID T.—The address of the Medical Defence Union is 4 Trafalgar Square, London, and that of the London and Counties Medical Protection Society is 31 Craven Street, Strand. The former is the older institution but either would probably answer your requirements.

MANCHESTER.—Your patient will be able to obtain any kind of bath you find it desirable to prescribe either at Matlock or Matlock Bath. The two places are about a couple of miles apart, and the system of baths, both at Smedley's Hydro, Matlock, and the Royal Hotel at Matlock Bath, is perfect. Each is under medical supervision, the former would, perhaps, be more congenial to a younger patient requiring amusement, the latter one being more suitable for one requiring absolute rest amid charming surroundings.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 24th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8 p.m.: Annual Meeting. 8.30 p.m.: Adjourned Discussion on Epilepsy (opened by Dr. R. Russell). The following gentlemen will speak: Dr. W. S. Colman (Epilepsy in Children), Dr. A. Turner (Treatment of Epilepsy), Dr. H. Campbell (Diet in Epilepsy), Dr. C. H. Bond (Epileptic Colonies).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. P. J. Freyer: Clinique. (Surgical). 5.15 p.m.:—Lecture:—Dr. J. J. Perkins: Cyto-diagnosis (with lantern slides).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, APRIL 25th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. E. Clarke: The Fundus Oculi in Health and Disease (with lantern slides).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Fevers (Dr. F. Thomson at the North-Eastern Fever Hospital, St. Ann's Road, N.), Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

FRIDAY, APRIL 26th.

BRITISH ELECTROTHERAPEUTIC SOCIETY (11 Chandos Street, Cavendish Square, W.).—8 p.m.: Council. 8.30 p.m.: Stereoscopes will be shown by Mr. C. A. Clark and Mr. A. D. Reid and a Simple Negative Viewer will be shown by Dr. G. B. Batten. Communication:—Dr. G. B. Batten: Simple Method of Epilating the Whole Scalp by Exposure to X Rays. Discussion on Dr. S. Sloan's Paper read at the meeting in February.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: Clinical Evening for the Exhibition of Cases followed by Discussion. Patients in attendance from 8 to 9 p.m.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. D. Grant: Clinique. (Ear.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

Inverness District Asylum.—Junior Assistant Medical Officer. Salary £100 per annum, with board, lodging, and laundry. Applications to the Medical Superintendent, District Asylum, Inverness.

Cameron Hospital, West Hartlepool.—House Surgeon. Salary £100 per annum, with board, rooms, and washing. Applications to J. G. Taylor, Secretary.

Weston-super-Mare Hospital.—House Surgeon. Salary £100 per annum, with board and residence in the Hospital. Applications to the Honorary Secretary.

Bradford Royal Infirmary.—House Surgeon. Salary £100 per annum, with board and residence. Applications to John Barron, Secretary.

County Borough of Warrington.—Medical Officer of Health. Salary £450 per annum. Applications to J. Lyon Whittle, Town Clerk, Town Hall, Warrington.

West Riding Asylum, Menston, near Leeds.—Fourth Assistant Medical Officer. Salary £150 per annum, with board and apartments. Applications to the Medical Superintendent.

Bradford Royal Infirmary.—House Physician. Salary £100 per annum, with board and residence. Applications to John J. Barron, Secretary.

County Borough of Derby.—Assistant to the Medical Officer of Health. Salary £120 per annum, with board and lodging. Applications to the Medical Officer of Health, Ford Street, Derby.

Edinburgh Provincial Committee for the Training of Teachers.—Lecturer on School Hygiene and Medical Officer. Salary £400 per annum. Applications to the Director of Studies, Training College Buildings, 16 Chamber Street, Edinburgh.

West Riding Asylum, Wakefield.—Pathologist and Assistant Medical Officer. Salary £140 per annum, with board, furnished apartments, washing, and attendance. Applications to the Medical Director.

Appointments.

DOBIE, CYRIL, M.B., M.S.Edin., Honorary Assistant Surgeon to the Chester Infirmary.

GOMES, SIDNEY, F.R.C.S.Edin., L.R.C.P.Edin., L.F.P.S.Glasg., Clinical Assistant to the Chelsea Hospital for Women.

HAMILTON, A. DOUGLAS, Honorary Assistant Physician to the Chester Infirmary.

KELLY, CHARLES ERNEST MACKENZIE, M.D., M.S.Lond., F.R.C.S.Eng., Medical Officer and Public Vaccinator to the Witney District and Workhouse.

MARTIN, ANTONY ALEXANDER, M.D.Lond., B.S., M.R.C.S., L.R.C.P.Lond., D.P.H.Lond., Honorary Assistant Medical Officer to the Princess Alice Memorial Hospital, Eastbourne.

MAYOU, M. STEPHEN, F.R.C.S.Eng., Assistant Surgeon to the Central London Ophthalmic Hospital.

ROBERTS, GEORGE A., F.R.C.S.Eng., Assistant Surgeon to the Royal Albert Hospital, Devonport.

ROMER, R. L., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Stanmore District of the county of Middlesex.

Births.

ANDERSON.—On April 18th, at Sanfield, Braunton, North Devon, the wife of Frederick T. Anderson, M.D., of a son.

BROWN.—On April 15th, at 2 Park Road, West Kirby, Cheshire, the wife of Wm. McIntyre Brown, M.B., Ch.B., of a daughter.

HUGHES.—On April 18th, at South Terrace, Littlehampton, the wife of Edgar A. Hughes, F.R.C.S., of a daughter.

TINDALL.—On Sunday, April 21st, at 5 Tenby Mansions, Nottingham Street, London, W., the wife of A. A. Tindall, junr., of a daughter.

Marriages.

BURROUGHS—TWYCROSS.—On April 10th, at the Parish Church, Brighton, Hastings Burroughs, M.R.C.S., 3 Elgin Park, Redland, Bristol, eldest son of the late Rev. W. G. Burroughs, Rector of Kilbeacon, Waterford, to Honora Mabella, only daughter of the late George Twycross, Esq., and of Mrs. Twycross, 23 Marine Square, Brighton.

PECK—BUTLER.—On April 20th, at St. Luke's, Camberwell, Grover Scarr, second son of the late Thomas Peck, Esq., M.D., of Alford to Mary Crawford, daughter of Capt. Butler, of 37 Victoria Road, Upper Norwood.

Deaths.

BENNETT.—On April 16th, at the Hollies, Clarence Road, Tunbridge Wells, Thomas Jarvis Bennett, M.D., formerly of Wilton, near Salisbury, aged 77.

HOWLETT.—On April 18th, at 191 Sutherland Avenue, London, Eleanor Maria Howlett, widow of the late Henry Howlett, F.R.C.S., in her 86th year.

RANSOM.—On April 16th, at 17 Park Valley, Nottingham, William Henry Ransom, M.D., F.R.C.P., F.R.S., aged 83.

RUDGE.—On April 15th, at Chur, Switzerland, Edwd. John Henry Rudge, M.R.C.S., L.R.C.P., aged 34.

SPOKES.—On April 20th, at Brighton, Agnes, the beloved wife of Peter Sidney Spokes, J.P., M.R.C.S., L.D.S., of 4 Portland Place, London, in her 43rd year.

WOODWARD.—On April 18th, at Pershore, Worcestershire, Ada Bridget, the third daughter of Martin Woodward, M.R.C.S., and Mrs. Martin Woodward, aged 41.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, MAY 1, 1907. No. 18

NOTES AND COMMENTS.

Shaving without Razors. LAST week quite a flutter was caused by the announcement that in future razors would be superfluous, and that a smooth chin could be obtained in the morning by means of a mysterious powder which would soften the beard, and a paper-knife which would sweep it away with a few brief strokes. Fanciful pictures were drawn of the added comfort which would accrue to the matutinal toilet, and the extra time that might legitimately be devoted to snoozing after the hot water was brought to the bedroom. Some enterprising person, it seems, had "discovered" the powder that was to add so much to the masculine comfort, and his name was to go down to posterity as one of the world's benefactors. The razor manufacturers were warned that their last hour had come. It will be interesting to see how long this magic powder will last in the public estimation. Without analysing it, the conjecture may be hazarded without much fear of error that one of the well-known depilatories enters into composition of the powder, and that its destructive action on the hair is exercised through such instrumentality. If this be so, it may not be long before people will begin to suffer from dermatitis after using the powder, and its use will soon be abandoned in favour of the more tedious method of shaving at present in vogue. In the meantime, the journalists are delighting themselves with the idea that some novel and miraculous find has been made, and doubtless it is wondered how medical men have allowed themselves to be beaten in therapeutic research by some unknown experimenter.

Telephone Sickness. THE advent of every new factor into industrial life brings with it a new train of diseases and disabilities, and though the telephone has been in use now for some years, it has lately increased in popularity so much that it is being worked under conditions of considerable pressure to the operatives. The Post Office having now a system of their own which they started without much practical experience, are beginning to find that the girls employed at the exchanges are liable to a great deal of sickness. This would appear especially to be the case in hot weather, when the constant strain tells on them severely. At the late Conference of Postal and Telegraph Clerks, some ominous facts were brought forward by Miss Mabel Hope, of London, and on them she asked the Conference to pass a resolution demanding an investigation. One of the speakers said that the cases of physical and mental breakdown amounted last summer to the extravagant height of 25 per cent. of the whole staff, and the resolution was passed by the meeting. If the state of affairs pictured be anything like that actually existing, the administration of the telephone system in London must be almost inhuman, and the Postmaster General should address himself vigorously to discovering how the strain on the operators may be reduced.

"Specialists and Immorality." THE Westminster City Council instituted a prosecution last week against a woman who was described as specialist in the cure of corpulency, and also as a *corsetiere*. It was alleged against her that she conducted rooms on the first floor of a building in Oxford Street for improper purposes, and she was aided by two assistants, described respectively as a "dressmaker" and a "cook." The house had been watched by the police, and the character of the visitors noted, and when the evidence was considered sufficient, the prisoners were arrested. We are very glad to see this sign of vigilance and activity with regard to quack "specialists," for it is notorious that the irregular practitioners whom society delights to countenance are in some cases not only swindlers, but criminals of a particularly odious type. Ever since the "massage-establishments" were closed after a long and flourishing career, the evil has cropped up in one form and another. Manicurists and some types of quack "specialists" are not always what they profess to be, and apart from out-of-pocket losses, the innocent patrons of some of these establishments run risks which they would be well-advised to avoid. Quackery, sexual immorality, and abortion-mongering run into each other remarkably easy, and ladies should be careful as to what places they go to for the trimming of their nails and the rouging of their faces.

The Value of a Name. CONSIDERING that the only protection a medical man has against illegitimate imitation is the fact that it is an offence for any unqualified person to describe himself by a title implying that he is on the medical register, it is surprising that many men who take up a special branch of practice prefer to be known by names which confer no such protection, or as to which the protection is doubtful. Ophthalmic surgeons always and properly object to being known as "oculists," which is the designation of the optician, and should not be applied to a medical man. But in other branches of practice the danger of the opposite course is probably not recognised, for some physicians for diseases of women do not object to the more convenient but unprotected title of gynæcologist; physicians for diseases of the skin, to being known as dermatologists, surgeons for diseases of the throat, as laryngologists, and so on. The quack will be alert enough to find out when the public know these terms sufficiently well to expect a qualified man when a gynæcologist, or dermatologist, or laryngologist is mentioned, and then the confusion will be as great as it now is between ophthalmic surgeons and oculists. It is all the more remarkable that this tendency should exist when the veterinary surgeon recognises the value of his designation so well and keeps to it closely, knowing that to be called a "canine specialist" would place him at once on the level of the cat stealer and dog-fancier.

Curative Human Radiations.

The sixth anniversary social evening of the Psycho-Therapeutic Society was held last week at the Bloomsbury Hall, New Oxford Street, and the members congratulated themselves on the progress their organisation has made. Some facts about this curious society are worth noting. The "operators" of the society are without medical qualification except, it is stated, in one instance, but they all possess the "magnetic faculty which no medical training can give." Their object is to "study, investigate, and practise medical hypnotism, suggestive therapeutics, curative human radiations, and drugless healing." No fee is charged except one of five shillings for "clairvoyant diagnosis," but grateful patients frequently give money to the general funds. It is certainly a wise precaution to charge for the clairvoyant diagnosis as so unsubstantial an entity might well be disputed, and when once the five shillings is safe it would be pretty easy to see who was good for further contributions. The list of diseases that have been successfully treated, is almost synonymous with the College of Physicians' nomenclature.

ALCOHOL—A MEDICAL COUNTER-MANIFESTO.

A manifesto with regard to the use of alcohol has lately appeared in a leading medical journal, and has received wide circulation. By reason of the high position in the scientific world held by its signatories, great importance has been attached to the views it expresses. As it appears to us that, both by reason of the wording of the manifesto and of the use to which it has been put, certain misconceptions may arise, we wish to say that we gravely dissent from much of its teaching, nor can we accept it as an authoritative statement of recognised medical opinion on the matter. Without asserting that alcohol has no value in the treatment of disease, we believe that its use is occasional rather than regular, and limited rather than wide. We regard the word "life-preserving" in connection with alcohol as misleading, and we consider the statement that alcohol has "the power to sustain cardiac and nervous energy" rests on no certain clinical or experimental evidence. On the other hand we strongly believe that alcohol is unnecessary as an article of consumption in the case of healthy men and women, and that its general use could be discontinued without detriment to the world's welfare.

Further, believing as we do that alcohol is one of the most fruitful causes of poverty, disease, and crime, we are pleased to add that it is now sparingly employed as a remedy by the majority of medical men.

Signed :—

Frederick Treves.
James Barr.
William Ewart.
Theo. B. Hyslop.
William Murrell.
T. N. Kelynack.
William Carter.
Thomas H. Bickerton.
F. Charles Larking.
Sims Woodhead.
J. Ward Cousins.
David Walsh, Editor,
(*Medical Press and Circular*).

LEADING ARTICLE.

THE ALCOHOL MANIFESTO.

The recent manifesto on the value of alcohol in diet and in medicine published in the *Lancet* maintains its interest in the public press. The immense mass of correspondence that has flooded the correspondence columns of the lay newspapers emphasises the widespread importance attached to the question thus raised. As might be anticipated in a contentious matter of this kind some writers have not hesitated to impute motives of a somewhat unworthy nature to the issue of a weighty declaration of this kind. That view may be at once dismissed, so far as concerns the gentlemen whose names are appended to the document. Their position is such that it would be impossible to doubt for a single moment the absolute purity and honesty of their motives, as well as those of the medical journal that published the manifesto. At the same time we cannot help feeling some amount of regret that they should have been led to make a formal public statement at this precise juncture, when the chances of drastic temperance legislation are being eagerly discussed. But we cannot so readily absolve the originator of the document until we have an authoritative statement as to his precise position in regard to temperance legislation, to the vested interest in alcohol, and to the medical profession. We are led to this observation because of imputations that have come freely from various quarters. To put the gist of the matter in a few brief words: "Who and what was the author of the declaration? Why did he draw up and issue such a document? Why and under what circumstances did he obtain the eighteen medical signatures?" As the opinions expressed in the manifesto have gone out to the world as an expression of accepted scientific medical opinion, we think that in common fairness the public no less than the medical profession are entitled to a clear and immediate statement upon all the issues involved in the answers to the foregoing questions. In any case it is somewhat difficult to recognise the overwhelming sense of duty that must have influenced the signatories in undertaking so grave a public responsibility, especially when we reflect that their scientific weight is, after all said and done, merely a question of personal guarantee, apart from argument deduced from experimental, statistical and other evidence. As the manifesto has been issued, however, and has attained wide publicity, we have thought it well to obtain an equally authoritative declaration of the scientific medical opinion which declares that alcohol is not a necessity for healthy persons, and has only a strictly limited use in medicine. Dr. Dawson Burns, a well-known authority on temperance matters, has aptly recalled the fact that on at least two previous occasions declarations adverse to the use of alcohol have been issued by medical men. The first of these was issued by a medical man, Mr. Julius Jeffreys, in 1839, and was signed by seventy-eight distinguished members of his profession. It ran:

"An opinion handed down from rude and ignorant times, and imbibed by Englishmen from their youth, has become very general, that the habitual use of some portion of alcoholic drink is beneficial to health, and even necessary to those subjected to habitual labour. Anatomy, physiology, and the experience of all ages and countries when properly examined must satisfy every mind well-informed in medical science that the above opinion is altogether erroneous."

In the year 1847, the following manifesto was drawn up by three medical men, and signed by nearly 2,000 medical practitioners in the United Kingdom:—

"We, the undersigned, are of opinion:—(1) That a very large portion of human misery, including poverty, disease, and crime, is induced by the use of alcoholic or fermented liquors as beverages. (2) That the most perfect health is compatible with total abstinence, from all intoxicating beverages whatever, in the form of ardent spirits, or as wine, beer, ale, porter, cider, &c., &c. (3) That persons accustomed to such drinks may, with perfect safety, discontinue them entirely, either at once, or gradually after a short time. (4) That total and universal abstinence from alcoholic liquors and beverages of all sorts would greatly contribute to the health, the prosperity, the morality, and the happiness of the human race."

Since the two foregoing declarations, a great deal of scientific knowledge has accumulated around the subject. It is to be regretted, therefore, that sixty years after the latter declaration eighteen leading medical men should have been induced to sign another declaration expressing views that are open to grave question alike by the medical profession and by the laity. As things stand at present we agree with the suggestion of some of our readers that it would be well to inform the world that the opinion of many, if not the majority, of the medical profession, is adverse to the habitual use of alcohol either as a medicine or as an article of diet.

CURRENT TOPICS.

Commission on Inebriety.

ONE of the few sensible articles on inebriety and its treatment, we might almost say the only sensible one by a non-medical man we have ever read, was contributed last week to the *Daily Chronicle* by Canon J. W. Horsley. The writer takes a clear and statesmanlike view of the question of the methods of reforming the drunkard, and while not eschewing drug-treatment, he exposes the fallacy of expecting a few weeks' dosage with this, that, or the other medicine to abrogate a moral and physical warp in the constitution. The habitual inebriate, as he shows, is not only a person who suffers from a double dose of original sin, but one whose tissues, especially those of the brain, have degenerated through years of abuse of alcohol, and therefore to restore that person to society in a condition to lead a decently useful life it is necessary not only that his immediate craving should be removed, but that a moral and physical reformation should be brought about as well. To accomplish this result steady pressure of a more than medical kind is necessary, and the inebriate, like the curable mental patient, should be detainable in an institution under healthful influences till the signs of restoration to a condition of responsibility are unmistakable. Canon Horsley dwells on the inefficiency of our present methods, and makes the valuable suggestion that the Government should appoint a Departmental Committee to inquire into the subject. It is a great pity that inebriety was not one of the matters referred to the Royal Commission on the Feeble-Minded, a body eminently fitted to deal with it, but as it was not included in their terms of reference, and as the present reformatory system is egregiously ineffective, it would be a highly beneficial move on the part of the Government if they instituted a separate inquiry. Considering the important questions of restraint and certification involved, the most authoritative form of investigation, namely, a Royal Commission, should be employed.

The "Dairy World" and the Milk Trade.

Our contemporary the *Dairy World* in a leading article last week, rejoices that the new London County Council have dropped the bulk of the milk clauses in their General Powers Bill now before Parliament. Of the advisability of that step we will only say that if these clauses were, as is stated, omitted merely to save the rest of the Bill, the necessity is a highly regrettable one. Happily there is an awakening with regard to milk dangers all over the country at the present moment, and some eighty authorities are seeking extended powers of control of their milk supplies, and we agree with the *Dairy World* that this activity makes out a strong case for national and uniform treatment of the whole subject. The present would be a highly opportune moment for the introduction by the Government of a Pure Milk Bill, but of that we see no sign; it would be a fatal error, therefore, for any local authority to stay its hand in the hope that such an eventuality is likely to occur. But we rub our eyes to see if we are awake when we read in the article referred to such phrases as "we do not recognise the pressing need for further legislation which other people see"; "the present conditions of supply are extremely satisfactory"; and "the metropolis is being supplied with a clean, wholesome article." We have heard it said that it is not possible to avoid gross contamination of milk, but we never heard it said that metropolitan milk was clean. Would the editor of the *Dairy World* allow us to put into his glass a tablespoonful or two of the deposit which can be obtained by centrifugalization of the milk supplied to London? Our idea of a clean fluid is not one containing dung, hair, and detritus, but perhaps surgical and bacteriological training give one exalted ideas of cleanliness.

Cerebro-Spinal Fever in the United Kingdom.

The epidemic of cerebro-spinal fever in various parts of the United Kingdom shows little signs of abating. In Dublin, it is true, the disease has for the time being disappeared, although a few cases still linger in the neighbourhood. In Belfast, on the other hand, the disease is in an active condition: during the week ending April 18th thirty cases of cerebro-spinal meningitis were reported, with twenty deaths from the disease within the same period. The number of cases notified since the commencement of the outbreak has reached the large total of 313, with the high proportion of 200 deaths. Scattered cases continue to be reported from various parts of Scotland. One of the more serious features of the outbreak in that country is the fact that the malady is spreading somewhat widely to the smaller burghs and county districts. One of the assistant medical officers of Glasgow has unfortunately contracted the disease, but is reported to be progressing favourably. During the month 35 cases have been reported in Edinburgh with 24 deaths. In England the epidemic does not appear to be spreading rapidly, but on the other hand it is not losing ground, and the history of previous invasions renders the outlook far from encouraging. Nothwithstanding the abundant opportunity for scientific investigation that has of late been forthcoming little advance has been made in the discovery of practical means of prevention of this disastrous infection.

The Supply of Bodies for Anatomical Teaching.

We are glad to see that the North Dublin Guardians will shortly have an opportunity of re-considering their decision regarding the supply of bodies to the medical schools of Dublin. At their meeting last week, the Guardians had before them two important documents bearing on the matter. One of these was a letter to the Local Government Board from Dr. McWalter, a medical practitioner, himself a Guardian, in which he pointed out the danger likely to be done to patients in a weak state of health by a direct question as to their wishes regarding the disposal of their bodies. The other was a letter from Professor Fraser, on behalf of the Anatomical Committee of the Dublin Medical Schools, drawing the attention of the Guardians to the irreparable injury their recent decision was likely to inflict on medical education in Dublin. The letter was worded in the most moderate terms, and permission was asked to send a deputation to discuss the question with the Board. In the event, notices of motion were handed in with the view of rescinding the resolution of the 17th ult. We trust that the Guardians will adopt a reasonable view of the state of affairs when the matter comes up for decision next week.

Fatal Anæsthesia.

Two deaths under anæsthetics last week in London are worthy of notice. In one case a child died at Guy's Hospital while undergoing an operation, the anæsthetic used being ethyl chloride. The case is of medical interest on account of the rarity of such an occurrence with that particular drug, and also from the age of the patient. In the second case a young baronet died under the influence of a mixture of chloroform and ether. The pathologist of St. Mary's Hospital testified at the subsequent inquest that there was enlargement of the spleen, tonsils, and lymphatic glands generally. This condition had been lately recognised by pathologists as the "status lymphaticus," and its presence indicates a tendency to sudden death. For some time past a similar association has been noted in the case of persistent thymus gland. Obviously, could the actual connection between lymphatic disease and death under anæsthetics be established it might be possible to reduce the number of fatalities from that cause. In any case it may safely be concluded that medical men will be consulted by the "intelligent patient" about to undergo surgical operation as to the presence or otherwise of the "status lymphaticus."

Phosphorous Poisoning.

The attention of the House of Lords was last week called by Lord Lytton to a recent death from necrosis of the jaw due to phosphorus poisoning in a match factory. He laid it down as a definite proposition that every kind of match the public would require might be made without the use of any dangerous form of phosphorus. His reasonable demand was that the United Kingdom should join the Convention of Berne forbidding the use of yellow phosphorus. Six European States,—namely, France, Germany, Italy, Holland, Denmark and Switzerland,—signed the undertaking in question last September. In his reply Lord Beauchamp stated that there had been only five cases of necrosis during five years, and of these cases two were fatal. The Government were of opinion that the special rules had been successful, and in adhering to them they were following the example of six other States represented at the Berne Convention, and also of Norway and Japan. A statement of that kind seems hardly worthy of a country claiming to have at heart the interests of the industrial classes. Five cases in five years of a wholly preventable trade malady like phosphorus necrosis are precisely five cases too many. If it be true, as stated by Lord Lytton, that our Government said they would join the Berne Convention only on the condition that every other country which imported matches should do the same, the assumption of such a position seems hardly compatible with the sturdiness of the national character. In the adoption of Free Trade, for instance, an incomparably larger experiment, the United Kingdom was strong enough to act independently of the whole army of trade interests concerned. Why fight shy of matches?

Proprietary Medicines in America.

There is no doubt that the general practitioner is often at a loss to know what proprietary medicines he may find of legitimate use in his practice. He has neither the time nor the ability to test the value of all the nostrums brought to his notice, and he would be ill repaid it he did so. Bearing such facts in mind, the American Medical Association a year or two ago determined to attempt a differentiation of proprietary drugs of real and legitimate value from those which a self-respecting practitioner had better avoid. The task has been to a certain extent completed and the Association has issued a list of drugs of the former class. No preparation has been admitted without its full formula having been furnished for publication, and no preparation—other than foods and disinfectants—has been admitted which is advertised to the public. Various other conditions have been imposed, and the result is a catalogue which can hardly fail to be of general utility. In its task the Association has naturally been met by violent opposition, not only from the vendors of secret preparations, but from many of the viler medical papers which are at the orders of those who advertise in their columns. It is to be congratulated in bringing its work to a successful issue in spite of this opposition.

The London and Counties Medical Protection Society.

The annual report of the London and Counties Medical Protection Society for the year 1906 points to continued prosperity and usefulness. The work achieved during the twelve months has been manifold and arduous, including as it does a great amount of litigation. The unsatisfactory nature of British law administration is conspicuously shown in an instance referred to by the Chairman, Dr. Heron. It was that of a case in which the Society successfully resisted the claim of a defeated opponent to appeal, yet, notwithstanding the decision in their favour, the action cost the Society out-of-pocket expenses to the extent of £500. One of the best features of this Society is the reserve and guarantee fund, which from all sources amounts to the very respectable sum of £9,000. Another important point emphasised by the Chairman, Dr. Heron, was the desirability of an arbitration clause being inserted into all partnership agreements between medical men.

PERSONAL.

The English medical man in attendance upon the Queen of Spain during her forthcoming confinement is Dr. Glendening.

A new Russo-German Medical Society has been constituted in Berlin under the presidency of Professors Von Leyden and Hildebrand, of that town, and Professor Bechterew, of St. Petersburg.

Mr. Richard Macartney, L.R.C.S.&P. Edinburgh, of Cinderford, was recently appointed Coroner for the Forest of Dean District at a meeting of the Gloucestershire County Council.

Dr. Barclay Smith is to be appointed to examine in human anatomy for medical degrees for the remainder of the year ending November 1, in the place of Dr. A. Macalister, who is unable to examine.

Dr. Archibald, Assistant Medical Officer of Health for Glasgow, who has himself fallen a victim to spotted fever, is progressing favourably.

The Royal Commission on Vivisection held their seventeenth meeting on April 22nd, Viscount Selby presiding. Sir T. Lauder Brunton gave evidence.

Sir William J. Collins, M.P., M.D., will take the chair at the New Reform Club on May 10th, when an address on "The Necessity for a Minister of Public Health" will be delivered by Mr. A. Rolland Rainy, M.P.

Dr. P. H. H. Pereira has been selected for the office of Assistant Port Health Officer, Medical Department, Singapore, and is to act for the present as Deputy Health Officer at Penang.

Dr. James Ritchie, who has held the appointment of professor and reader in pathology at Oxford for the last six years, has accepted the position of superintendent of pathological laboratories in connection with the Royal College of Physicians at Edinburgh University. Dr. E. W. A. Walker, Fellow of University College, has been appointed deputy until Mr. Ritchie's successor is appointed.

A CLINICAL LECTURE

ON

GLAUCOMA. (a)

By ARTHUR HY. BENSON, M.A., M.B.Dub., F.R.C.S.,

Surgeon to the Royal Victoria Eye and Ear Hospital, Dublin; Ophthalmic and Aural Surgeon to the Royal City of Dublin Hospital.

Gentlemen,—The subject which we have to consider to-day is one of the most important in our whole list. Glaucoma, the many-headed hydra of ophthalmology, presents itself in numerous forms, differing widely in almost every particular except one, viz., the increased tension of the eye. This, then, is the cord that binds together all the various conditions which are grouped under the one heading as glaucoma.

If we seek to frame a definition of glaucoma, it is not at all easy, and most writers are content to describe the condition without defining it. Priestley Smith has, however, defined it as "An excess of pressure within the eye, plus the causes and the consequences of that excess." High tension is only a symptom, but it is such an important symptom that one is in danger of regarding it as the disease itself; but the causes and the consequences of the high tension are necessary to the full definition of the disease.

It is impossible in one short lecture like this to do more than lightly touch upon a few out of the many important points which present themselves for consideration.

Classification of Glaucoma.

Glaucoma is commonly divided into two great divisions:—

I.—*Primary Glaucoma*, where no obvious cause for the condition is discernible. This is subdivided into (1) Acute, where the attack is sudden, intense, and painful, with vascularity and rapid loss of vision. (2) Sub-acute, where symtoms are much less severe and where pain is not constant. (3) Chronic, where there are no signs of inflammation, no pain, and the loss of vision is very gradual.

II.—*Secondary Glaucoma*, where the high tension is obviously the result of some previous pathological condition, such as an intra-ocular tumour, iritis (which was followed by adhesions between iris and lens, or iris and cornea), or swelling or dislocation of the lens, &c. It is primary glaucoma that we are to-day considering.

Ophthalmoscopic Appearances.

The hazy "ground glass" appearance of the cornea, the shallow anterior chamber, the dilated and sluggish pupil, the opalescent (or, at times, greenish) look of the pupil (which may easily mislead a careless observer to diagnose cataract), and, in acute glaucoma, the general vascularity, and, in old chronic glaucoma the large dilated varicose veins on the sclerotic, all these can be easily seen with the naked eye.

With the ophthalmoscope you can usually in chronic glaucoma observe an excavation of the disc, which, from the intra-ocular tension, is depressed below the surface of the surrounding retina, and is also paler in colour (at times having a dull greenish gloomy look that is very characteristic). Over the edge of the depressed or cupped disc the vessels of the retina seem to tumble with a suddenness that shows the steepness of the sides of the depression.

Three kinds of cupping of the disc are commonly recognised: (1) The physiological cup, which is V-shaped, and never occupies the whole surface of the disc; (2) the atrophic cup, which is shallow and more like a saucer than a cup; and (3) the glaucomatous cup, which always occupies the whole of the disc, is deep, and has steep sides over the edges of which the vessels disappear abruptly. In acute glaucoma the disc is often not cupped, as there has not been sufficient time for the change to take place.

Intra-ocular Secretion.

The globe of the eye is mostly filled with liquid or semi-liquid transparent fluids—the aqueous and the vitreous. In these the lens and the iris are suspended, and are more or less movable. These fluids allow the rays of light that enter the eye to pass through them to the retina, they preserve the globular shape of the eye, they keep the retina and chorioid pressed against each other and against the sclerotic (the strong fibrous capsule of the eye), and they regulate the pressure that is constantly exercised upon the blood-vessels within the globe.

The great secreting organ within the eye is the ciliary body, which may be regarded as a muscle and a gland combined. It (with some assistance from the iris) secretes the aqueous and the fluid of the vitreous, it nourishes the lens which (after fœtal life) is entirely without blood supply of its own, and by keeping up a flow of nutrient fluid, maintains the tension of the eye at an almost constant degree. If the ciliary body is irritated its secreting function may increase, and for the time it may pour more than the normal amount of fluid into the globe, and the tension will rise. If the irritation goes on to true inflammation, the secreting power of the ciliary body diminishes, the fluid it pours into the eye is scanty in amount and defective in quality, and you get a low tension with subsequent defects of nutrition evidenced by opacitus in the vitreous and lens, and often on the posterior surface of the cornea, with muddiness of the aqueous and all the conditions that terminate in phthisis bulbi.

The fluids secreted by the ciliary body, having flowed through and nourished the vitreous, escape from the eye in part by the lymph spaces about the optic nerve. Most of the fluid, however, percolates through the suspensory ligament of the lens, and, joining with the iritic secretion in the posterior aqueous chamber, passes through the pupil into the anterior chamber, and escapes from the eye at the angle of the anterior chamber, where the iris and the cornea meet. The very minute spaces of Fontana in that situation permit the passage of the aqueous from the eye into the canal of Schlemm (a circular sinus in the sclerotic), which is in direct connection with the veins of the general circulation.

(a) Delivered at the Royal Victoria Eye and Ear Hospital, Dublin.

If the ciliary body secretes the normal amount of fluid, and if the filtration spaces allow the normal amount to escape the tension of the eye remains a constant.

If the ciliary body secretes too much, or if the filtration spaces excrete too little, the tension rises just as the water in a river will rise if there is too much rain, making a flood, or if a dam is built across the river producing an obstruction to the normal outflow.

In the eye the commonest cause of high tension is not the "flood" but the "dam." It is not usually hyper-secretion, but defective excretion that causes the glaucomatous condition.

POSITION OF OBSTRUCTION.

There are three places within the eye where this damming back of the stream may take place—(1) The narrow space between the margin of the lens and the ciliary body, occupied by the suspensory ligament of the lens; this "peri-lenticular space" is considered by Priestley Smith to play a very important part in the production of primary glaucoma. (2) The pupil is the next tight place through which the fluid has to pass on its way to the canal of Schlemm. Here, under normal circumstances, the iris though touching, is not adherent to, the anterior capsule of the lens; it can be easily moved, and so allow the fluid to pass into the anterior chamber. If, however, there has been iritis, and the iris and lens are stuck together with lymph (synæchia posterior), then the iris cannot be separated from the lens capsule, and the fluid in the posterior aqueous chamber cannot pass into the anterior chamber, and again a high tension may occur. High tension so produced is called "secondary glaucoma," because it is due to some obvious cause, viz., the iritic adhesions. (3) The third and most important place where a dam may be formed is at the angle of the anterior chamber itself. The root of the iris may be pressed against the cornea, and thus the percolation spaces may be obliterated and the aqueous after successfully negotiating the peri-lenticular space and passing through the pupil, may find its passage barred by the iritic angle.

TREATMENT.

In a large majority of cases of primary glaucoma it is the angle of the anterior chamber that is at fault, and treatment has to be directed mainly in that direction.

In secondary glaucoma, the indications for treatment vary according to the cause. If iritic adhesions are the cause, an iridectomy will cure it; if a swollen traumatic cataract is the cause, the lens must be removed, and so on.

In primary glaucoma, blocking of the angle of the anterior chamber (the "iritic angle") is the direct cause of the high tension; and treatment must be adopted whose object is either to re-open the normal percolation spaces, or obtain abnormal filtration of the intra-ocular fluids through the coats of the eye.

Until a comparatively short time ago, no cure had been discovered for this disease, and every case of glaucoma was morally certain to go blind. Thanks to the genius of Von Græffe and others, the disease is now capable, under early and skilled treatment, of most satisfactory and successful cure.

Myotics, *i.e.*, drugs that contract the pupil, such as Eserin and Pilocarpin, when instilled into the eye (1 per cent. solution), help to put the iris on the stretch, so that there is less of it tending to fill up the angle of the anterior chamber. The aqueous is thus more easily able to escape through the spaces of Fontana into the canal of Schlemm. A myotic is, in some few cases, sufficient by itself to re-establish the balance between secretion and absorption, and the tension may become normal, at least, for a time.

In most cases, though myotics reduce the high tension, they do not cure the disease, and operation is required.

Iridectomy is the operation that suits a vast majority of cases of glaucoma, but in certain instances sclerotomy, either anterior or posterior, is preferable. My advice to you is in every case of increased tension that comes under your care, at once use eserin or pilocarpin, stop all use of the eyes, and if the tension does not very soon subside, either do an iridectomy yourself, or send the case up *without delay* to a specialist. It is fatal to keep watching a case of glaucoma from day to day and week to week, before making up your mind to have the case treated properly.

In *acute* glaucoma, not only every day, but every hour of delay means irreparable injury to the sight, and I cannot insist too strongly upon the necessity—the absolute necessity—of *immediate* treatment.

Acute glaucoma often comes on so suddenly, with violent neuralgia-like pains in head, and vomiting, that it is mistaken for acute biliousness, and precious time is lost in giving antibilious medicine, instead of at once attacking the *fons et origo mali*, the high intra-ocular tension.

In these cases of acute glaucoma, the conjunctiva becomes congested, the cornea becomes hazy, like ground glass, the pupil dilated, and the anterior chamber shallow. Such cases are often mistaken for iritis, and are treated with atropin—a fatal error, for atropin by still further dilating the pupil crowds up the angle of the anterior chamber and increases the difficulty of the outflow of fluids from the interior of the eye.

Never use atropin in any case without feeling the tension and assuring yourself that it is normal.

FIELD OF VISION.

The field of vision, (*i.e.*, all that one can see, in addition to the object looked at, without movement of the eye) is always much contracted in advanced glaucoma, and by careful testing of the field the earliest sign of the advancing disease may often be obtained; but to test the field accurately, and to detect slight changes, requires some skill and the use of a special instrument, called a Perimeter.

In an advanced case, it is easy to recognise the defect if you get the patient (seated about two feet away from you with one eye covered) to look at your eye. Then move a very small piece of white paper, attached to the end of a pen-handle, about half-way between your eye and your patient's eye. You will be able, while you look at his eye and he looks at yours, to see the piece of paper moving about.

If your patient is not able to see it as far out to the periphery as you are, it indicates (other things being equal) a defect in his field.

In this test, in order to compare his field and yours, you should only keep open the eye the patient is looking at. If you are testing his left eye, he should look at your right eye, and you should keep your left eye shut.

Prognosis.

The prognosis depends to a large extent upon the length of time the disease has lasted, and its severity. Acute glaucoma can almost always be cured by *prompt* treatment, but every hour is of vital importance.

Chronic glaucoma, also, can usually be cured, if taken in good time, but its onset is often so insidious that it is not detected by patient or medical attendant till it is fairly far advanced.

The sooner any case of glaucoma is placed under proper treatment the better the prognosis.

Warnings.

Never use atropin in elderly people without good reason, and watch the tension all the time they are using the drug.

In all cases of iritis, or irido-cyclitis, feel the tension before ordering atropin to be used, and also after using it.

In all cases of "bilious vomiting," feel the tension, for acute glaucoma often simulates a bilious attack.

In all cases of failing sight, with or without cataract, examine the tension carefully, for chronic glaucoma often simulates senile cataract and may easily be mistaken for it.

In all cases of increased tension immediate treatment is urgent, and should not be delayed.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by John Poland, F.R.C.S., Eng., Senior Surgeon to the City Orthopædic Hospital, London. Senior Surgeon to the Miller Hospital, Greenwich. Subject: "The Use and Abuse of Skiagraphy in Fractures and Dislocations," lecture delivered at the Medical Graduates College and Polyclinic.*

ORIGINAL PAPERS.

CEREBRO-SPINAL MENINGITIS; ITS RELATION TO OTHER FORMS OF MENINGITIS. (a)

By W. B. WARRINGTON, M.D., F.R.C.P.Lond.,

Physician to the David Lewis Northern Hospital, Examiner in Clinical Medicine and Lecturer in the University of Liverpool.

Robert Whytt, in 1786, is said to have been the first who accurately recognised the clinical picture of tuberculous meningitis, and Papovoine, in 1830, showed its real nature. In a recent leader in the *British Medical Journal* it is stated that the first recognition of an epidemic of meningitis was in Geneva in 1805. Since then the independence of these two diseases has been clearly recognised. But it is only since the rise of bacteriology that the ætiology and symptomology of the forms of meningitis have been precisely studied. All cases of acute meningitis are cerebro-spinal in their distribution, but the term "cerebro-spinal meningitis" is now accepted to mean that form of disease caused by a specific micro-organism, viz., the diplococcus intra-cellularis meningitidis, first described by Weischelbaum in 1887. Sporadic cases of meningitis caused by this organism are always present in any large city, and their clinical, anatomical, and ætiological features, as met with in children, were first clearly described by Lees, Barlow, and Still, whose classical article is in Clifford Allbutt's system. These writers gave the name of "Posterior Basic Meningitis" to the disease; but on the Continent and in America it is referred to as the sporadic form of cerebro-spinal meningitis. Of 38 cases of meningitis seen by me in the last five years, I find 17 were tuberculous, including two adults, nine pneumococcal, of which one was primary; in three there were pneumonia only, in two endo and pericarditis, and in one the primary source was the ear. Another occurred in a child with broncho-pneumonia, and another in an adult with aspiration pneumonia secondary to carcinoma of the æsophagus. Four were due to the streptococcus, in two the ear being the primary site; the other two due to injury. One case was staphylococcal, and in six cases the meningococcus was the cause of the disease. Two of these cases recovered, one of whom was an adult.

All evidence goes to show that when meningitis affects a large number of people at the same time, its cause is meningococcus. Many recent observations are given in the leader referred to in the *British Medical Journal* from epidemics in New York, Syracuse, Portugal, Lisbon, and Glasgow. The important points for consideration are: (1) Are the epidemic and sporadic forms identical; (2) the characteristics and life history of the organism; (3) the mode of contagion; (4) the recognition of the disease during life; and (5) its morbid anatomy.

With regard to the identity of the two diseases, I have said that Continental and American observers consider them to be the same. The organism, described by Still, in the Great Ormond Street cases, and that since found in other sporadic cases, agrees in all essential particulars with the meningo-coccus found in epidemics. My case of a man, æt. 25, would, had it occurred now, have certainly been notified as cerebro-spinal meningitis. Its fulminant onset, violent symptoms, the positive findings from the examination of the cerebro-spinal fluid, and its termination in recovery precluded any other causal agent for the meningitis.

A number of facts about the organism and its history are now known. It is a biscuit-shaped diplococcus, and whilst, in the early days of the illness, is often found to be intra-cellular, it is also found, especially at a later period, existing free in the cerebro-spinal fluid. It stains readily with ordinary dyes, but has the important characteristic of failing to stain by Gram's method. It is not an easy organism to cultivate, the best medium being nutrose acitic agar, called nasgar. It also grows well in a mixture of one part of acitic fluid and 10 of broth, and can be cultivated on blood agar. These media should, therefore, be used when a positive diagnosis is required from the examination of the cerebro-spinal fluid. It is important to note that the growth of the organism is arrested at temperatures above 42 deg. or below 25 deg. C. The organism is found in the pus of the meninges of the brain and cord, but not infrequently it is also found in the blood, causing a septicæmia. In one of the New York epidemics this was found to be the case in 25 per cent. of 130 cases, and in the remarkable case described by Andrews, a fatal case of purpura was found to be due to meningococcal septicæmia, although there was no evidence of meningitis. The organism does not live as a saphrophite outside the body, and in healthy persons in non-epidemic times observers have failed to find this organism in any of the secretions. In the naso-pharynx of those who come in contact with the sick the organism is not infrequently found, and attention must especially be directed to the upper part of the passages and posterior nares. Lingelsheim found the organism in 24 out of 346 healthy persons who were in contact with the sick, and Ostermann demonstrated its presence in no less than 17 out of 24 persons belonging to families, some of whose members were sick with the disease.

Mary Goodwin and Anna Shelley have recently shown that the organism may be found in 50 per cent. of the naso-pharynx in those suffering from meningitis, and in 10 per cent. of those who come in contact with the disease. Conjunctivitis is sometimes one of the complications, and Canby Robinson reports the presence of the organism in the pus from this source. It is, therefore, obvious that these secretions may become foci from which an epidemic may start. Dr. Blynn met with one epidemic in which all the children affected attended the same school. House epidemics have been recorded. Sanitary conditions are of great importance. In the United States ship Minneapolis, whose normal complement of 500 men was increased to 1,450, 26 were affected, and all from the main deck, which was especially overcrowded and lacking in ventilation. The soil on which the organism is engrafted is important. Cerebro-spinal meningitis and infantile palsy have much in common. They both are due to infective processes, both have their maximum incidence during certain months of the year, and when epidemic both may occur together, and both diseases can be met with in the same person.

(a) Read before the Liverpool Medical Institute, March 7th, 1907.

An unusual number of cases of Landry's paralysis have also been met with during epidemic times, and it is worth noting that the pathogenic organism obtained from this case by Farquhar Buzzard was a non-Gram staining tetracoccus. A similar example has also been obtained from another example of Landry's paralysis, and Risien Russell considered the organism he found in a case of meningo myelitis as similar to that isolated by Still in the posterior basic cases. The epidemic itself shows certain peculiarities. It prevails severely in widely separated areas, but it does not spread widely, it never becomes a pandemic. Its mortality ranks among epidemic diseases next to the plague. In the last two years in New York 3,000 out of 4,000 persons attacked, died.

With regard to the morbid anatomy the sporadic cases certainly present a picture on the autopsy table, differing sharply from those forms of meningitis due to the tubercle bacillus, the pneumonoccus, and other pyogenic organisms. The lesions of the tuberculous and other forms are well known. In the sporadic cases a striking feature is the collection of fluid, either clear or purulent, in the posterior arachnoid cistern—a sac formed by the two layers of the pia-arachnoid, and limited in its external boundary by the further attachment of this membrane to certain parts of the brain. The sac extends as far forwards as the inner and anterior margin of the temporo sphenoidal lobe, and from there passes over the optic chimasa, interpeduncular space, and anterior surface of the pons. Posteriorly the great basal space thus formed passes round the medulla, limited behind where the arachnoid becomes again attached to the pia on the under surface of the cerebellum. It is the accumulation of inflammatory products in this great cistern which has suggested the name of posterior basic meningitis. The inflammation is, however, not limited to these regions, extending to a slight extent on to the lateral surface of the hemispheres. The pneumococcal meningitis, on the other hand, is distinguished by the vertical distribution of thick, characteristic, greenish pus, and in those streptococcal forms which I have seen taking origin from ear disease, though the posterior cistern contains a good deal of fluid, the inflammation was much more visible over the upper surface of the brain than in the posterior basic forms. Now, in the epidemic forms the published accounts show that there is much wider distribution of the inflammation than in the sporadic cases, yet its maximum intensity falls on the posterior aspect of the brain. This appears to be the rule, but in some cases the exudate is however quite as marked over the sides and vertex of the brain. The cord is more affected than in other forms of meningitis—a thick band of purulent material may be found in the pial meshes down its whole length. I have, however, seen this feature well shown in a pneumococcal case. The naked eye appearances, therefore, are not so characteristic in the sporadic as in the epidemic cases. Amongst associated lesions broncho-pneumonia and collapse are not infrequent. A true croupus pneumonia is, in the epidemic as in the sporadic cases, uncommon, thus contrasting markedly with the findings in pneumoncoccal meningitis. Hydrocephalus is, as well known, one of the occasional sequela of the sporadic and epidemic forms, and it is not unlikely that the true cause of this is an inflammation of the ependyma which lines the ventricles. The curious form of amaurosis usually ending in recovery, and the permanent deafness due to inflammation of the labyrinth, are met with in both forms.

Briefly, comparing the symptomology of the epidemic and sporadic types they agree in essential particulars. In no other form of meningitis is the head retraction and tonic spasms of the back muscles so well marked. In both the onset is sudden in contrast with the more common forms of tuberculous meningitis. In both temporary amelioration may take place, and in both the convalescence is long and tedious. The points in which the epidemic seems to differ from the sporadic type are (1) greater virulence. Speaking to the students of the Edinburgh University last month, Professor Osler said: "We know of no disease which can strike patients with such lightning-like rapidity, in so fulminant a manner, as cerebro-spinal fever. There are instances in which death has occurred within six or eight hours. A few years ago in Washington I saw a robust, healthy man, who had left his house immediately after luncheon, and who, as he was stepping out of a tramcar at about 2.30 p.m., had a sudden pain at the back of his head. I saw him that night at ten o'clock; he was in a condition of extreme prostration and high fever, violent delirium, with a temperature of 104. At three o'clock in the morning he was dead." It should not be forgotten, however, that pneumococcal meningetic may in children be most rapidly fatal.

(2) The presence of skin eruptions, notably herpes, which is frequent, purpura, which, in the present cases in Britain is rare, and generally of erythema. (3) The septicæmia indicated by the typhoid state and large spleen. (4) The age of the patient. The majority of cases in the sporadic type are under one year old; the epidemic attacks all ages. At the bedside in diagnosis the two questions are: (1) Is the disease meningitis, and (2) if so, what is its nature?

The first question is, of course, one often confronting us. The fevers, influenza, and otitis media may show cerebral symptoms without meningitis being present. Whether the case is really one of meningitis or not can only be answered by a knowledge of general medicine, aided by the findings of lumbar puncture. The latter procedure will also show with what form of meningitis we are dealing. It appears quite certain that if, in a person suspected to be suffering from meningitis, the cerebro-spinal fluid withdrawn by lumbar puncture, shows the presence of a considerable number of cells, the case is one of meningitis. The method is easy of performance in children, and in those in a semi-comatose state; but if there is much spasm of the back muscles, it may be very difficult without an anæsthetic. After the fluid is obtained it should be carefully centrifugalised, and the deposit extracted by a capillary tube. Under the microscope attention must be directed to the kind of cells present, and also to the existence of micro-organisms. I have made this examination in a large number of cases, and find it most reliable. In the tuberculous forms, the cells are of the lymphocytic type—small and mononuclear. The bacillus may be not infrequently obtained after careful centrifugalisation. In all other forms of meningitis the cells are, on the contrary, large and multinuclear, except in long standing cases of cerebro-spinal meningitis where lymphocytes appear in considerable numbers. The pneumococcus and other pyogenic organisms can usually be recognised and identified. The meningococcus, however, may, if lumbar puncture has not been done early in the disease, be difficult to find. If a suspicious organism is found a positive report may be given after careful bacteriological examination. Even, however, if the organism is not found, the true nature of the case may be discerned by considering the clinical history, duration of the disease, and the absence in the cerebro-spinal fluid of the pyogenic organisms, commonly found, together with the presence of multinuclear leucocytes.

Treatment.—Grave as this form of disease is, it is the only form of meningitis in which we are not compelled to give a practically hopeless prognosis; 30 per cent. to 40 per cent. of cases recover. Flexner is endeavouring with some success to obtain an anti-serum. Until such a product is obtainable, we can only rely upon opium and hot baths to relieve the pain and suffering, and if followed by relief, repeated lumbar punctures should certainly be done. In cases which become chronic emaciation is often very marked, and the greatest care should be taken in feeding. Prophylaxis is, of course, the most important, and the methods to be adopted will be gathered from what has been said in the earlier part of this paper.

There is no doubt that sick persons should be isolated, though the direct contagion of the disease from person to person is probably no greater than in pneumonia. The secretions must be disinfected, and it would be well if those engaged in nursing would use antiseptic lotions to the naso-pharynx, bearing in mind that it is especially in the upper part of this passage that the organism has its dwelling-place.

ON THE PRESENT POSITION OF THE TREATMENT OF TUBERCULOSIS BY MARINE CLIMATES. (a)

By WILLIAM EWART, M.D.Cantab., F.R.C.P.

Senior Physician to St. George's Hospital and to the Belgrave Hospital for Children.

PART II.

In estimating the results obtained at the seaside and elsewhere, the precision of the mathematical method is illusive. It is wasted upon a clinical material ill-suited for statistics, with its features of latency at the beginning, of continued uncertainty as to the type and severity of the disease, and of precariousness at the later stages. Greater reliance can be placed upon experienced clinical observations and upon some of those great simple facts which, like the face of the sun, are rarely looked at. The first group—that of *threatened*, or of the earliest demonstrable, tuberculosis—furnishes the best results of marine treatment. The second, that of *tuberculosis in progress*, is difficult, anxious, and uncertain. The pyrexia may stop. Who knows that this was not automatic, given the individual and his lesions? Or it may last interminably, and who will say that the given lung and the given strain of bacillus could have behaved any better inland, or on the heights? The truth may be revealed to the acute perceptions of the clinician, but there can be no strict proof. Inference, however, does suggest that any conditions which are demonstrably favourable in the stage of confirmed phthisis are likely to be those best suited to its stage of progress. This brings us to the consideration of the *advanced cases*.

This third group provides us with much more definite tests for climates. Any climate which could effectively protect life, and preserve the survivors for indefinite periods, would become a sort of clinical museum of these rare specimens. Is that clinical display one of the features of our seaside resorts? If not, is this due to the cures effected being so substantial as to render unnecessary a permanent residence at the sea? At Davos the acknowledged prolongation of life in phthisis is attested by an unique and ever-growing popularity. It is traceable to two circumstances—the utmost protection against secondary infections, and the absence or brief duration of any ordinary catarrhs owing to the purity and the glacial dryness of the air in winter, and to its stillness. Healing lungs are safe so long as bright weather or dry frosts prevail. At the same time, it is remarkable how well the change of season is borne even by much excavated lungs provided they are not exposed to influenzal infection.

A favourable predisposition doubtless helps to explain the immunity of those well-seasoned survivors. But there are less fortunate subjects whom an excessive liability to catarrh unfits for the benefits of the Alpine winter. The cold is too intense an irritant for their sensitive mucous membrane. These are precisely the subjects whose catarrh does not heal at the coast, and whose only chance of a temporary lull in its encroachments lies in the protection afforded by warmer winter stations. These patients appear to form a smaller minority at Davos than at our marine resorts. These facts point a lesson in the management of those less advanced cases whose tendencies are not fully declared. It is of supreme importance that they should be allowed if possible the highest rather than any lower degree of safeguard against the risks of catarrh; and for them the altitude *cæteris paribus* seems to offer the best chance and the quickest method of recovery. However, as the masses who are chiefly concerned cannot avail themselves of the altitude, our attention must be confined to our own valuable marine climates.

The Aerotherapeutic Factors of Sea-Air in Pulmonary Tuberculosis and Catarrh.

In our treatment of tuberculosis, it is not the open-air that kills the bacillus, safely sheltered in the depth of air-tight tissues. The "airing" is for the man, not for his microbe. But sea-air can reach the respiratory surface and influence its condition, and it is credited with the following activities:—(1) *The Tonic action* is both local and general. It strengthens the membrane by direct contact, and every tissue and function by raising the cardio-vascular tone. (2) *The Cutaneous action* is exercised upon the epithelial, the glandular, the vascular, the muscular, and the nervous elements of the skin, and in virtue of the close nervous and vasomotor sympathy of the skin with the respiratory mucous membrane it is capable of strong reflex effects upon the latter. *The Respiratory or Inhalation action* is dependent upon any undescribed volatile properties of the atmosphere, but mainly upon its salt, its moisture, and its temperature. At Mont Dore ordinary catarrhs are cured by inhalations of steam mixed with pulverised saline water. Any stray cases of "latent" tubercle, if improved thereby, must be regarded as having benefited in spite, rather than because, of that combination. The heat and moisture must favour the growth of bacilli, and their dissemination in the tubes by hydrating the mucus. From these risks the inhalation of sea-air is free. It is true that the air is never dry nor glacial; but it is sufficiently cool in winter, and the salt may act as a corrective for the moisture. The "salting" of the mucous membrane is effected partly by suspended crystalline particles, and partly by concentrated droplets in which the saline solution approaches to saturation, and is therefore desiccating. This high degree of concentration is a dehydrating factor to set against the effect of damp air. As a paradox I might speak of this as "dehydration in the wet way." We are familiar with the effect of "brine" upon animal tissues; the healing effect of sea air upon common catarrh and upon bronchial delicacy probably belongs to the same kind of action. This dredging with dry salt and this spraying with brine are of an infinitesimal order, but they are continuous, whereas the much more powerful artificial treatment in the inhalation room is of brief duration.

Sea-Fog.—Special attention may be claimed for this subject in the debate. The common sea-fog is analogous to the Mont Dore inhalation, with the difference that the vapour is a cold one; it cannot be regarded as an essential, nor perhaps as a desirable phase of the sea-air treatment of pulmonary tuberculosis; but it may be of less serious detriment than is commonly thought. I have known recovery take place from extensive caseation and catarrh in spite of continued exposure to its prevalence.

(a) Opening Address to the Debate at the Hastings Meeting of the Balneological and Climatological Society on March 16th, 1907.

Among the *exhalations*, a distinction may be made between those of the sea itself and those from the shore, where animal and vegetable matter is always undergoing decomposition. It is here that iodine is likely to be liberated in large quantities, together with other odoriferous and perhaps stimulating effluvia, in addition to any other volatile organic contents in the pure air blown from the sea. A practical question arises in connection with these seashore exhalations. An opinion is said to have been expressed by Walshe, and has been endorsed by Dr. A. Ransome (*a*), to the effect that the actual seashore is bad for phthisis. Dr. Wm. Gordon informs me that "he has known of cases of obstinate hæmoptysis in *sea-front* lodgings close to the water, lose their hæmoptysis when sent a short distance (about a quarter of a mile or less) further from the sea." This is a serious indictment against the reputation of the beach well deserving of elucidation in our discussion.

The Meteorological Factors in the Aerotherapeutics at the Seaside compared with those at the Altitude.

The winter climate of Davos is famed for its stillness, clearness, powerful sunshine, and pure, cold, dry, rarefied air, which affords little conduction for heat or electricity, and is highly ozonised and, according to Jessen's recent estimations, also highly radioactive. With the exception of our sunshine which is tempered by a thicker atmosphere, and of our sea ozone, it might be said that the contrast presented by our seaside climate was almost absolute. At the coast, atmospheric pressure is at its maximum, as well as the density of air, its moisture, and its conductivity for heat and electricity. We might have expected even greater divergencies than are observed in the results. As a fact, the chief difference in the latter is one of degree. Nature, ever adaptive, has supplied some elements of compensation which tend to restore the balance.

At the sea, general metabolism is stimulated by cutaneous stimuli, through loss of heat and of electricity instead of through their conservation; and catarrhs are benefited by sea-air because of its salt and in spite of its moisture. A stimulation of the respiration forms part of this all-round stimulation, and is more specially connected with the increased muscular activity called forth by loss of heat. But there is nothing analogous to the considerable gain in thoracic diameter induced by the automatically increased respiratory labour in the rarefied air. The Alpine "Liege-kur," whilst resting the lung and the heart from all strain of bodily exertion and of cough, involves in reality a good deal of unconscious respiratory exercise. This perpetual cardio-respiratory work and blood aeration without any general exercise or muscular wear and tear, are a speciality of the altitude. At the seaside any increase in respiratory function is dependent upon muscular work, and in response to the more chilling cutaneous stimuli; and, bodily exercise being directly called for, the conditions for the pulmonary rest-cure are less favourable, and the complications of biliousness and hepatic congestion, which are quite exceptional at the altitude as a result from immobilisation, are much more likely to occur.

The Suitability and Selection of Marine Climates.

The task of selection for purposes of cure is more responsible than that for mere *Euthanasia*. The safety, comfort, and cheerfulness of our best protected seaside resorts might spare many enfeebled sufferers the fatigue of distant travel, which others so keenly desire. There are two criteria of personal fitness for a moderately bracing sea-side climate—good power of "reaction," which is primarily a nervous and vasomotor question; and a good cardio-pulmonary adequacy, which is primarily a question of the extent of the lung surface available, and of the amount of work to be permitted to fall upon it and upon the heart in the particular case. The heart, it goes without saying, must be able to back the effort at pulmonary repair. Any doubt as to this double endowment must point to the need for a protecting rather than a stimulating station.

The Importance of the Cardio-pulmonary Factor is well displayed in the cases of "surgical tuberculosis." The integrity of their respiratory function is their efficient weapon against the infection. But where the lung itself is the seat of the disease, its safety becomes the first consideration, and this forbids the respiratory risks attendant upon the stronger climatic treatment. Should, however, the lung lesion be strictly limited and without associated catarrhal tendency as in the "latent" cases, then it may be possible, with the help of the same test, to conciliate these opposing ends. The less relaxing stations may be the best for them, as moderate exercise may be allowed; and the same may apply to some cases of healed or arrested phthisis.

The following definite statements may now be put forward:—

1. In regard to tuberculosis *other than pulmonary*, the present position of the marine treatment is quite sound, but its advantages are still imperfectly utilised.

2. *Pulmonary Tuberculosis* is the difficulty. Sea-air will not cure bad cases that inland air cannot cure. But sea-air is specially fitted to cure the liability to tuberculosis. Its powers in prevention have hardly been fully turned to account.

3. In connection with the modern ideas of treatment in pulmonary phthisis the sea-side has been at a disadvantage in two directions: (*a*) It possesses *no germicidal* virtues comparable to those aimed at by bacteriological methods; (*b*) *The Rest-cure*, which is the unchallenged doctrine of the day is not its special strong point; on the contrary, muscular exercise is the soul of marine climatic treatment.

4. Both these objections are believed to be temporary; and, when they have ceased to be applicable, a greater future will be opened up to the sea-coast for the efficient treatment of phthisis.

5. Meanwhile our policy must be opportunist; and as we have not any altitudes to choose from we should make the most of our seaside advantages, by selection, by protection, and by local improvement. Climatic seaside treatment is of great value not only in the large categories of surgical tuberculosis and of scrofula, but also in the ill-defined but important group of "latent," or early, "local" tuberculosis of the lung, in which the necessity for the lung rest-cure cannot be so strongly urged. Those subjects who are merely threatened, being still in possession of their pulmonary adequacy, may be sent to the more bracing stations such as those suited for the scrofulous and for surgical tuberculosis. But where the presence of a bacillary lesion can be made out, the choice must be adapted to the condition, with every safeguard against catarrh or over exertion.

6. *In declared early phthisis* the same applies yet more stringently. But here climate, even of the best, does not suffice. Treatment is required which shall be planned on the Hospital idea combined with the Sanatorium idea. For the present, until the bacillus is no longer invincible and until the rest-cure ceases to be a moral obligation, much might be gained by improved methods of protection against undue asperities of climate, so that, for instance, bracing air might be available without the complicating evil of wind.

7. Lastly, *advanced phthisis* is an unprofitable field. As there is little promise in treatment, the highest degree of climatic protection is the main indication. And that is also the requirement for the select few who survive the long ordeal of phthisis. For them, and for those still fighting a hard but not yet hopeless struggle, our marine climates are imperfectly adapted and may not ever be capable of competing with the altitude.

(*a*) "Treatment of Phthisis," page 133.

The "Present Position."

The present stage is to be viewed as one of evolution. The great resources which our sea-coast affords are still undeveloped because two great facts before us have not yet been pressed upon us with compelling force. Nature has supplied decimating diseases for purposes of her own, and although she may offer some remedies (not the less great because they are primitive), still these simple cures are not adequate for the most virulent of our infections—small-pox, anthrax, sleeping sickness, and the rest. Tuberculosis is a much less formidable affair; and most often it is curable spontaneously, or with the additional help of "airing" and "salting." The unfortunate fact is that the cure of the vicious circle of complications superadded in the lung by the complex structure and functions of the organ is beyond the competence of mere hygiene and climate, and needs to be engineered by the joint efforts of general and anti-bacterial therapeutics. In the recent past these had been discredited in favour of "open air" pure and simple. There are signs of an approaching period when the Hospital treatment will be regarded as the essential and the Sanatorium as the accessory, unless the more perfect scheme can be realised of combining the advantages of Hospital and of Sanatorium treatment after the example set by Davos.

The other fact is that our only hope of stamping out tuberculosis lies in *prevention*. The only practical policy is that of not only checking the dissemination of the infection, but of stopping its reproduction by rendering the entire growing generation as tubercle-proof as possible. Short of an efficient vaccine, the best means would be to utilise our marine climates on a large scale for the benefit of all children not sufficiently protected by their native robustness or by their surroundings. The outlay would be great even with the facilities of modern engineering for supplying the simple accommodation required; but it would be a permanently profitable outlay for the purposes of health instead of serving a temporary purpose as in the case of the small-pox hospitals and similar makeshifts.

A greatly extended use of our seaside climates is also indicated for our young adults threatened with tuberculosis and for a considerable section of the large group of surgical and glandular tuberculosis.

For all these categories, in which the prevention of pulmonary tuberculosis is to be aimed at rather than its cure, our best marine climates are suitable just as they are.

For the purposes of Cure, they are suitable for another large group—that of the non-catarrhal localised pulmonary infections in their earliest stages. But it is clear that neither for these nor less still for any cases of declared catarrhal phthisis, the best of marine climates can be an ideal one, since being so variable it is too often not in its best phase. Special provisions require to be made, particularly in the direction of shelter from wind, to secure the greatest possible good with the least disadvantage, and it is probable that a great deal more may be done in the future than hitherto achieved

These, then, are the main propositions. We possess in proportion to our population an unparalleled wealth and variety of marine climatic stations. Their powers for prevention are vastly in advance of their powers for cure. Prevention is *par excellence* the use to which they should be put, and this is also the steadily growing tendency of the Sanatorium movement. In this country the place for the "Prevention-Sanatorium" or "Preventorium" is the sea-coast.

The late Mr. Richard Sumner Fowler, F.R.C.S., of Belmont, Bath, who distinguished himself particularly among the poor during the small-pox epidemic at Bath, has left by his will £250 each to the Royal United Hospital, Bath, Royal Medical Benevolent College, Epsom.

CLINICAL RECORD.

CASE OF RUPTURED OVARIAN CYST (MALIGNANT) GENERALISED PERITONITIS, WITH SECONDARY GROWTH IN UTERUS AND VAGINAL WALLS APPEARING SOME MONTHS LATER. (a)

By F. BOWREMAN JESSETT, F.R.C.S.,
AND
J. HOWELL EVANS, F.R.C.S.,
Cancer Hospital, Brompton.

E. C., æt. 35, was admitted into the Cancer Hospital, suffering from acute abdominal pain on September 12th, 1905. She had been married nine years, but never been pregnant. Menstruation regular. Very small in amount, accompanied with a good deal of pain. Always enjoyed good health until July, 1905, when she first noticed pain in the left iliac region, accompanied by constipation and vomiting. This, however, passed off in the course of a week, and she remained in good health until the end of the month of July, when a similar attack occurred lasting three days. Since this time she has noticed uneasiness in the lower part of abdomen, becoming more acute on September 2nd, accompanied by vomiting. The pain continued very acute until the time she applied to the hospital, most marked in the right iliac fossa. The abdomen had become distended, and the pain more intense, vomiting occurring occasionally.

Present State.—On examination, pulse was found to be small, quick (120), and thready; tongue red, raw, and somewhat dry. Abdomen—general distension; veins distended on wall. On palpation a tumour was felt in the lower abdomen rather to the right, but crossing the middle line. It is difficult to define the upper margin, owing to pain and rigidity of the muscles. Dulness on percussion in flanks. Respiration shallow; abdominal walls very rigid.

Per Vagina.—Whole uterus retroverted. Os and cervix infantile. She was admitted into the hospital, and Mr. Howell Evans operated on her the following day by the usual median incision. A large amount of dark fluid was found in the abdomen; the parietal and visceral peritoneum very congested; some flakes of lymph adherent to intestines. On removal of the fluid a cyst of right ovary was found, necrotic in parts, and partly solid inside as large as a fœtal head. The pedicle was ligatured, and the growth removed. Mr. Howell Evans mentioned that it had probably been twisted and ruptured. The abdomen was flushed out with saline fluid, and the parietal wound closed in layers, and a small gauze drainage in pelvis. There was some little suppuration in wound, but otherwise the patient made an excellent recovery, and was discharged on October 28th.

The pathologist reported that the cyst was partly solid, partly fluid, papiliferous, and of active cellular hyperplasia.

She applied at the hospital again in December, 1906, about fourteen months subsequent to her discharge after previous operation. For some months she has had pain in the right iliac fossa and repeated floodings. On examination nothing could be felt by the abdomen.

Per Vagina.—Uterus retroverted and mobile. In the recto-vaginal septum is a small, hard, irregular swelling with granular surface, which bleeds on examination. The finger can reach above into the posterior vaginal forum, which appears free.

On December 11, 1906, I operated on her, first removing the mass in the posterior vaginal wall freely with the mucous membrane covering and around it. The sound passed into the uterus for 3½ inches. I dilated the cervix up to No. 18 Hegar, and curretted the cavity. The scrapings were sent to the pathologist for examination, who reported them to be suspicious of new growth presenting a mass of cells of all sorts and sizes without any differentiation of tissue. I therefore at once proceeded to perform vaginal hysterectomy in the usual manner, experiencing no difficulty, with the exception of some adhesions which existed in Douglas's pouch, which were readily broken down. The vagina was plugged with iodoform gauze. The patient made an uninterrupted recovery, and was discharged on January 12 of this year.

(a) Read before the British Gynæcological Society, April 11th, 1907.

Dr. Paine, who has kindly examined this specimen, reports as follows:—

1. The ovary removed in September, 1905, showed the characteristic changes of a papillomatous cyst. There were very active proliferous changes occurring in the cylindrical epithelium covering the papilla.

2. The growths in uterus and vagina removed on December 11, 1906. The growth in the posterior wall of the uterus and vagina showed changes identical with those occurring in the ovary. In places the cystic formation with intra-cystic papilla is marked, though for the most part this is not so much in evidence as in the primary growth. There was little tendency to degenerative changes in the epithelium.

This case is of considerable interest, I think, as it is very unusual to find malignant diseases of the uterus and secondary growths in the vaginal walls following in ovarian carcinoma, but in this case, as you will see by the slides which are under the microscope, the types of disease are identical in each case.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

TUBERCULOUS ABSCESS WITHIN THE ABDOMEN.—Mr. PEYTON BEALE operated on a boy, æt. about 6, who had been admitted under him at Mr. Macready's request with the following history: He had suffered from severe attacks of abdominal pain associated with temporary complete intestinal obstruction for the last three years, and had had in all about twelve attacks. Within the last eighteen months a tumour was felt in the abdomen and appeared to be about the size and shape of a large sausage, freely movable, and attached to the small and large intestine, for, during the attacks of obstruction, peristaltic movement of the large intestine could be seen through the abdominal wall, and the gut was then obviously in connection with the tumour. Before and after the attacks of obstruction, a good deal of mucus and muco-pus had been passed per rectum, but there was no history of a passage of any blood. The condition was thought by Mr. Macready to be one of chronic intu susception, and, as the boy was becoming weaker, and the attacks of pain were increasing in severity, Mr. Beale was asked to operate. The abdomen having been opened in the middle line, a part of the tumour presented itself, appearing like a large yellow sausage-shaped mass soft to the touch and attached to several coils of small intestine, and also to the great omentum and transverse colon. It was at once obvious that the condition was due to a large mass of caseating tuberculous mesenteric glands which had all fused together, and had gradually encroached upon various coils of intestine. The difficulty Mr. Beale pointed out, was to know how to deal with it, for, if the mass was simply opened and the caseous material scraped away, it was fairly certain that subsequent cicatrisation and contraction would lead to complete intestinal obstruction; whereas on the other hand, if any attempt were made to free the various coils of intestine from the mass, Mr. Beale knew by previous experience that one or more fæcal fistulæ were inevitable. However, as this seemed to be the only means of preventing subsequent complete obstruction, it was adopted. In all, between thirty and forty ligatures had to be employed to separate three or four coils of intestine, and after considerable trouble the mass was isolated and as much as possible of it removed. A large gauze plug was inserted in the abdominal wound. Three days after operation, the patient had symptoms of obstruction and when the gauze plug was withdrawn, a portion of small intestine, evidently becoming gangrenous, was observed. This was brought outside the abdomen and freely opened a few hours later; and in the course of the next few days the gangrenous part was cut away, leaving a fæcal fistula. Mr. Beale remarked that this was by no means an uncommon experience in dealing with extensive tuberculosis within the abdomen; the reason why fæcal fistula was so common in these cases was that the intestine itself was nearly always tuberculous, either studded with tubercles or actually undergoing tuberculous ulceration, and so directly any portion of its blood supply was interfered with more or less of it became gangrenous and a fæcal fistula was the result. In the case he had operated upon he proposed to do an intestinal anastomosis as soon as the patient's condition should admit of it.

ACUTE MASTOID DISEASE AND BASAL MENINGITIS.—The same surgeon operated on a girl, æt. about 20, who had been admitted with typical symptoms of acute mastoid disease on the left side. An ordinary complete mastoid operation was performed, but only a very small amount of pus was found. The patient did very well, but during the next fortnight her temperature remained up between 99° and 100°, and she had marked leucocytosis. Lumbar puncture was performed; the cerebro-spinal fluid was obviously under considerable pressure, but normal in character, and it was proved to be sterile. Still, the patient did not get perfectly well. Mr. Beale gave it as his opinion that she was suffering from slight basal meningitis, but she had other symptoms which were not inconsistent with the presence of a cerebral abscess in the temporo-sphenoidal lobe; he therefore trephined her in this region and, on probing the brain in various directions found nothing abnormal. On tapping the lateral ventricle, however, a very large quantity of cerebro-spinal fluid was obtained; this also proved to be normal and sterile. During the next few days the patient was very much better—in fact, perfectly well—but one morning she became suddenly unconscious, with fits of screaming and restlessness. In two or three hours she had very marked retraction of the head and died with all the symptoms of acute basal meningitis. At the post-mortem examination, the whole of the medulla was found surrounded by pus.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD APRIL 26TH, 1907.

The President, Mr. H. H. CLUTTON, in the Chair.

MR. LAWRIE MCGAVIN shewed

TWO CASES OF LATERAL VENTRAL HERNIA TREATED BY THE IMPLANTATION OF VERY LARGE FILIGREES OF SILVER WIRE.

Case I.—A woman, æt. 38, had a hernia at the site of an operation that had been done a year before, the gap measuring 5in. by 3in. The whole of the old cicatrix was removed by an elliptical incision 11in. in length. The divorced strip of aponeurosis was sutured to the cut edge of the posterior sheath of the rectus muscle, and upon this, as a bed, a silver wire filigree, measuring 8 in. by 4 in., was laid, the inner loops being disposed deep to the rectus muscle, and the outer deep to the oblique muscles. The remains of the rectus muscle were now brought out of the sheath and sutured, as far as possible, to the oblique muscles, over the filigree. This caused a weak spot at the middle line of the abdomen, and necessitated the opening of the sheath of the left rectus muscle, which was drawn across the middle line to meet its fellow, where it was sutured. The skin and superficial fascia were closed over all by thirty five Michel's clips, and no belt had been worn since convalescence.

Case II.—The patient had had a large hernia after an appendicitis operation. On measurement, the gap measured 7in. in length by 3in. to 4in. in width. The bowels were adherent to the skin, and she was completely incapable of any exertion, as on standing up the larger part of the abdominal contents prolapsed into the sac, causing nausea and vomiting. The patient has worn no belt since her convalescence. A similar operation to that of Case I. was done, and the result had been most satisfactory.

Mr. A. E. J. **Barker** congratulated Mr. McGavin on his results. The method was certainly superior to any the speaker had used, and saved a great deal of time and manipulation. He had used interlacing wire in about thirty cases and in only two instances had it to be subsequently removed. He referred to the respiratory embarrassment he had seen occur after the replacement of enormous herniæ. He asked whether Mr. McGavin had ever experienced much difficulty in stripping the peritoneum from the transversalis fascia.

Mr. **McGavin** said in reply that in cases presenting this difficulty he placed the filigree between the rectus muscle and of the posterior sheath. He had not had to remove the filigree in any of the sixteen cases he had done.

Mr. **Lawrie McGavin** shewed

CASE OF INGUINO-SCROTAL HERNIA IN A MALE TREATED BY IMPLANTATION OF FILIGREES OF SILVER WIRE.

The patient, a man æt. 42, had suffered from a traumatic hernia for two years. The length, from the centre of Poupart's ligament to the bottom of the scrotum was 11in., and the circumference at the widest part, which was just above the testis, was 18½in. A very large vaginal hydrocele was present, which dragged heavily on the cord. The testis and cord were therefore removed, and the two separate filigrees were used—one to defend the pubic portion of the canal, placed deep to the conjoined tendon, and the other to defend the iliac portion and internal ring, placed on the surface of the internal oblique muscle and overlapping the outer end of the inner filigree for about three-quarters of an inch.

Mr. **Douglas Drew** shewed

TWO CASES ILLUSTRATING THE USE OF A FILIGREE OF SILVER WIRE IN THE RADICAL CURE OF UMBILICAL HERNIA.

Case I.—Woman, æt. 49. The hernia had appeared twenty-five years ago. It had been about the size of a cocoanut and was irreducible. The recti muscles had been widely separated above and below the ring. The filigree, 8in. by 4in., was inserted beneath the recti muscles, which were drawn together over it, as also were the edges of the sheath.

Case II.—Woman, æt. 41. The hernia had appeared four years ago and measured 4in. in diameter. The filigree, 4½in. by 3in., was used in the same manner as in Case IV.

Mr. **Douglas Drew** shewed a case of

HABITUAL DISLOCATION OF THE PATELLA (? CONGENITAL).

Female, æt. 13 years. The child first came under observation when six years old with severe genu valgum and dislocation of the patella when the knee was flexed. McEwen's osteotomy of the femur was performed April, 1900. The present condition was much the same as seven years ago. On flexing the knee the patella slipped completely over to the outer surface of the external condyle, whereas, when the knee was extended, it lay over the extended condyle. It was suggested to treat the case by dividing the capsule on the outer side of the patella so as to allow of the reposition of the bone, and by shortening up the capsule on the inner side, and deepening the patellar surface on the femur.

Mr. **Walter G. Spencer** advised the removal of the patella, care being taken not to damage the aponeurosis.

Mr. D. **Drew** recalled a case operated on in the way he now suggested, by Mr. Pollard sixteen years ago, with an excellent result.

Dr. **Frederick E. Batten** shewed three cases of

ACUTE ATAXIA (ENCEPHALITIS CEREBELLI).

Case I.—Boy, æt. 6 years. This case was exhibited before the Society in October, 1904. In April, 1904, he vomited, had general convulsions, and passed into a comatose condition. On regaining consciousness he was wildly ataxic both as regards his legs, arms, and trunk. From this he very slowly recovered, and when exhibited before the Society in 1904 was still very ataxic. He now walked fairly well but was still unsteady, especially on the left leg. The articulation was still slow and hesitating. The reflexes were normal. Sensation to touch and pain was perfect. He could appreciate the shape of objects put into his hands.

Case II.—A boy, æt. 11, was quite well up till April 1st. He had severe headache, vomited the whole day, and was unable to feed himself or stand. On April 5th he tried to get out of bed, and walked like a drunken man. On April 9th he had marked ataxia of both legs, some ataxia of the hand, and nystagmus on looking to the left side. There was loss of tone in the muscles of the lower limbs. The knee-jerks were active, and the plantar reflexes flexor. The boy had rapidly improved, so that he now only exhibited slight ataxia in the lower extremities.

Case III.—A boy, æt. 12, had always been backward. For the last seven years patient had had attacks of petit mal. In September, 1906, he had a series of 130 fits, and was unconscious for three days. On recovery he could move arms and legs, but had no control over them, and had not been able to walk since. His mental condition was poor, his articulation was slow and jerky. There was unsteadiness of the trunk and head. There was general weakness of the arms, and a well-marked intention tremor was present. He could not walk without aid, and his gait was wildly ataxic. The knee-jerks were active, the plantar gave a reflex response. There is a lateral curvature in the dorsal region.

Dr. **Batten** referred to the favourable prospect in these cases and recalled Dr. Frederick Taylor's case that made only slight improvement in the first three years, but had perfectly recovered when seen twenty-five years later.

Mr. C. **Gordon Watson** showed two cases of

MODIFIED PIROGOFF'S AMPUTATION.

The operation was performed for very severe talipes equinovarus following infantile hemiplegia. Tenotomy of tendo Achillis, and subcutaneous division of all contracted tissues in the immediate neighbourhood. Excision of astragalus and amputation of foot in front of os calcis. Removal of internal malleolus and cartilage from lower end of tibia. External malleolus left intact, but cartilage removed. Small portion of anterior extremity of os calcis removed. Patient can now walk well, and has a very comfortable stump.

Mr. H. H. **Clutton** said that the result of this new operation was excellent.

Mr. **Reginald Miller** showed a case of

ENCEPHALITIS CHIEFLY AFFECTING THE MID-BRAIN.

Patient was a boy, æt. 3 years, under the care of Dr. Colman, at the Hospital for Sick Children, Great Ormond Street. In October last, child was suddenly taken ill with a convulsion, in which the left side of the face was drawn up, and this was followed by three weeks' unconsciousness. When seen in November there was some weakness of the right side of the face and the right external rectus with slight lateral nystagmus. There had been inability to walk or talk, extreme emotionalism, some rigidity of the right arm and leg, and a slow tremor (about 5 per second) of the head and limbs, which showed more in the proximal than in the peripheral parts of the limbs and was absent only during sleep. The fundi were normal, the abdominal reflexes absent on the right side and feeble on the left, the knee-jerks brisk and about equal, and the plantar responses flexor. The facial and ocular signs quickly cleared up and the tremor became of the "intention" type; the abdominal reflexes became normal, but the rigidity of the right side remained. He had now regained the power to walk but could not yet speak intelligibly. Recovery had been slow but continuous.

Mr. **Miller** discussed the diagnosis as contrasted with the cases Dr. Butler showed.

Drs. W. G. **Stone** and F. **Norman** showed a case of

TUMOUR OF TONGUE IN A BOY ÆT. FIVE YEARS.

The right side of the tongue had been severely bitten three years ago. Since then it was reported that there had always been a swelling under the tongue about the size of a hazel nut, with a smooth surface and of the same colour as the rest of the tongue. There was now an irregular purple swelling on the under surface of the right half of the tongue with hardened edges.

Mr. A. E. J. **Barker** said that the case was probably one of mixed lymphatic nævus, and asked if no lump had been noticed previous to the biting of the tongue.

Dr. **Stone** replied in the negative.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Obstetrics.

Meeting held Friday, April 12th, 1907.

Sir A. V. Macan in the chair.

A VULSELLUM FORCEPS.

Dr. **Ashe** exhibited a vulsellum forceps, which he had had made in order to get over the tendency of the bullet forceps to slip out of the cervix, and the discomfort attending the holding of it for any considerable period. The chief features of the vulsellum forceps were that the points interlocked instead of meeting outside, while they were flatter on the under surface than the ordinary bullet forceps so as to offer a greater resistance and not pull through the tissues. The handles were so shaped that no matter how they were held they were a great deal more comfortable. There was no difference as to the cost of production.

The Chairman, Dr. Hastings Tweedy, and Dr. Spencer Sheill complimented Dr. Ashe on his exhibit, and the latter replied.

CHART REPRESENTING THREE YEARS IN THE LIFE OF AN ECLAMPTIC.

Dr. **Spencer Sheill** exhibited a chart showing diagramatically the dates and occurrences during the last three years in connection with an eclamptic patient. He had brought the case before the Academy a year ago, and he thought the further history of the case would be of interest. About 1900 nephrectomy was done for tuberculous left kidney. In 1904 she married and became pregnant. The remaining kidney, having the extra strain of pregnancy put upon it, began to fail; and in March, 1905, when about six months pregnant, she went to him suffering from eclampsia. Induction of labour was satisfactorily done, but the child was lost. In August of the same year she became pregnant again. The usual treatment was adopted, and as far as the kidney was concerned it was fairly satisfactory. In December of the same year the kidney again showed signs of failure. In the following January, when about eight months pregnant, the symptoms became so marked that he determined to induce labour. He delivered her of a living child, and about three hours afterwards she had an eclamptic seizure. Although strictly spoken to abou the dangers of a third pregnancy, she again becam pregnant, and in November of that year the kidney showed symptoms of rapid failure. After consultation with two other doctors, it was determined, in December, 1906, when only three months pregnant, to save her life by entering the uterus. It was emptied by him under anæsthesia, and in about three days the amount of urine became normal. In January of this year it was thought advisable to prevent any further pregnancy, and after consultation, and with the leave of the husband and the patient, her Fallopian tubes were resected. The chart raised certain points of interest, such as the postponement of marriage for at least three years after the removal of one kidney and the question as to the induction of labour in order to save the life of the mother and the child. There was also the point as to the significance of the amount of urea in the urine. If he had gone by the amount of albumen he would never have done anything with the case; it never rose beyond 0.15 per cent., whereas the amount of urea excreted fell as low as 7½ grains per ounce in 14 ounces in twenty-four hours. There were also the points as to the advisability of inducing abortion, and of sterilization.

The **Chairman** asked if the urine was examined between the pregnancies, and whether she had a very small quantity of urea.

Dr. **Sheill** said the kidney was functioning absolutely normally between the pregnancies, and was quite capable of carrying on its work. The urine was examined at frequent intervals in order to be quite sure on that point.

Dr. **Hastings Tweedy** said the result had absolutely justified Dr. Sheill's treatment, but he had never heard of a woman being deliberately sterilized when no symptoms were present, and when there was no suggestion that she would ever become pregnant again. He did not suggest that anything but the right thing was done, but it was a very bold procedure, and if he had to contemplate such an action he would be very glad to be able to refer to the record of a successful result in a case of a similar kind.

Dr. **Jellett** could not agree with Dr. Tweedy as to the particular boldness or rarity of removing the tubes for renal disease. It was on all fours with the very old treatment of osteomalacia One could not wait until pregnancy in order to resect the tubes. He could not look on the patient as being a healthy woman. Her kidney might be acting at one time, but it was amply proved that it would not act under the adverse circumstance of pregnancy.

Dr. **Kirkpatrick** instanced a case of a girl, æt. 20, who became pregnant last year and had eclampsia at the time. She died with all the symptoms of failure of the kidneys. At the *post-mortem* they found she had an old and chronic tubercular disease of one kidney, which had completely destroyed its function; the other kidney was amyloid. She recovered from the eclampsia, but died some months afterwards from failure of the single kidney.

Dr. **Horne** said that, considering the age of the patient, twenty-eight, and her apparent fertility, he thought Dr. Sheill was perfectly justified in his action. If he had allowed her to become pregnant again he would probably have had to repeat the former operation with less favourable results. In his experience albumen was always found persisting in the urine six or eight months after delivery where eclampsia had occurred.

The **Chairman** agreed with Dr. Horne, and said that the chart showed very graphically the condition of the patient.

Dr. **Sheill**, replying to a question by Dr. Neil, said the patient was not on an absolute non-nitrogenous diet except when she was showing kidney insufficiency. Between pregnancies she was on a mixed diet, but warned against taking the usual amount of meat.

THE METHOD OF BIER IN GYNÆCOLOGY.

Dr. **Spencer Sheill** read a paper on the above. He said the paper dealt with Bier's treatment of disease (by hyperæmia artificially produced) as applied *locally* in gynæcology, and some actual experiences with it in a variety of gynæcological ailments were related by the author. The tendency nowadays of imitating Nature's methods of combating disease was discussed. Dr. Sheill dismissed the "arterial" hyperæmia as produced by hot air, and the "venous" form by "constriction," because he had had no experience of the former, and the latter he considered inapplicable to gynæcology. The "suction" form, creating mixed arterial and venous hyperæmia, was the kind he used, and he showed a simple form of apparatus which had been successfully used in a number of cases. The author said that in order to be beneficial the "suction" must be intermittent, and must not be so strong as to cause pain. Three minute application and one minute interval for half-hour sittings daily or weekly as the case might be, were recommended. He also spoke of the value of intermittent action, "massaging" the uterus being valuable in cases of adhesions and relaxed pelvic ligaments. Dr. Sheill had used the treatment in two cases of amenorrhœa without obvious cause, the results were negative in so far as the menses were concerned, although in one case other pelvic symptoms were relieved. A case of endometritis was very favourably influenced. In two cases of old pelvic exudate and adhesions the result was specially gratifying. The author suggested that in gonorrhœa the suction treatment would be valuable to prevent the upward spread of the infection. Also for the safe and easy removal of tenacious mucus from the cervix of nulliparas desirous of becoming pregnant. Klapp, an assistant to Bier, was quoted as recommending "suction" in cases of suppurative mastitis. Dr. Sheill described a case of his own experience—since writing the paper—the result was excellent. In conclusion, the writer of the paper expressed a hope that others in this country would give the treatment a trial and that those who have used it would compare results obtained, because he believed it to be a distinct advance in gynæcological methods.

The Chairman said the method appeared to improve the defensive force of the tissues against invasion. Personally, he did not think that the mere drawing of a little blood into the cervix was likely to have much effect.

Dr. Ashe and Dr. Tweedy also spoke, and Dr. Sheill replied.

THE REPORT OF THE ROTUNDA HOSPITAL.

Dr. Hastings Tweedy read the Report of the Rotunda Hospital for the year 1905–6.

On the proposal of Dr. Neil, seconded by Dr. Horne, discussion on the paper was postponed till the next meeting of the section.

A NEW UTERINE DILATOR.

Dr. A. J. Horne exhibited for Dr. Duke a new uterine dilator. Dr. Duke said that anyone who had performed the operation of dilatation must have noticed the contraction of the cervix uteri on the curette taking place during the proceeding. The cervical wall may also require scraping, and owing to the contraction spoken of it becomes a difficult matter, if not impossible. The canulæ shown were designed to be introduced after dilatation according to the amount of room required, the curetting being carried on through the canula, which is gradually withdrawn, thus effectually preventing the contraction of cervix on curette.

Dr. Tweedy expressed the Section's appreciation of Dr. Duke's kindness in giving them the opportunity of seeing his interesting appliance.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held April 19th, 1907.

Dr. G. Chapman in the Chair.

The Chairman read a paper on two cases of

GLANDULAR FEVER,

occurring in a lady æt. 30, and her daughter, æt. 3½ years. There were the usual enlarged glands in the cervical region, without lesion in the throat, nose or ears to account for the adenitis. There was fever, enlargement of the spleen, and epistaxis. The child had a similar illness, but of milder character.

Dr. Porter Parkinson considered this collection of symptoms was not a definite entity, but, as in the case of purpura, it was probably due to a variety of infections.

Dr. T. R. Whipham showed a girl, æt. 8, of alcoholic parents, who had threatened to murder her. She began to stutter, and developed stridor, and deafness. Double ptosis and transient anæsthesia appeared, and there was some atrophy of the tongue. Intellectually she was bright, but supersensitive, and talked of religion, marriage, and maternity. The diagnosis lay between *neurosis* and *disseminated sclerosis*. Dr. Whipham showed a girl, æt. 11, with adherent pericardium and aortic and mitral regurgitation due to acute rheumatism eighteen months previously. The diastolic murmur had occasionally disappeared. There was systolic retraction of the intercostal spaces near the left nipple.

Dr. Fletcher Beach showed a boy, æt. 6 years, the subject of

VON RECKLINGHAUSEN'S DISEASE.

There were two growths on the head, one above the right eye and one over the occipital region. The left side of the face and the left eye were smaller than the right. There is extreme spinal curvature in the dorsal region, and much thoracic deformity. On the abdomen and back are areas of brown pigmentation, some being as large as a five shilling piece.

Dr. Porter Parkinson, showed a girl æt. 2 years and 4 months with *right-sided hemiplegia and motor aphasia* due to encephalitis superior in February. The illness began with fever and a convulsion, a week later the paralysis was noticed. For six weeks she was quite unable to speak a single word, merely screamed and made unintelligible noises, though she recognised her relations and understood all that was said to her. Since then she has gradually learnt to speak, and a little power has returned in the paralysed limbs; the electrical reactions were normal.

Dr. F. J. Poynton showed a case of

ADDISON'S DISEASE

in a girl æt. 9. For the last year she had suffered from lassitude, occasional vomiting and fainting attacks. For the last month the face had been getting darker in colour, and there is some pain in the abdomen and back. There was some pigmentation of the mucous membrane of the left cheek and soft palate, and the skin of the abdomen and back. The blood pressure was only 60 mm. of mercury, but there was no anæmia, the red cells being actually increased in number.

Mr. Duncan Fitzwilliam showed an infant, æt. 9 months, with twenty-seven abscesses distributed subcutaneously over the head, body and limbs. There was no history of syphilis, and they were probably due to the staphylococcus.

He also showed a

SYREN FŒTUS

which had a single lower extremity. The bones of the pelvis were normal; the femur was thick, and below it were two bones partly separated at the upper end. The bones of the paddle-like foot were normal. The mother was delivered at the eighth month.

Mr. G. Pernet showed a girl, æt. 3, with erythema iris on the arms, due to intestinal intoxication. Also a girl, æt. 15, with

ERYTHEMA PAPULATUM HÆMORRHAGICUM,

who was stated to be a vegetarian, having a natural distaste for meat.

Mr. Jaffrey exhibited an infant, æt. 6 months, with a cartilaginous tumour attached to the whole length of the left side of the nasal septum, filling up the left side. It bleeds very freely.

Dr. J. T. Tallent showed a case of double retained testes in a child, æt. 2½. When six weeks old a swelling appeared in the right groin, but disappeared again in about five minutes, this has frequently happened since.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting at Manchester, April 19th, 1907.

Dr. E. O. Croft (Leeds), President, in the chair.

Dr. **Lloyd Roberts** (Manchester) exhibited a Malignant Ovarian Tumour removed by abdominal section from a multiparous widow, æt. 65 years. Menopause 20 years ago. Abdominal swelling had been noticed for eight months. There had been no pain or loss of flesh. The physical signs were those of an ovarian cyst with ascites. On account of the enfeebled condition of the patient a preliminary paracentesis abdominis was performed followed by ovariotomy four weeks later. The opposite ovary was cystic, and therefore also removed. Recovery was uneventful. Microscopically the growth was an adeno-carcinoma.

Dr. **Fothergill** (Manchester) showed compressed swabs for use in abdominal sections in private practice.

Dr. **Blair Bell** (Liverpool) showed a specimen of Sarcoma of the clitoris removed from a woman, æt. 56, 6-para, nine years past the menopause. A lump in the external genitals had been noticed for about six months, and caused considerable discomfort in walking. There was no pain, bleeding, or difficulty in micturition and no loss of flesh. The growth was widely removed, and consisted of a large irregularly spherical mass, more or less necrosed on the surface, and extending to the left labium minus. Microscopically it was shown to be a large spindle-celled sarcoma, the cells composing the tumour, having large oval nuclei. There was a somewhat unusual amount of inter-cellular substance.

Dr. **Arthur J. Wallace** (Liverpool) related a case in which a very large fibroid had been removed with the uterus from a woman aged 53. The tumour had burrowed between the layers of the left broad ligament and up beneath the peritoneum covering the posterior wall of the abdomen, and during operation the lower part of the descending colon and its sigmoid flexure had to be stripped off the growth. Forty hours after operation the patient began to have a continuous discharge from the rectum of dirty, watery, slimy fluid, very occasionally streaked with blood. All general and local remedies proved ineffective, the discharge persisting until the sixteenth day. Dr. Wallace was inclined to think that the cause of the condition was damage to the nervous supply of the colon during operation, with resulting vaso-motor paralysis and trophic disturbances in the wall of the bowel involved and sepsis within its canal. Six weeks after operation a temperature of 104 suddenly developed, and for a week the temperature was rarely below 100. The patient's general condition steadily improved during this time, and no cause could be discovered for the temperature. Operation wounds had healed by first intention, and there had been no return of the diarrhœa. Now, four months after operation the patient was in good health, but she still had elevations of temperature for which there was no apparent cause.

Dr. **Arnold W. W. Lea** (Manchester) related a case of bilateral axial rotation of ovarian cysts during pregnancy. The patient, aet. 27, was suddenly seized with severe abdominal pain and vomiting whilst pregnant three and a half months. A tense cystic tumour occupied the right side of the abdomen, and a smaller cystic mass was felt on the left side, the uterus occupying the central position. Abdominal section was performed. Both ovaries were converted into dermoid cysts, each of which had undergone acute torsion. The tumour on the left side had ruptured, and the peritoneal cavity contained blood. Both tumours were removed; fifteen days later miscarriage occurred spontaneously. The foetus had evidently been dead for some days. Bilateral ovariotomy has now been performed during pregnancy in at least sixty cases, and it is remarkable that in the great majority the pregnancy has continued the full term.

Dr. **Grimsdale** (Liverpool) communicated the case of K. J., æt. 29, who had never menstruated, but complained of pain in the back, which lasted for two days each month. Her general health was good. There was no cough, and no abnormal signs to be detected in the lungs. There were healed scars in the right groin, suggesting old suppurating glands, and a depressed healed scar on the inner side of the lower part of the right thigh, suggesting old necrosis of the femur; there were also some healed scars over the right tibia. The patient could not give any account of these scars. She was well developed, and apparently a strong, healthy girl. There was no abdominal tumour. The vaginal examination was made under an anaesthetic. The uterus was found to be somewhat enlarged and movable. There was a definite elongated swelling to the left of the uterus. An endeavour to pass the sound failed; it would only pass three-quarters of an inch. The diagnosis of malformation of the uterus with possibly some retention of blood, was made. The abdomen was opened, and the uterus and Fallopian tubes removed; the vermiform appendix adhered to the right tube, and also to the upper part of the rectum, into which it had opened. Both Fallopian tubes were distended with thick pus. The uterus contained caseous pus in its cavity, and also disseminated through its walls. The case was one of tubercular disease of the uterus and appendages causing primary amenorrhœa.

ULSTER MEDICAL SOCIETY.

Meeting in the Medical Institute, Belfast, Thursday, April 25th.

The President, Dr. D. P. Gaussen, in the Chair.

Dr. **J. Singleton Darling** (Lurgan) read notes of a case of "Cystoma of the Ovary," weighing 70 lbs., removed under local anaesthesia. The patient was a woman of about 75, apparently almost moribund on admission to the Lurgan Infirmary. As the symptoms were urgent, and she seemed too ill to take a general anaesthetic, Dr. Darling opened the abdomen under local anaesthesia produced by cocaine. He found an enormous cyst, adherent to the anterior wall, and drained off 48½ pints of fluid, then dissected out practically without pain the tumour, which, with the fluid measured, but not allowing for a quantity lost, weighed 70 lbs. The pulse improved rapidly, and the patient showed an extraordinary craving for food. She did well till the third day, when lung trouble set in, and she died on the fourth day, without any signs of septic trouble or any abdominal symptoms. Drs. O'Neill, Dempsey, and Fielden discussed the case. The last pointed out that if ether had been given in this case, it would probably have been put down as the cause of the subsequent pneumonia.

"THE DIAGNOSTIC VALUE OF THE OPSONIC INDEX."

A paper on this subject, by Drs. Houston and Rankin, was read by the former, In two former communications to the Society, they had described the methods used, so they did not enter into that, but gave their conclusions from a large number of examinations in various conditions. 1. In chronic affections, without temperature, the opsonic index is below normal, and remains so. 2. In acute affections the index is in every case above 1, and generally up to 4, 6, 8 or even, as in the case of the meningococcus, to 60. 3. No great stress need be laid on slight variations, as errors easily creep into the most careful work, but if the results of several examinations correspond, more value attaches to them. Examples were then given of the aid to diagnosis afforded by such examinations. (*a*) A lady had complained for some time of pain and tenderness over the ileo-sacral joint. The diagnosis lay between hysteria, a strain, or early tubercular disease. At two examinations the opsonic index was .68 and .66 for tubercule, and the diagnosis thus made was confirmed by the subsequent course. (*b*) A patient suffered from ascites and pleural effusion, suggestive of tubercule. At two examinations of the blood, the index for tubercule was normal, as it was also when the fluid was examined. A tumour subsequently developed, and the patient was found to have malignant disease of both ovaries. (*c*) A patient was admitted to the Ulster Hospital acutely ill, with a temperature of 104, and signs of typhoid, but the Widal test was negative, and the index for tubercule was 1.5 The after-progress showed the case to be tubercular. (*d*) A weak anaemic patient had suffered from mucous diarrhœa for months, which was suspected to be tubercular, but the index was normal, and the case proved to be one of pernicious anaemia, as revealed by an examination of the blood. (*e*) A young man was seen with symptoms pointing to pressure on the cord, which had been diagnosed as tubercular. The index was normal, and under antisyphilitic treatment he improved. (*f*) A patient who had suffered from septic arthritis for years, and had diarrhœa. The index for tubercule was normal, but that for staphylococcus was low. (*g*) A case of persistent frequency of micturition, with normal temperature. Coli were found in the urine, and that this was not an accidental infection was proved by the presence of a low index for B. Coli. (*h*) The last example is a most interesting one; a case of the President's, of which he will give a full account later. The patient, a lady, suffered from irregular rises of temperature of an undulatory type, exactly like Malta fever, but as she had not been out of the country for fourteen years, this was not considered a likely diagnosis. She developed an acute cystitis, and the index for Coli rose to 1.2 and 1.4. Inoculations of Coli vaccine were given till the index was raised to 3, but the febrile attacks continued to come on. Agglutination tests for the Malta micrococcus tried five times were negative, and attempts to isolate the micrococcus failed. The opsonic index was tried, and in repeated examinations was always above normal, and varied with the temperature. The diagnosis of Malta fever was made, and as it is known that in chronic cases the agglutination test fails, the failure in this case was not surprising.

Meningococcus.—For some months past they had been working specially at the meningococcus, and the difficulties of technique which constantly arose were well illustrated here. A variety of degeneration forms arose on culturing the coccus, and accurate counting was impossible at first; but happily Professor Summers had discovered a medium on which the coccus grew well, a special sort of peptone with ascitic fluid. On this sub-cultures were taken daily, and they found that at the thirty-fifth generation, which they had now reached, degeneration forms had almost disappeared, and no agglutination occurred, as generally was the case early. For their experiments they used six-hour growths in a thick emulsion. They found that the opsonic power of normal serum was extremely low, but on the other hand the opsonic power of the serum from cases of cerebro-spinal meningitis was very high. Their routine was for two men to count in every case, as a control. In many cases the leucocytes were so packed with the cocci that the latter were unaccountable, and these they took as containing fifty, though, in many cases, it must have been much more. They had examined sixty-four cases, and details of tests were given. The general results were as follows:—

(1) From the sixth day all showed an opsonic index over four. Sometimes it was high on the second day, often on the third, and always on the sixth.

(2) The opsonic index seems a more delicate test than agglutination, which was never seen till the index was five times the normal.

(3) The combination of the two tests was most valuable for diagnosis.

(4) From the very definite results obtained, it seems that this method will prove of value in diagnosing sporadic cases, and cases of posterior basic meningitis.

(5) It may also be relied upon to show if a suspected coccus is the true meningococcus.

(6) It may be used to test the efficacy of sera recommended for treatment. In the case of one serum advertised as having an agglutinative power of 1 in 50,000, they found it to be nil at a dilution of 1 in 3! This was confirmed by its clinical results, which were nil. It was, of course, possible that certain sera were specific for certain varieties of the coccus only, and this point they were endeavouring to elucidate. There may be different strains of the coccus in different places, as is the case with streptococcus, apparently, though not with A, the typhoid bacillus, as tested with Widal's reaction, which is universally applicable.

The paper was criticised and the writers warmly thanked, by Sir John Byers, Drs. Calwell, Robb, Cecil Shaw, and McQuitty.

Dr. Hanna read short notes of a case of "Extradural Abscess," following middle ear disease, with recovery after operation.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, April 27th, 1907

Treatment of Pleurisy.

The treatment of pleurisy consists in obtaining the absorption of the effusion or in evacuating it if necessary.

Thoracentesis, hitherto systematically recommended, becomes inadvisable only under two conditions: where the abundance of the liquid threatens to compromise life or where the effusion is absorbed but slowly and at the end of a month has not perceptibly diminished in volume.

On the left side thoracentesis is indicated when the heart is deviated towards the right and on the right side where the liver is pushed below the false ribs. The quantity of liquid to be drawn off at one sitting is variable, but a quart and a half may be extracted provided the aspiration is not done too rapidly.

During the acute period the patient should be put on milk diet, two quarts a day.

As to medicinal agents, Prof. Robins prescribes the first day two grains of calomel every hour for four hours as a purgative. The following day, ten grains of salicylate of soda four times a day for six or eight days.

To persons of strong constitution, and in whom there exists no displacement of the heart, jaborandi may be given in infusion (1 drachm macerated in half a glass of brandy for an hour, then add 6 ozs. of boiling water and leave to infuse twenty minutes; to be taken in one dose).

In patients depressed, or where the heart is deviated, jaborandi is dangerous.

Blisters are useful when the liquid remains stationary and may be applied every five or six days.

If the temperature is high one of the following wafers may be given in the evening:—

Bi-hydrochlorate of quinine, grs. 8
Pyramidon, gr. 4

In case of violent pains in the side, wet cupping or a subcutaneous injection of morphia will give relief.

If oliguria is present, the diuretic mixture

Oxymel of squills, oz. 1
Acetate of potash, grs. 30
Nitrate of potash, grs. 30
Infusion of broom tops, ozs. 6

A tablespoonful every two hours.

When the adhesions have formed the patient can get up and begin to take substantial food, and:

Arseniate of soda, gr. 1.
Iodide of potassium, drachm 1.
Water, ozs. 10.

Two tablespoonfuls daily before meals.

Igni-puncture or large applications of tincture of iodine may be ordered to stimulate the vitality of the tissues, while the patient will practise respiratory gymnastics against muscular atrophy. Lying on the healthy side he will make eight or ten deep inspirations, to dilate the compressed lung, several times a day.

When possible a hydro-mineral treatment may terminate the treatment. Sulphurous springs for those who cough and are a little oppressed; arsenical for those who cough no longer.

WRITER'S CRAMP.

The treatment by elastic ligature employed by Bier for arthritis has been also used with success in such muscular disorders as contractions, spasms, cramps, etc.

A typical case of writer's cramp is one of the most recent triumphs of this method. A man, æt. 37, employed in a commercial house, complained of difficulty in writing, which had already lasted fifteen years, and which a neurologist diagnosed as writer's cramp. When he wanted to write the patient was seized with stiffness in the fingers, which prevented him from forming the letters, and more especially f, g, h, m, n, u. The stiffness varied in intensity from one day to another, and was less marked in the evening than in the morning. The general condition of the patient was excellent, but he was evidently of a nervous and impressionable temperament. Different treatments were employed without success; prolonged rest from writing, strychnine, galvanisation, gave but temporarily relief, and finally he was told that his trouble was incurable.

M. Hartenberg advised the treatment by elastic ligature, consisting in winding around the arm, above the biceps, an elastic band, sufficiently tight to arrest the venous circulation below the band, and maintained twenty minutes morning and evening. The results were remarkable. At the end of a fortnight the patient wrote a letter to his doctor showing a considerable improvement in the writing, and two months later a second to announce a complete cure.

GERMANY.

Berlin, April 26th, 1907.

At the Medizinische Gesellschaft Dr. Kausch spoke on

Cancer of the Stomach and Surgery.

His observations were based on the result in the surgical treatment of cancer of the stomach obtained by Mekulicz in the Breslau Klinik. Resection was performed in 163 cases. During his last four years the mortality had been 33.8 per cent., when all deaths occurring within thirty days of operation were reckoned as due to it. If other surgeons obtained better results, it was due partly to a selection of cases, and partly to this fact that the operation as performed by Mekulicz was a very radical one.

An improvement in the statistics might be expected with improved technique and advancement as regarded asepsis; much would not be made out in these ways, however. The most important improvement would take place when the cases for operation reach the surgeon earlier. In 92 cases that left the Klinik as recovered, later inquiries had been made as to their fate; 62 were already dead of recurrences, only a very few of late recurrence, that was, more than three years after operation. This gave a percentage of 14 alive more than three years after operation.

Boas had recently expressed a doubt as to whether cases could be sent for operation much earlier, as in some cases the symptoms only made their first appearance later on in the disease. Mekulicz's observations also showed that in many among those who came soon after the onset of symptoms, resection was no longer possible, more, in fact, than among those who had suffered a longer time, and in whom a tumour gradually developed. On the other hand, the prognosis was more favourable in those who had been only a short time ill, and when the strength was not exhausted.

Gastro-enterostomy was indicated only when the motor disturbance was great. The speaker rejected jejunostomy completely.

Exploratory laparotomy could not be too much commended in all cases in which symptoms and examination gave grounds for a suspicion of carcinoma which it could not be proved positively to be present.

Hr. Ewald laid stress on the difficulty of diagnosing cancer even when all aids to diagnosis were made use of, and of fixing the moment when operation should be performed. That operation should be performed when a tumour could be felt there could be no question, but these cases formed only a fractional part of the whole. During the last ten years he had had 255 cases of cancer of the stomach in the wards; but in spite of every disposition to operation, only 59 of them had been found suitable for operation. No change could be expected at present, as patients could not yet be brought to understand the need for exploratory laparotomies.

The Deutsch Med. Zeitung, April 11th, has a reference to a paper by Priv. Doc. Dr. Wandel on

The Pathology of Poisoning by Lysol and Creosol.

Lysol, which acts as a poison on the animal system by the creosol given off, causes injury at the spot to which it is applied, and by reabsorption passes to the cells, first to the cell protoplasm, later to the pigment substance, the injury being proportional to the concentration of the solution. Even with comparatively weak solutions of creosol considerable injury is inflicted on the blood and on the blood vessels, where it is taken up from the intestinal canal, more especially the portal vein that returns the refuse of the blood to the liver. This shows the more marked cell injury, from slight parenchymatous degeneration to total destruction, as in acute yellow or red atrophy. The liver collects the creosol out of the intestine, and furnishes the material for an antidote in the shape of its constituent carbo-hydrates and albuminous bodies. In this way the liver loses an essential constituents of its protoplasm, that is expressed histologically in a washed out look in the cells, in disappearance of glycogen in the wider circle around the portal vein, whilst the cells in the hepatic vein show minor changes—a proof that here the non-poisonous combination of creosol with glycopurin of sulphuric acid is present, by which excretion throughout kidneys takes place. In case of graver poisoning there is total disappearance of cells, and nuclei in the liver become scarcely capable of regeneration, thus necessarily leading to substitution of connective tissue, if consistent with prolongation of life at all. If free creosole finds it way in large quantities into the blood tract, it shows itself as a poison here as in the portal vein: cases of hæmoglobinuria in lysol poisoning are explained in this way. It acts further as a protoplasmic poison in all organs to which it gains access in a free state. Tolerance for creosoe independent of the species of animal and the contents of the stomach is dependent on the material present in the liver capable of combining with it, and secondly, on the secretion of bile by which extraordinarily large quantities of creosol are removed from the liver and carried into the intestines. From this they are again absorbed, and in thinner concentration combine again in the liver. The enormous production of bile in some herbivora perhaps explains the tolerence of rabbits, for instance, in regard to lysol.

The heart and brain suffer injury when the liver does not succeed in passing the creosols, or when they escape it when absorption takes place through the lungs. Large quantities can be rendered innocuous by passing through the liver. The renal epithelium is first damaged when free uncombined creosols circulate in the blood. The albuminurias present at the early stage are probably of toxic hepatic origin. They generally disappear more quickly than the toxic hepatic carbohydrature which persist after the other symptoms of poisoning have passed off.

AUSTRIA.

Vienna, April 27th, 1907.

Contractions in Right Hand.

At the "Gesellschaft fur Innere Medicin" Salomon exhibited to the members a peculiar case of contraction in the right hand. The patient was æt. 42, and a teacher in an elementary school. The disease is attributed to writing, drawing, and playing the harmonium, which he is now unable to accomplish. There was no particular weakness, only cramp at first, which was followed within eight days by œdema of the whole hand, and fourteen days later by shaking in the right fore-arm with severe pain in the right hand. The first impression was of its being an athetosis located in the one hand, and this opinion was supported by the conjunction of pneumonia and a transient form of paralysis attacking the left side. From these symptoms the morbid changes appeared to indicate an encephalitis, as frequently appears in children where cerebral paralysis is dominant. The cause of the athetosis is usually a morbid centre in the thalamus or in the region of the optic thalmus, such as the lenticular nucleus and the processus cerebelli ad corpora quadragemina. The same symptoms have been obtained by injuring the cortical of the brain in this region, which adds to the complexity of the symptoms.

In addition to this the patient had suffered for five years previously from neurasthenic symptoms, such as narrowing of the field of vision, functional paresis of the left extremities, œdema of the hand associated with intense pain that drugs could not relieve.

Fuchs said he had repeatedly examined this patient, and concluded that it was not hysteria, but organic in origin. The movement of the right arm led him to diagnose athetosis; the tendon reflex on the upper and lower part of the right arm was accentuated, agreeing with the athetosis on this side; also clonus of foot and patella of the same side. The Reflexes of the abdomen scrotum and soles of the feet were weaker on the left side than the right. The palate and fauces were more tense on the right side than the left, indicating a paresis of the tensor veli palati of left side.

If we consider these symptoms in conjunction with the history which commenced with an attack of influenza producing encephalitis, probably the pyramidal path on the right side became involved with hemiparesis on the left side, and weakening of the cutaneous reflex. Later the disease seems to have extended to the optic centre with the resulting hemianopsia. The third centre affected produced the right hemiparesis in the upper extremity and athetosis, with clonus in the lower extremity with increased cutaneous reflex but no "Babinski." Conclusions arrived at were—a morbid centre in the subcortical path (motor), probably in the region of the process, as cerebelli ad corpus.

Although the case was at first diagnosed as one of hysteria, Fuchs avowed he never saw a symptom with the hysteria to confirm this opinion.

Chromaffine System.

Wiesel again brought forward his chromaffine connected with renal cardiac hypertrophy. In patients that die from chronic nephritis associated with cardiac hypertrophy he has always found a well-defined elovation in the medullary substance, in many cases eight to ten millimetres wide, while the corticle substance is not diminished, but has a normal appearance. Histologically there is an hypertrophy of the medullary substance and an increase in the chromaffine cells, but no other pathological change is present. In cases where the disease is of a relatively short duration there is an increase of the medullary substance from the accumulation of cells apparently induced by the sympathetic ganglia. How this cardiac hypertrophy coincides with the chromatic change he has no positive hypothesis to offer, but is under the impression that the hypertrophy in the chromaffine system precedes the cardiac hypertrophy. In cases of acute nephritis where no cardiac hypertrophy existed, there was no increase of the chromaffine system, from which he reasons that the cardiac hypertrophy always succeeds the chromaffine system.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

The Royal Visit to Glasgow.—During their three days sojourn in the western capital their Royal Highnesses the Prince and Princess of Wales fulfilled a number of engagements in connection with the medical and educational affairs of the city. On April 23rd, after having received the Freedom of the city the Prince and Princess drove to the University to take part in the graduation ceremonial and to inaugurate the new medical and natural philosophy departments. In the Bute Hall the proceedings opened by the Principal calling on the Dean of the Faculty of Law to present for the degree of LL.D. "certain persons," as the phrase goes, and first in the list of distinguished recipients came the name of the Prince and Princess. The Prince stood patiently in front of the Chancellor as his long list of titles was read out to the assembly, and having been capped by the Chancellor and robed by the Bedellus, he shook hands with the Chancellor and resumed his seat. A similar ceremony was also gone through by the Princess. The LL.D. was also conferred on other distinguished persons, including the Lord Provost of Glasgow, Sir William Copland, Miss Galloway, Secretary of Queen Margaret College, Professor Jules Henri Poincaré, Sorbonne, Paris, Professor J. G. McKendrick, Principal Macalister, Professor Harnack, Berlin, and others. After the capping was over, the convener of the new buildings committee, Professor Gray, read a statement concerning the buildings, and thereafter the Prince of Wales delivered an address, in which he alluded to the vitality which the ancient seat of learning showed, and its prompt recognition of the development of scientific study and teaching required by the practical spirit of the age. Leaving the Bute Hall the Prince and Princess and the platform party then went directly to the new buildings in the immediate vicinity, and without further formality declared them open. Luncheon was served in the large laboratory of the natural philosophy department, and at its termination the Royal party left the university to fulfil other public engagements.

The Royal Infirmary.—On April 24th the Prince and Princess came into the city to lay the foundation stone of the new reconstructed Royal Infirmary. On their arrival they were received by the Lord Provost, who presented to them Mr. Hedderwick, chairman of the managers; Mr. McCowan, convener of Finance Committee; Dr. Neil Carmichael, convener of medical committee; Dr. Middleton, Dr. Barlow, and others. Mr. Hedderwick then read an address from the managers to their Royal Highnesses, and in reply the Prince of Wales said "The Princess of Wales and I thank you heartily for the kind welcome given us here to-day. When invited to Glasgow it was a special satisfaction to be asked to join this important undertaking—the reconstruction of the Royal Infirmary—for I sympathize with the progressive spirit of the citizens of Glasgow who realize that, notwithstanding the great work the institution has accomplished, it is now neither in construction nor equipment capable of meeting the medical and surgical requirements of to-day. I congratulate Glasgow on its decision to make this reconstruction a memorial of our late beloved Sovereign Queen Victoria. We are gratified by your kind tribute to the interest taken by the King, the Queen, and my family generally in the welfare of the sick poor. Every year's experience on the work of our hospitals, so nobly supported by voluntary aid and by the gratuitous services of those most eminent on medicine and surgery impresses one with the vital importance of guaranteeing to the public, through whose liberality these enormous institutions are maintained, that they are administered in a business-like system. Before proceeding to lay this foundation stone I beg to commend this splendid work to all who can afford assistance in raising the large sum still necessary for the completion of the scheme." His Royal Highness then, in the usual form, declared the stone to be well and truly laid. The ceremony concluded by a prayer by Dr. Donald Macleod. Afterwards the Royal party were conducted over the Electrical Pavilion by Dr. Macintyre and Dr. Riddell. Amongst other novelties shown them was a gramophone record of the voice of a patient who had undergone an extensive operation on the tongue. On their departure a cheque for £100 from the Prince was handed to Mr. Hedderwick.

CEREBRO-SPINAL MENINGITIS.—This disease is still prevalent in Edinburgh and Leith, 35 cases having been intimated in Edinburgh during April, and 31 in March. Although not excessively numerous, the mortality among the cases has been very great; probably over 90 per cent. In Leith the Public Health authorities have isolated the meningococcus from the noses of contacts, and accordingly these have been isolated in a reception house, and are having their noses and throats disinfected. The sudden drop in the number of cases notified within the last month is believed to be due to this system of controlling persons belonging to infected households.

POST-GRADUATE WORK IN EDINBURGH.—The resuscitated post-graduate course held in Edinburgh last year met with so large a measure of success that it will be repeated in an extended form this September. Last year the course lasted for three weeks; this year it is proposed to be divided into two courses of a fortnight each, the second supplementary to the first, yet each more or less complete in itself. In certain of the classes the members will be limited—diseases of the blood (elementary and advanced), bacteriology (elementary and advanced), gastric methods, pathological methods, opthalmoscopy, refraction, diseases of the throat and ear, and X-Ray work, and for these an additional fee of 1 guinea will be charged. Otherwise, the composite fee for the month is 5 guineas, for either fortnight 3 guineas. The course this year will be a very complete one, and the time-table has been so arranged that no clashing will take place. Dr. Edwin Bramwell, 3, Drumsheugh Gardens, will again act as honorary secretary, and Mr. Stirton, University New Buildings, as secretary of the course.

BELFAST.

PUBLIC HEALTH PROSECUTIONS.—A secondary effect of the Health Commission is seen in a remarkable activity in the Public Health Department in instituting prosecutions for breaches of the by-laws. One of the chief complaints against the department for years past has been their apathy in prosecuting offenders, so that the by-laws relating to public health were simply scoffed at by those whose interest it was to infringe them. Last week in the Summons Court three cases of this sort were heard. In the first a milk vendor was summoned for milking a cow, "his hands not being thoroughly clean and free from all infection and contamination." The defendant said he had never heard of the regulation, which was no doubt quite true, for few people have done so, but he promised future attention to it, and was let off with a fine of 10s. and costs. In the second case another milk vendor was summoned for failing to take reasonable and proper precautions in conveying milk for sale. This was the first prosecution aimed against a practice common in Belfast—that of collecting kitchen refuse from houses where milk is delivered, and taking it off in the milk cart, as food for pigs. It is, of course, a most objectionable plan, and one often sees tubs and buckets piled high with disgusting rubbish, among the milk cans. The magistrate said that it was most important that persons distributing milk should distribute it from carts on which there was nothing but milk. If there was refuse it might directly or indirectly lead to contamination. The practice must be stopped, and the case against the defendant would be adjourned for four weeks to see if there was any repetition of the offence. In the third case, the River Plate Fresh Meat Company, Ltd., which has branches in various parts of the city, as well as in England, was summoned for exposing for sale putrid sausages, and was fined £10 and costs.

CEREBRO-SPINAL MENINGITIS.—During last week there were 36 cases of this disease notified, and 24 deaths, bringing the total cases up to 337, with 227 deaths. In Purdysburn Fever Hospital there are at present 107 patients, of whom 43 are cerebro-spinal meningitis, and ten out of the twelve deaths which occurred there during last week were from that cause.

THE HEALTH COMMISSION.—The Commission has resumed its sittings, and has begun to hear evidence on the water supply. A report will be given next week.

LETTERS TO THE EDITOR.

MILK AND TUBERCULOSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is gratifying to me to know that "A Family Doctor" has found my letter "interesting and even amusing." Where the amusement comes in he does not tell us. To my mind, the matter is much too serious to have an amusing side, however presented. It is to "the practical point of view" that I have desired to call attention, and to keep it fixed.

While I admit that "it is probably correct that 'live' tubercle bacilli can be conveyed in milk," I not only seem to suggest, but do actually maintain, that "although milk thus (said to be) infected may be partaken of in any quantity, the danger of setting up tuberculosis in those fed upon it is never to be regarded seriously."

I ask "A Family Doctor," as I asked before, to refer me to a solitary case in which there was even a probability that tuberculosis had been conveyed by milk, and unless he can do so I have a right to say that the idea is a pure assumption. A case was reported in Belgium where a young lady in a school was said to have contracted tuberculosis by drinking the milk of a tuberculous cow kept on the premises. But it was promptly disavowed on the discovery that the pupils did not consume any of the milk of this cow. In reply to this question, I do "hold the same opinion with regard to milk containing (it is said) the contagion of typhoid fever." Will he answer this question? What is the contagion of typhoid fever? I anticipate his answer, viz., the bacillus typhosus. Does he not know that in the case of the Maidstone epidemic (King's Lynn also) not one solitary bacillus was found, although the most experienced bacteriologists were engaged in the search for it? Does he not know also that many epidemics have been recorded in which it was "impossible to accuse the water supply?" I refer him to special report upon the very serious epidemic which broke out among the reserve troops of the United States during the American-Spanish War. In the first instance, the Army medical officers attributed it to the water supply, but a Special Commission proved that this was impossible. It would occupy too much of your space to give the most concise epitome, and I must refer him to the report published in the *British Medical Journal* some time back. I presume "A Family Doctor" holds that milk containing the contagion of typhoid fever could only do so by the addition of what he would call infected water. The *contagion* of typhoid fever has yet to be discovered.

If we have not yet attained to a "scientific demonstration of the entire sequence of contributory causes, and of the mode of attack in tuberculosis," how are we to adopt means "to prevent the dissemination of the poison"? He admits the effect of "contributory causes," but I presume he is of opinion that there is one *essential* cause, viz., the tubercle bacillus, and that without it there can be no tuberculosis. Does he not know that the tubercle bacillus has never been found in the early stage of the disease, and that it is not found in the sputum until necrosis has set in? Moreover, it is often absent from the sputum in the last stage of pulmonary tuberculosis.

Perhaps "A Family Doctor" will be good enough to give us his views as to how the cow gets tuberculosis. Until he gives us his explanation, I refrain from trespassing further on your space.

I am, Sir, yours truly,
Geo. Granville Bantock.

April 27th, 1907.

"THE TOOTH-BRUSH IN SCHOOLS."

To the Editor of The Medical Press and Circular.

Sir,—I do not pretend to judge of the way in which other special subjects are dealt with in your paper; but I find always that your editorial utterances upon dental questions are based upon scientific knowledge and inspired by common sense. This is eminently the case in your paragraph under the above heading in your last issue. It is amazing to see the amount of neglect which teeth of first rate structural quality will bear without injury, whilst no amount of care will save from early destruction teeth the enamel and dentine of which are imperfectly formed and calcified. If, by the use of the tooth-brush, especially with soap or some simple antiseptic tooth powder, children of the poor can be made to keep their mouths clean, some good may be achieved; but the efforts of sanitarians ought to be mainly directed to improvement of the general physique. Rickets is the cause of early tooth decay in a vast proportion of poor children. The teeth are dermal, not osseous appendages, and their destruction in rickets is perhaps due as much to the foul state of the mouth, which always accompanies the disease, as to the inferior quality of the dental tissues, which is also always observable. Rickets is virtually always due to improper food and feeding. If, therefore, mothers were taught, and made able to suckle their offspring for the proper period; and if they were taught, and made able to feed their children properly during the first five years of their lives, much of the tooth degeneration now prevalent would be put an end to. It must be always borne in mind that enamel and dentine once fully formed are physiologically unalterable, and that the exteriors of the crowns of all the permanent teeth being fully calcified by the fifth year, no treatment directed to improvement of the tissues can be of any avail after that age has been passed.

I am, Sir, yours truly,
A Hospital Dentist.

London, W. April 25th, 1907.

RAILWAY DUST, DIRT, AND DARKNESS.—WHY?

To the Editor of The Medical Press and Circular.

Sir,—May I, as a medical man, trespass upon your space to state a case and to propound a query?

1. I live near Victoria Station and have relatives residing near the Crystal Palace.

2. On Sundays I frequently journey to the station nearest to my relatives, which happens to be on the L.B. & S.C. suburban line—about midway between Victoria and London Bridge Stations.

3. The journey from Victoria is on Sundays so unspeakably depressing that I elect to travel *via* District Railway from Victoria to Monument Station, cross London Bridge, and proceed from the station of that name to destination.

4. Travelling second class, I seat myself in one of the damp, dark, dusty, dirty, deplorable dens, misnamed compartments.

5. Before the train crawls out of London Bridge Station, I invariably sneeze and continue sneezing until New Cross is reached. Next day there is sore throat—of course.

6. Why should these things be?

Will *you*, Mr. Editor, cast your X-ray light upon this problem and earn the lasting gratitude of

Yours ever,
Idris ap Harrby.

London, S.W.,
St. George's Day, 1907.

[The bacteriology of the railway carriage is by no means exhausted. Anyone with a sensitive nasal membrane travelling on the particular line mentioned is apt to learn that pathogenic organisms are constant travellers in its cars. Perhaps some of our readers may be able to offer some satisfying suggestions to our correspondent. A good deal might be said about the political side of the question, and the slothful ways of monopolist and non-competitive companies; but that lies somewhat outside the scope of a medical journal.—Ed. M.P. & C.]

OUR CLIMATE.

To the Editor of The Medical Press and Circular.

Sir,—It is of the greatest importance that when we are discussing the climate of any district we should look carefully into the nature of the soil—that is, into its geological character. I was surprised at the way in which the late discussion of the Balneological Society seemed to show great ignorance of this matter. The variations in the atmospheric differences between the East Coast and the West of England depend on the character of the soil, more than upon anything, and it would be well if those who are interested in climatology would study geology more carefully than they are doing.

I am, Sir, yours truly,
Robert Lee.

Pwllheli, North Wales.

OBITUARY.

JOHN PICKERING BATES, M.R.C.S. (England).

On April 21st, there died at his residence, near Morpeth, Dr. John Pickering Bates. Receiving his early education at the Grammar School of King Edward VI., he chose medicine as his profession, and pursued his studies in both the Edinburgh and London Schools, qualifying M.R.C.S. in 1855. At South Shields he pursued for many years a successful and influential practice, among the public appointments he held being that of police surgeon. On retiring into private life, he returned to his native town, for which he had ever a deep affection. Dr. Bates was a student in other lines than those specially pertaining to his profession. He was well read in the histories of ancient empires and civilisations; and took a keen interest in antiquarian subjects. He had travelled much in Europe and also in the north of Africa, and had a special liking for the recent discoveries of the Egyptologists, not a few of which he had visited.

Towards the end of last summer it became known that Dr. J. E. Brooks, of Colwyn, is to be presented with a beautiful silver tray on the occasion of his retiring from practice in that town.

Dr. John Carswell, who was shot with a revolver and severely wounded by a man named William Purves in Duke Street on Tuesday afternoon, is making satisfactory progress. His injuries, however, are more severe than was at first believed.

NEW BOOKS AND NEW EDITIONS.

The following have been received for review since the publication of our last monthly list :—

- Appleton, Sidney (London).
  - Diseases of the Lungs. By Robert H. Babcock, A.M., M.D. Illustrated. Pp. 809. Price 25s. net.
- Arnold, Edward (London).
  - A Handbook of Skin Diseases and their Treatment. By Arthur Whitfield, M.D., F.R.C.P. Pp. 320. Price 8s. 6d. net.
- Bailliere, Tindall and Cox (London).
  - Ulceration of the Cornea. By Angus Macnab, B.A., B.Sc., &c. Illustrated. Pp. 196. Price 5s. net.
  - The Diagnosis and Treatment of Pulmonary Consumption. By Arthur Latham, M.A., M.D., F.R.C.P. Third Edition. Pp. 260. Price 5s. net.
  - Manual of Anatomy, Systematic and Practical, including Embryology. By A. M. Buchanan, M.A., M.D., &c., &c. Vol. II. Illustrated with 631 drawings, coloured and plain, mostly original. Price 12s. 6d. net.
  - Treatment by Hypnotism and Suggestion, or Psychotherapeutics. By C. Lloyd Turkey. M.D.Aberd. Fifth Edition, revised and enlarged. Pp. 418. Price 10s. 6d. net.
- Cassell and Company, Limited (London).
  - First Lines in Midwfery. A Guide to Attendance on Natural Labour for Medical Students and Midwives. By G. Ernest Herman, M.B. Lond., F R.C.P. New edition. Pp. 222. Price 5s.
  - Diseases of Women (A Clinical Guide to their Diagnosis and Treatment. By George Ernest Herman, M.B., F.R.C.P. Illustrated. Pp. 900. Price 25s.
  - Worry: The Disease of the Age. By C. W. Saleeby, M.D., F.R.S. Pp. 312. Price 6s.
- Churchill, J. and A. (London).
  - On Diseases of the Rectum and Anus. By Harrison Cripps, F.R.C.S. Third Edition. Illustrated. Pp. 588. Price 10s. 6d. net.
  - Cancer of the Rectum : Its Surgical Treatment. By Harrison Cripps, F.R.C.S. Fifth Edition. Pp. 255. Price 5s. net.
  - Nursing, General, Medical and Surgical. By Wilfred J. Hadley, M.D., &c., &c. Second Edition. Pp. 370. Price 3s. 6d. net.
  - Lectures on Medicine to Nurses. By Herbert E. Cuff, M.D., F.R.C.S., Fifth Edition. Pp. 269. Price 3s. 6d. net.
- Heinemann, William (London).
  - Metabolism and Practical Medicine. By Carl von Noorden, Professor of the First University Medical Clinic, Vienna. Vol. I.: The Physiology of Metabolism. By Adolf Magnus-Levy, Berlin. Vol. II.: The Pathology of Metabolism. By Carl von Noorden, Fr. Kraus, Ad. Schmidt, W. Weintraud, M. Matthes, and H. Strauss. English Issue under the Editorship of I. Walker Hall, Professor of Pathology, University College, Bristol. In three volumes. Pp. 452 and 525. Price £2 12s. 6d. net.
- Lewis, H. K. (London).
  - Police-Surgeon's Emergency Guide. By C. Graham Grant, L.R.C.P. & S. Edin. Pp. 77. Price 2s.
- Lippincott Company, J. B. (London).
  - International Clinics: A Quarterly. Edited by W. T. Longcope, M.D. Vol. I. Seventeenth Series, 1907. Pp. 318. Price 35s. net.
- Longmans, Green and Co. (London).
  - The Essential of Chemical Physiology. By W. D. Halliburton, M.D., LL.D., F.R.S. Sixth Edition. Pp. 258. Price 4s. 6d. net.
- Maclehose, James and Sons (Glasgow).
  - Eye Injuries and their Treatment. By A. Maitland Ramsay, M.D. Pp. 210. Price 18s. net.
- Macmillan and Co., Ltd. (London).
  - Inflammation: An Introduction to the Study of Pathology. By J. George Adami, M.A., M.D., F.R.S., Pp. 240. Price 5s. net.
- Philip and Son, Ltd., George (London).
  - Builders of the Body: Or Lessons on Food Values. By Eustace Miles, M.A., and Miss M. John. Pp. 179. Price 1s. 6d.
- G. A. Putnam's Sons (London).
  - Alcohol: The Sanction for Its Use. Translated from the German by Dr. J. Starke. Pp. 317. Price 6s.
- The Public Health Engineer (London).
  - The Disinfectant Value of Chlorine. By Eminent Specialists. Pp. 62. Price 5s. net.
- Schulze and Co., Otto (Edinburgh).
  - Letters on Psychotherapeutics. By Professor H. Oppenheim, of Berlin University. Translated by Alex. Bruce, M.D., &c., &c. Pp. 60.
- Spottiswoode and Co (London, E.C.).
  - The Dentists' Register: Printed and Published under the Direction of the General Council of Medical Education and Registration of the United Kingdom, pursuant to an Act passed in the Year XLI. and XLII. Victoriæ, Cap. XXXIII., entitled an Act to Amend the Law Relating to Dental Practitioners. 1907. Pp. 251. Price 3s. 4d.
- University Press (Manchester).
  - A Comparative Study of the Influence of Cod-liver Oil, and Cod-liver Oil Emulsion, upon the Nutrition of Normal and Tuberculous Pigs. By J. W. Wells, M.D., D.P.H., F.C.S. Pp. 83. Price 2s. 6d. net.
- Turney, F. S. (London).
  - The Cure of Cancer, and how Surgery Blocks the Way. By John Shaw, M.D., Lond. Pp. 229.
- Wright and Co., John (Bristol).
  - Invalid and Convalescent Cookery. By Mary E. Birt. Pp. 23. Price 6d.

At the meeting of the Limerick Guardians on April 18th, a letter was received from the Local Government Board stating that, in reply to a resolution of the Guardians asking for a sworn inquiry into the election of Resident Medical Officer of the Union, the Board were unable to accede to the request.

REVIEWS OF BOOKS.

HEWITT ON ANÆSTHETICS. (a)

Dr. Hewitt's book on Anæsthetics has already become so well known in its first and second editions, that we are sure there will be many to welcome this, the third, which not only embodies all that was best in its predecessors, but contains fresh and useful features besides. Of course it has been necessary to incorporate a new chapter on ethyl chloride, which has grown so rapidly in favour in the last few years, though oddly enough we learn that it was used in surgical practice as long ago as 1847. We rather gather that the author is not much attached to this drug, although he does not say so definitely. Indeed Dr. Hewitt throughout the book is rather cautious about committing himself to dogmatic statements, which is sometimes rather disappointing when one turns to an anæsthetist of his experience for specific guidance. But, on the other hand, this characteristic gives him the opportunity of setting forth the views and opinions of others the more impartially, and this he does scrupulously. There is a good deal of new work to record in connection with chloroform-anæsthesia, especially with regard to percentage-dosage and mechanical methods of administration, and here again we find Dr. Hewitt shrinking from the newer plan, though giving full and fair descriptions of the Vernon-Harcourt and other inhalers, both in their conception and in their construction. No doubt an experienced and skilled anæsthetist can keep his deaths from chloroform down to a very low point; but we have to remember that owing to the extent to which ether is used many men in general practice have comparatively little experience of chloroform-administration, and that the dangers of unconscious over-dosage are proportionately increased. No doubt, too, the inhaler at present made and used is not ideal; there are inconveniences and drawbacks of one kind and another, but can it be doubted that in these scientific times a type will some day be evolved which will come into universal use? One cannot believe that empirical dosage will eventually triumph over exact measurement. Fresh evidence is brought forward in favour of shock, especially of the circulatory variety, being due in many cases to surgical procedures, such as pulling on richly-innervated structures, during a condition of lowered blood-pressure, induced by chloroform-narcosis. These cases are not instances of chloroform-poisoning, the patient frequently being fully but not deeply under the anæsthetic, but of reflex inhibition of the medullary centres brought about by afferent impulses. The distinction is clearly shown by Crile's work, quoted by Dr. Hewitt. A good *resumé* of the subject of acid intoxication after anæsthetisation is also given, although the author himself has been fortunate in never having had a death from this cause. But though the question has only recently been brought into prominence, there is no reasonable doubt as to the actual occurrence of acetone-poisoning as an occasional sequel of anæsthetisation, at any rate with chloroform, and the possibility has to be borne in mind. The old features—the directions, the discussions, and descriptions—of Dr. Hewitt's book remain as good as ever, and the work is one of the standard authorities on its subject. It is noticeable that the author is styled "Physician-Anæsthetist to St. George's." Is this a sign of the times? If so, it is remarkable that while the obstretric physicians are becoming gynæcologists, physicians to the skin department, dermatologists, surgeons to the throat department—laryngologists, and so on, that the anæsthetist's nomenclature should be evolving in the opposite direction.

(a) "Anæsthetics and their Administration." By Frederick W. Hewitt, M.V.O., M.A., M.D.Cantab., Anæsthetist to His Majesty the King: Physician-Anæsthetist to St. George's Hospital, etc. Third edition, with illustrations. 15s. net. London: Macmillan and Co Ltd. 1907.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT SURGICAL LITERATURE.

Antitetanic Serum.—Terrier reports (*Revue de Chir.*, January, 1907) two cases of compound fracture in each of which the wound had been contaminated with earth and dung, and in which tetanus was feared, in each case 10 ccs. of antitetanic serum was injected within a few hours of the injury, in the first case seven days after the accident tetanus developed, the patient dying from it in three days; in the second case tetanus only developed eighty-seven days after the receipt of the injury, just as the wounds were healed up; this patient, after a protracted illness, recovered. These two cases show that one injection of 10 ccs. of the antitetanic serum is insufficient to prevent tetanus, though failure depends probably more on the state of the wound than on the amount of the injection. Septic wounds in which foreign bodies remain are specially favourable to the development of tetanus, hence the necessity for most careful cleansing of the wound. The writer recommends that in wounds suspected of being infected with tetanus, 10 ccs. of antitetanic serum should be at once injected beneath the skin, and a similar dose injected once a week until all danger of infection is over. The wound should be carefully cleansed and kept irrigated. In order to reach the lacerated nerve endings, though the toxin appears to enter the nerve sheath and so travel to the central nervous system, it is well to powder the wound itself with dry, pulverised antitetanic serum. G.

The Technique of Tendon Suture.—O. Frisch (*Wien. Klin. Woch.*, February, 1907). The best method of tendon suture is that introduced by Lange, called by him tendon weaving, beginning from the cut surface somewhat eccentrically, the needle and silk suture are passed in and out from one aspect of the tendon to the other over a length of several centimetres, it is then similarly returned down the other side and emerges parallel to its entrance, each thread is then woven up the other piece of tendon for a few centimetres, the ends are tightened and knotted. Great firmness is secured, as the strain is distributed over a considerable length of tendon, and the greatest strain is on that part furthest from the wound, and consequently in the soundest tissue. Exact adaption of the divided ends to one another is not difficult: there is only one knot, instead of several crowded together, an important point for the smooth working of the tendon. The suture is not easily loosened or extruded if local inflammation occurs, the firmness of this suture allows of early after-treatment, thereby adhesions are prevented. If several tendons are divided at about the same level, the sutures may be knotted alternately at the distal and proximal sides, so that the knots do not all lie together. As a gaping of the divided ends is no longer of consequence, the operation may be postponed until the danger that the wound was infected at the time of the accident has passed. The writer does not as a rule operate until after the fourth day. G.

Carcinoma of the Breast.—C. Ewald, in a note (*Zentralblatt fur Chir.*, April 6th) on the after treatment of cases of amputation of the female breast for carcinoma, calls attention to the difficulty many women experience after this operation in raising the arm on the operated side, sufficiently high to allow the hand to reach the back of the head, to get over this difficulty, the author has adopted the following plan with marked success:—As soon as the patient has recovered from the anæsthetic she is put sitting up in bed, to the head of the bed is attached an upright metal tube extending some three feet above the patient's head, it then bends at right angles, extending a similar distance beyond the side of the bed at which the affected arm lies. The patient's hand is now bandaged and straps pass from the hand, and are hooked on to the end of the bent metal rod, the supporting straps being of such a length that the arm is kept at right angles to the body. A second support is then passed under the patient's elbow and also attached to the metal head-piece; this makes the position easy and comfortable for the patient. The arm is kept in this position for three or four days, after this time it is let down several times during the day, until such time as the patient is allowed to leave bed altogether. In most cases by the end of the second week the woman was able to put her hand easily to the back of her head, and this without causing her any pain. Drainage of the axilla may have to be kept up rather longer than in ordinary, as the position of the arm makes it difficult to avoid leaving a cavity in the axilla which fills with either lymph or blood. In two years' experience of this method of after-treatment the author has had no bad results. G.

Rupture of the Colon Induced by Fæcal Impaction.—G. McCaskey records a case (*American Med.*, February, 1907) of a lady, æt. 42, who had for a long time suffered from constipation, and for some months past from severe pain in the region of the sigmoid, symptoms pointing to some obstruction, a laparotomy was done, but no narrowing of the bowel was found. This operation gave no relief, the pain continuing, and with this, violent peristaltic movements of the descending colon, small, hard fæcal masses came away from the rectum in the injections which were given daily, and the case was looked on as one of fæcal impaction. For two months her condition kept better; then suddenly one morning violent pain came on in the lower part of the abdomen, patient became collapsed, and died in three hours, there being no time to do an exploratory laparotomy. The *post mortem* examination showed a longitudinal tear extending from the upper part of the sigmoid up along the bowel for three inches; through this opening the colon contents had escaped into the abdomen causing intense peritonitis. A careful dissection of the colon below the tear showed a distinct narrowing of the lumen of the tube, amounting to a moderate stenosis, yet not sufficiently marked to allow of its being found during the previous operation. Above this obstruction was a hard fæcal mass, the rent had evidently been caused by the violent peristaltic movements of the bowel in trying to force this mass through the narrowed gut. There was no sign in the intestine of any induration or ulceration at the place where the bowel wall had given way; laceration probably occurred in connection with the direct and not with the reverse peristaltic contraction. G.

An Early Case of Formal Operation for the Separation of Jointed Twins (Xiphopagus).—Kieffe (*Med. Record*, April 6th, 1907) relates the history of a negro, æt. 66, which he has verified as being substantially correct. The patient's mother was captured and herded aboard a slaver for export to America. While in mid-ocean she fell in labour and suffered for nine days without being delivered. On the eighth day of her trial the slaver was seized by a Spanish corvette. On the following day the woman's condition was discovered, and the naval surgeon on board, José Brito y Boin, performed Cæsarian section, and removed a xiphopagus monster. Both were well-formed males and both were living. The mother died the same day. On the day of their birth the surgeon separated the two children. The patient's brother died in three days. One of the slave women acted as foster mother and reared the patient. The patient is at present under treatment for extensive keloid, which began in a scar over the sternum, marking the location of the fusing with his mate. When he was eight years old, in 1848, it had grown to such proportions that it was operated on and removed. The keloid reappeared in this locality, but never grew to be very thick. He has at present several other keloidal masses which appear to be becoming malignant. S.

Fracture Dislocation of the Spine.—Lloyd (*Medical Record*, March 23rd, 1907) points out that most fractures of the spine are fracture-dislocations. Fracture-dislocations resolve themselves into two classes: (1) Those in which the spinal cord is not injured, and (2) those in which there is more or less interference with the functions of the cord itself. For the first set of cases operative treatment would not be indicated in the beginning. The symptoms directly due to the fracture are those common to all fractures, but also the patient is unable to walk, and is markedly shocked. Local signs are usually unsatisfactory. When some slight irregularity of the spine is associated with marked tenderness on pressure—localised pain increased materially whenever the position of the patient is altered—or with fracture of the sternum, it is almost conclusive evidence of the localisation of fracture. The greatest care is necessary in making these examinations to avoid further injury. In these cases the author does not favour the application of plaster-of-Paris, unless there is marked mobility of the fragments, but thinks that the patient is better if placed in a horizontal position on his back, on a springless bed, and with sufficient extension and counter extension to compel him to remain in the dorsal position. Where there is marked mobility of the fragments, and it is difficult to keep the patient quiet, a plaster jacket should be applied. A much more complicated picture is presented when the spinal cord is involved. These cases are divided into three types: (1) Those in which the cord is crushed; (2) those in which doubt exists as to whether the cord is irremediably damaged; and (3) those in which it is fair to assume the cord is not irremediably damaged. Fracture of the spine with complete transverse lesion of the cord is accompanied by immediate relaxed motor paralysis involving the parts below the level of the lesion, with entire absence of rigidity, spasm, convulsive movements, or other irritative sign in the motor sphere. Partial injury to the cord, including the results of hæmorrhage, may be indicated by as lower onset of paralysis, by unilateral or irregular distribution, by the preservation, or comparative preservation of reflexes, and by rapid improvement. The author discusses operative treatment. If an operation be undertaken at once, there is danger of interference where a spontaneous recovery would result if the patient were left alone. If, however, operation is delayed too long, and a compression be allowed to continue a degeneration may result, which would be as serious as though the function of the cord had been destroyed by the original injury. In those cases where no improvement follows the recovery from shock, and yet a suspicion remains that there has not been complete crushing of the cord, operation should be immediately undertaken. Where the lesion of the cord is incomplete, and where symptoms of compression are extending, as evidenced by increased paralysis, etc., operation should be immediately directed to control hæmorrhage, inflammation thickening, or acute pressure, which are threatening to destroy the cord. In those cases where improvement is noted at first, but is arrested later, operation should be done as soon as it is settled that improvement has ceased. When paraplegia or other symptoms develop at a late date, after almost complete recovery under the usual conservative methods, this is probably due to the compression of callus and necessitates operative interference. It is essential, in order to secure success in operation to:—(1) To remove sufficient laminæ to absolutely settle the fact that there is no remaining compression of the cord; (2) to chisel off any projecting bone; (3) to remove all blood clots, whether extra-dural or intra-dural; (4) to look out for thickening and compression due to inflammatory processes. The author on two occasions of apparently complete transverse section of the cord, removed the pulpy mass and sutured the ends of the cord together. One patient lived three weeks, and the other ten months, but neither showed any signs of regeneration of the cord. S.

Gastroscopy.—Chevalier Jackson (*Medical Record*, April 6th, 1907) reports and illustrates eight additional cases (six cases having already been published) in which positive results have been obtained by his gastroscope. The author summarises the position of gastroscopy thus: (1) History: Gastroscopy has failed up to the present because no practical instrument has been devised. (2) Usefulness: It is useful for the detection and removal of foreign bodies in the stomach, the diagnosis of many pathological conditions, as inflammation, ulceration, scars, neoplasms, dilated vessels, and the treatment of at least one of these, namely, benign ulcer. It is a substitute for exploratory operation in many instances. (3) Results: The author has diagnosed by the gastroscope chronic gastritis 2, malignant disease of the cardia 2, of the pylorus 3, (in two of which a specimen was taken), peptic ulcers 5 (one of which was cured by direct applications). He removed a foreign body, and diagnosed gastric syphilis. (4) Limitations: Negative results are of limited value. (5) Anæsthesia by ether is preferable. (6) Dangers: In a patient with normal œsophagus and stomach the only danger is that of ether anæsthesia. An ulcer of œsophagus of stomach constitutes an exceedingly slight risk, unless the ulcer is on the point of perforation. In chronic inflammatory states no risk is incurred. (7) Any physician can learn to examine the stomach with a gastroscope. S.

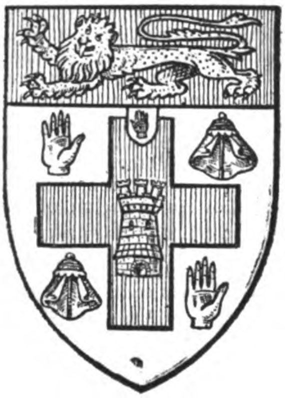
Enucleation under Local Anæsthesia.—On account of the possibility of the law of France being construed as holding a surgeon responsible for the death of his patient while under a general anæsthetic, unless its dangers have been explained beforehand, Terrien (*Arch. d'Ophthal.*, February, 1906) recommends the adoption of cocaine anæsthesia when possible. He has found it very suitable for the enucleating of the eye, and recommends the following method: A conjunctival anæsthesia is produced by two or three instillations of 4 per cent. cocaine or stovaine, adrenaline being used if the conjunctiva is inflamed. Over each rectus a sub-conjunctival injection of 1 in 150 is given, about 30 minims being used. At this stage, a hypodermic injection of morphia is made at some convenient spot. The conjunctiva and recti muscles having been gently divided, anæsthesia of the deeper parts is produced by injection of .5 c.c. of a solution of cocaine and morphine 01 each, stovaine and chloride of sodium each 02, sterilized water 5. Terrien uses an Anel's syringe with a blunt curved point for this last injection. After waiting some minutes the optic nerve may be divided and the operation finished. Cases of panophthalmitis are contra-indicated. M.

Dr. David B. C. Evans has been appointed resident assistant medical officer to Swansea Workhouse Infirmary.

Dr. Louis Corbett, Trinity College, has been appointed University lecturer in Pathology until Michaelmas, 1911.

Medical News in Brief.

Royal Augmentation to Shield of Arms.



In our last issue we referred briefly to the fact that the King had conferred upon Sir Frederick Treves and Sir Francis Laking the distinction of being permitted to use an augmentation of their arms, to which they are henceforth entitled to add one of the lions from the Royal Arms. Our readers will be interested to see that this honour is represented by the lion at the top of the shield.

Sudden Death of a Baronet under an Anæsthetic.

At Chelsea, on April 22nd, Mr. Luxmoore Drew held an inquest on the body of Sir Henry Leslie Huntington, who died at the Clock House, Chelsea, while under an anæsthetic. The deceased baronet was only 21 years of age. Sir Charles Huntington, the deceased's brother, who has now succeeded to the title, gave evidence of identification. Of late the deceased had good health, but he had grown too fast, though he was strong enough for field sports.—Dr. W. J. Frankish, of Sloane Street, said he would not call the deceased a strong man. He was 6ft. 3½in. in height, and was very much overgrown, especially of late years. The witness prepared him for the operation, and called in Dr. Hilliard to administer the anæsthetic. When the witness had made the first incision it was found that the deceased had stopped breathing and was changing colour. He, however, regained his colour and the breathing went on, but before the operation could be completed his pulse stopped, and the breathing became shallow. Artificial respiration was resorted to, but death occurred in a few minutes.—Dr. Spilsby, pathologist at St. Mary's Hospital, said that on making a post-mortem examination he found fatty degeneration of the walls of the heart with a little dilatation. That was a very unusual thing in the case of a young man. He also found enlarged abdominal glands, an enlarged spleen, and enlargement of the tonsils and lymphatic glands. The condition of deceased was known as status lymphaticus or lymphatism. That was a condition which had only recently engaged the attention of pathologists in this country, but was better known in Germany. It would not be recognisable during life, but persons subject to it seemed to be specially liable to sudden death from trivial causes. In this case death was due to syncope.—By the Coroner: Does this reveal a new danger in the administration of anæsthetics?—The Witness: Yes.—Dr. Hilliard was recalled, and said he had heard of the condition described by Dr. Spilsby, and if it were sufficiently marked to be noticeable in life of course an anæsthetic would not be administered.—The Coroner: But many people may be walking about with this condition undiscovered?—The Witness: Yes.—A verdict of death by misadventure was returned.

Famous Surgeon Drowned.

Scientific men in Austria are deeply grieved at the tragic death of Hofrath and University Professor Albert von Mosetig, one of the most prominent of Vienna surgeons. Professor von. Mosetig had not appeared for two days either at his house or at the hospital clinic under his direction. On April 26th, in the Danube meadows, some clothing was found, which was recognised as his, and witnesses say that on April 25th he jumped or fell into the water near the spot where the clothing was discovered. The cause of this sensational occurrence is enveloped in mystery. Professor von Mosetig made many discoveries in surgery, and his works are known to surgeons all over the world. In scientific circles he was known as having first employed iodoform in surgery.

Medical Treatment of Indian Women.

The annual meeting of supporters of the North India School of Medicine for Christian Women was held at Exeter Hall last week, Dr. J. L. Maxwell presiding. The committee reported that the Punjab Government had given a substantial grant, proportionate to the number of students, with an extra grant for students entering after passing a University entrance examination. Sir Charles Rivaz, the Lieutenant-Governor, had paid a visit of inspection to the school and hospital at Ludhiana; and the inspector-general of civil hospitals, Colonel Bate, had given valuable assistance. The principals of mission schools for girls were urged to help in supplying suitable students. Dr. Anna M. Fullerton reported that 46 out of 55 graduates were now actively engaged in medical work, 36 of them in connexion with 12 missionary societies.

Instructions in Military Medical Organisation.

In consequence of the success which, in the West of London, attended the movement for initiating the formation of an organised Army Medical Civilian Reserve, it is proposed to hold another class this summer. The instruction will be given by specially experienced officers of the Royal Army Medical Corps at a convenient place for medical men residing in the metropolis. The importance of this class is increased by the certainty that trained civilian medical co-operation will have to form a part of the organisation of the new "Territorial Army." Gentlemen desirous of joining this class are requested to send in their names to the acting Hon. Secretary, Mr. Herbert Chambers, 101, Goldhawk Road, London, W.

Effects on Health by the Adulteration of Wines and Spirits

An important conference was held in London on Monday last at the Institute of Hygiene, of medical men and others interested in the suppression of adulteration. Sir Wm. Bennett, K.C.V.O., F.R.C.S., presided and remarked that although opinions were divided as to the necessity of alcoholic beverages, there could be no question that when used they should be pure. Dr. Fredk. J. Smith proposed that "the adulteration, substitution, and misrepresentation of wines, spirits, and beer affects the health and strength of the people, especially in connection with its tendency to induce a craving for drink, and that the Local Government Board, licensing and other authorities, be called upon to take such steps as are necessary to prohibit the sale of liquors which are not what they profess to be and the medical profession be appealed to, to exert their influence to prevent their consumption." This resolution was seconded by Dr. Wm. Ewart and carried unanimously. Several further resolutions of a similar character, especially in regard to so-called medicated wines, were also passed, and it was decided to submit the same to the Prime Minister and to the President of the Local Government Board.

The Nutrient Value of Plasmon.

In an action brought last week by the International Plasmon Syndicate against MacSymons, Limited, to recover damages for alleged libel, Dr. Robt. Hutchison, the well-known authority on food and dietetics, stated in evidence that he had analysed Plasmon, and had found it most nutritious and sustaining. Considering what Plasmon was, he could not conceive that it could be anything else than health sustaining, containing as it did a large proportion of protein, which was a tissue-forming substance. Dr. Passmore, confirming this view, said that he had been acquainted with Plasmon as a food since 1899. It was all made out of milk. A pound of Plasmon contained as much nutrition as 27 pints of milk, and as much protein as a half-pound of steak. Ultimately the jury returned a verdict for the plaintiffs with damages £100 and costs.

PASS LISTS.

Royal College of Physicians of London.

The following candidates, having passed the final examination in medicine, surgery, and midwifery of the Examining Board in England, the Licence of the Royal College of Physicians of London has been conferred upon them, viz.:—George H. Adam, Frederick O. Arnold, B.A.Cantab., Hugh T. Ashby, B.A.Cantab., Philip H. Bahr, B.A.Cantab., Harold J. Beddow, B.A.Cantab., Richard C. P. Berryman, John Birch, Robert E. Brayne, Robert D. Brown, Josiah Browne, Charles W. G. Bryan, Martin B. S. Button, L.S.A., Harry V. Byatt, B.A.Cantab., William J. Chapman, M.D., C.M.Toronto, Percy, J. Chissell, Spencer Churchill, B.A.Cantab., Edward B. Clayton, B.A.Cantab., Horace C. Colyer, L.D.S.Eng., Percival S. Connellan, Paul A. Creux, Timothy H. Davies, Arthur H. T. Davis, Herbert E. T. Dawes, B.A.Cantab., George Denholm, M.B., B.S.Durham, Arnold T. Densham, Horace Dimock, B.A.Cantab., Maurice M. Earle, Howard R. Elliott, Carlton A. Ellis, William A. Fairclough, M.B., Ch.B., John H. Farbston, Marmaduke Fawkes, Norman Flower, B.A.Oxon, William E. L. Fowler, Claude H. S. Frankau, William D. Frew, L.D.S.Eng., Percy C. Garrett, Harold Gibson, William S. Gibson, L.S.F., Alexander S. Graham, George Graham, B.A.Cantab., William R. Greening, Frederic W. W. Griffin, B.A.Cantab., Robert E. V. Hale, B.A. Cantab., H. McCormick Hanschell, Robert N. Hartley, Lionel C. Hayes, Arthur W. Hayward, Charles E. K. Herapath, George A. F. Heyworth, B.A.Cantab., Walter de Marchot Hill, Hendrik Houwink, Henry O. Howitt, M.D., C.M. Richard de Silva Illesinghe, L.M., Charles G. Jarvis, M.D.Paris, Richard S. Jenkins, William G. Jones, L.D.S., Alexander J. Kendrew, Solomon Krestin, M.D., B.Sc., Malcolm Leekie, Harold H. Leeson, William S. Leicester, B.A.Cantab., Richard L. Ley, B.A.Cantab., Conrad Loddiges, William Lovell, L.S.A., Frederick B. Lowe, M.R.C.V.S., James B. Macalpine, M.B., Ch.B., Colin F. F. McDowall, M.B., B.S.Durham, Charles G. McGreer, M.D., Eric L. Marchant, M.B., Ch.B., William B. Martin, John H. Mayston, Brian B. Metcalfe, Henry L. Morgan, Edgar L. R. Norton, Henry S. Ollerhead, Arthur O'Neill, Gerard L. Parsons, Basil T. Parsons-Smith, Walter Patey, Stanley Paulin, M.B., Charles Pemberton, Edward C. Pope, Otto C. W. Prausnitz, M.D., Geoffrey Price, John L. Rankine, John A. Renshaw, Kenneth Robinson, Cecil F. Rumsey, L.D.S.Eng., Alfred L. Sachs, M.A.Cantab., Leslie St. Vincent-Welch, John Selfe, Edgar A. Shirvell, Arthur L. Singer, William F. Skinner, L.S.A., Francis G. Snoad, Edward C. Sparrow, B.A.Cantab., Lionel D. Stamp, Frank Standish, George Stone, Arthur A. Straton, Joseph R. Sutherland, M.B., Ch.B.Glasgow. Ronald E. Todd, Sohrab S. Vazifdar, L.M., Charles E. Waldron, John L. Walker, M.D., C.M., Norman H. Walker, B.A.Cantab., Harry G. Webb, Henry B. Weir, B.A.Cantab., Harrie B. Wickham, Joseph W. J. Willcox, Cecil L. Williamson, Lorton A. Wilson.

The Royal University of Ireland.

The following candidates have passed the M.B., B.Ch., B.A.O. Degrees Examination:—

Upper Pass.—Charles R. Harvey, Rowland Hill, B.A., John J. Kearney, Victor J. McAllister, Richard V. Slattery, B.A., O'Connell Sullivan, John P. Waters, B.A.

Pass.—James Barrett, John W. Beirne, John A. Boyd, Daniel Boylar, George F. Campbell, Nicholas M. Donnelly, Francis T. Dowling, B.A., Jane M. Fulton, William McKee, Charlotte E. Mitchell, Jerome B. Murphy, B.A., Joseph Nunan, Patrick O'Hart.

The following candidates may present themselves for the further examination for Honours in the groups set after their names:—Charles R. Harvey (Medicine, Surgery, Midwifery), Rowland Hill, B.A. (Medicine, Midwifery), John J. Kearney (Medicine), Victor J. McAllister (Medicine, Surgery, Midwifery), Richard V. Slattery, B.A. (Surgery), O'Connell Sullivan (Surgery).

The M.D. Degree Examination.—Robert J. Bethune, M.B., B.Ch., B.A.O., Michael J. O'Flynn, M.B., B.Ch., B.A.O., Henry E. S. Richards, M.B., B.Ch., B.A.O.

The M.Ch. Degree Examination.—Cecil B. F. Tivy, M.B., B.Ch., B.A.O.

The following candidates have passed the Second Examination in Medicine:—

Upper Pass.—*James Byrne, John Cullen, *Arthur V. J. Harrison, William S. Haydock, *Henry C Malcolm, *Walter Mooney, B.A., David V. S. Willis Those marked with an asterisk may present themselves for the further examination for Honours.

Pass.—James S. Bellas, Patrick J. Campbell, John J. Dennehy, Blanche G. C. Griffin, Michael J. Hackett, Jeremiah Holland, Thomas H. Houston, George E. Hull, Melville C. Irwin, John L. Jackson, Barkley McCullough, B.A., Patrick McGinnis, Thomas C. McMurray, Patrick J. Mockles, Henry C. Mulholland, Arthur F. N. Mullane, Patrick F. Murphy. Michael J. O'Connor, William H. O'Grady, William F. O'Regan, William Prendwille, Thomas W. Ruttledge, Walter Stevenson, Robert W. Vint, John F. Walsh, Hill W. White, Timothy Woulfe.

Percy M. J. Brett is exempt from further examination in Anatomy and Physiology.

The Stewart Scholarship in Medicine has been awarded to William W. D. Thomson, Queen's College, Belfast.

Cambridge University.

Dr. Barclay Smith has been appointed to examine in human anatomy for medical degrees for the remainder of the year, ending November 1, vice Mr. A. Macalister, who is unable to examine.

The following candidates have satisfied the examiners in both parts of the sanitary science examination:—E. J. Brown, J. B. Cook, Catherine Fraser, F. H. G. Hutchinson, D. C. Kirkhope, C. H. Lindsay, D. McKail, P. Mackessack, J. S. New, W. G. Parker, J. C. Robertson, J. B. Smith, A. N. Stevens, F. E. Stokes, and T. M. Strang.

Royal College of Surgeons in Ireland.

A Meeting of Fellows will be held on Tuesday, May 7th, at 4.30 p.m., pursuant to the provisions of the Supplemental Charter, for the Election of Examiners.

"Graduates of any University which may be from time to time recognised by the College shall be eligible for election as Examiners in the subjects of General Education. All the other Examiners shall be Fellows or Licentiates of the College, or Professors or Lecturers in any School of Medicine recognised by the College. Persons engaged in private teaching are not eligible to be Examiners."

Conjoint Examinations in Ireland.

The following candidates have passed the Second Professional Examination of the Royal College of Physicians and the Royal College of Surgeons, held during April, 1907:—

H. Gray (with Honours), A. M. T. Blake, A. G. Bennett, J. P. Egan, J. M. Gage, H. Hunt, T. Murray, J. T. O'Boyle, J. J. O'Connor, J. G. O'Mahony, J. Patton.

Royal Colleges of Physicians and Surgeons, Ireland.

The following candidates have passed the Third Professional Examination:—A. L. Clarke, B. W Farrell, J. Farrell, J. P. Grainger, C. Greer (Victoria Australia), J. Humphreys, C. Macauley, J. C. Murray M. Power, M. J. Saunders, A. Sheridan, C. Stringer.

Society of Apothecaries of London.

The following candidates, having passed the necessary examinations, have received the L.S.A. diploma of the Society entitling them to practise medicine, surgery, and midwifery:—H. A. Fenton, C. S. Spencer, F. A. K. Stuart, and W. V. P. Teague.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Binder.—There are several common varieties of domestic fly. The chief are *musca*—the common house-fly; *Bucentes Ceneoubatus*, a blood-sucking fly, commonly found in the house; the stable fly, which is bred in dung—especially in stables—and bites man and horses. It too is frequently found in the house.

PASSING OF THE MEDICAL PROHIBITION BILL.

This measure, the object of which is to stop derelicts of the profession from joining commercial companies which persistently evade the Medical and Dental Acts, passed the second reading in the House of Lords on Monday night.

Serum.—One of the earliest, if not the very earliest, attempt to provide scientific instruction for the people was that made at Manchester in 1866, when Sir Henry Roscoe, Dr. T. Alcock, Professor Stanley Jevons, and Dr. J. E. Morgan gave a series of evening lectures on Chemistry, Zoology, and Physiology. Upwards of 4,000 people attended these courses, a charge of a penny being made for admission. The audiences were composed of people of the class for whom the lectures were designed, and the attention given is described as having been remarkable.

M.B., Ch.B.—Certainly it is possible to treat congenital phimosis without operation. The difficulty in drawing back the prepuce is due to adhesions of the contiguous mucous surfaces. Frequently these can be broken down by a probe gradually inserted and worked round between the prepuce and glands. Great care must be taken not to enter the meatus. After repeating the process several times at short intervals, the prepuce can generally be drawn back, and the need for the operation consequently vanishes.

Mr. J. Baer is thanked for his note on Cerebro-Spinal Meningitis. So far as we are aware Professor Symmers is the first to have succeeded in the cultivation of "the meningo-coccus for many generations." The serum of the Berne Bacteriological Institute, is well-known and appreciated in this country.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 1st.

Obstetrical Society of London (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Mr. J. Bland-Sutton, Dr. Lewers, Dr. M. Thorne, and Dr. Lowgridge. Short Communication:—Dr. C. R. Porter (introduced by Dr. R. Andrews): Case of Fatal Rupture of the Bladder during Labour. Paper:—Dr. A. Doran: A Case of Malignant Vaginal Polypus Secondary to an Adrenal Tumour of the Kidney.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. A. H. Tubby: Clinique. (Surgical). 5.15 p.m.:—Lecture:—Dr. P. Stewart: Migraine.

North-East London Post-Graduate College (Tottenham Hospital, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, MAY 2nd.

North-East London Clinical Society (Tottenham Hospital N.).—4 p.m.: Discussion on the Use of Posture in Surgical Treatment (opened by Mr. H. W. Carson).

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. E. Clarke: The Fundus Oculi in Health and Disease (with lantern slides).

North-East London Post-Graduate College (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

FRIDAY. MAY 3rd.

Society for the Study of Disease in Children (11 Chandos Street. Cavendish Square, W.).—5 p.m.: Clinical Evening for the Exhibition of Cases, followed by Discussion. Patients in attendance at 4.30 p.m.

Epidemiological Society (11 Chandos Street, Cavendish Square, W.).—8.30 p.m.: Paper:—Dr. A. K. Chalmers: Some Recent Manifestations of Cerebro-spinal Meningitis.

West Kent Medico-Chirurgical Society (Royal Kent Dispensary).—Presidential Address:—Mr. C. J. Heath: The Duty and Power of Restoring the Hearing when Operating for Chronic Suppuration of the Middle Ear.

Laryngological Society of London (20 Hanover Square, W.).—5 p.m.: Exhibition of Cases and Specimens.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. B. Harman: Clinique. (Eye.).

North-East London Post-Graduate College (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

Wandsworth Union Infirmary, St. John's Hill, near Clapham Junction.—A Male Junior Assistant Medical Officer. Salary £100 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Lewes Dispensary and Infirmary and Victoria Hospital.—Resident Medical Officer. Salary £120 per annum, furnished apartments, board, coal, gas, washing, and attendance. Applications to the Hon. Secretary.

Berry Wood Asylum, Northampton.—Junior Assistant Medical Officer. Salary £150 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

West Bromwich District Hospital.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to Honorary Secretary T. Foley Bache, Esq., Churchill House, West Bromwich.

Rochdale Infirmary.—House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to the Hon. Sec., R. W. Shaw, Esq., Moss House, Rochdale.

Camberwell.—Parish of St. Giles.—Assistant Medical Officer at their Infirmary, Brunswick Square, Camberwell. Salary £120 per annum, with apartments, board, and washing. Applications to Charles S. Stevens, Clerk to the Guardians, Guardians' Offices, 29 Peckham Road, S.E.

Cuninghame Combination Poor-house, Ayrshire.—Medical Superintendent. Salary £300 per annum, with house, fuel, light, vegetables, and laundry work. Applications to Wm. Gray, Secretary, 5, Montgomerie Street, Ardrossan.

North Stafferdshire Infirmary and Eye Hospital, Hartshill, Stoke-on-Trent.—House Physician. Salary £100 per annum, with furnished apartments, board, and washing. Applications to the Secretary and House Governor.

Alnwick Infirmary.—House Surgeon. Salary £120 per annum, with furnished apartments, attendance, coals, and gas. Applications to Wm. T. Hindmarsh, Honorary Secretary of the Alnwick Infirmary, 26 Bondgate Without, Alnwick.

Bradford Children's Hospital.—House Surgeon.—Salary £100 per annum. Applications to C. V. Woodcock, Secretary.

Johannesburg Hospital.—House Physician and House Surgeon. Salary £300 per annum, with board and lodging. Applications to Ronald P. Mackenzie, M.B., C.M., D.P.H., Superintendent, Johannesburg Hospital, Johannesburg.

West Riding Asylum, Wadsley, near Sheffield.—Fifth Assistant Medical Officer. Salary £140 per annum, with board, &c. Applications to the Medical Superintendent.

Appointments.

Briscoe, James R., M.R.C.S., L.R.C.P.Lond., Junior House Surgeon at the Great Northern Central Hospital.

Brown, A. Carnarvon, M.R.C.S., L.R.C.P.Lond., Senior House Surgeon at the Great Northern Central Hospital.

Doble, F. Carminow, M.R.C.S., L.R.C.P.Lond, Junior House Surgeon at the Great Northern Central Hospital.

Faulder, T. Jefferson, M.A., M.B., B.C.Cantab., F.R.C.P.Eng., Honorary Assistant Surgeon to the Throat Hospital, Golden Square, W.

Gunn, R. M., M.B., B.S.Aberd., Senior House Physician at the Great Northern Central Hospital.

Hutchinson, F. A. Stewart, M.D., B.C.Cantab., M.R.C.S., L.R.C.P. Lond., Honorary Assistant Surgeon to the Sussex Eye Hospital Brighton.

Lavington, Cyril C., M.B., B.S.Durh., Out-patient Physician to the Bristol Royal Hospital for Sick Children and Women.

Matheson, R. Murdoch, M.D.Edin., F.R.C.S., Clinical Assistant to the Royal Victoria Hospital for Consumption, Edinburgh.

Milburn, Oscar, M.R.C.S., L.R.C.P.Lond., Junior House Physician at the Great Northern Central Hospital.

Parsons, George Gooden, L.R.C.P.Lond., M.R.C.S., L.S.A., Medical Officer for the Workhouse of the Westbury and Whorswelldown (Wiltshire) Union.

Stevenson, Howard, M.B., B.Ch.R.U.I., F.R.C.S.Irel., Assistant to the Professor of Surgery, Queen's College, Belfast.

Births.

Barnes.—On April 26th, at 455 Mansfield Road, Sherwood, Nottingham, the wife of R. G. Barnes, L.R.C.P., L.R.C.S.Ed., L.F.P.S. Glasg., of a daughter.

Cox.—On April 24th, at Anderton, near Plymouth, the wife of H. P. Cox, M.R.C.S., L.R.C.P., of a daughter.

Crabtree.—On April 13th, at Furneux Pelham, Herts, the wife of E. F. Crabtree, M.R.C.S., L.R.C.P., of a daughter.

Gaman.—On April 26th, at Caistor House, Caistor, Lincolnshire, the wife of F. R. S. Gaman, M.R.C.S., L.R.C.P., of a daughter.

Sedgwick.—On April 23rd, at 95 Richmond Road, Kingston-on-Thames, the wife of H. R. Sedgwick, M.B., B.C., of a son.

Wilgress.—On April 24th, at 45 Cheriton Road, Folkestone, the wife of J. H. F. Wilgress, M.B., B.C., of a daughter.

Marriages.

Craigie—Monkhouse.—On April 25th, at St. Bartholomew's Church, Bobbing, Kent, the Rev. John Alexander Craigie, M.A., son of the late John Craigie, Esq., M.D., C.B., to Mary Eleanor Maria Monkhouse, daughter of the late William Thomas Monkhouse, Esq.

Fernie—Harding.—On April 24th, at St. Mary's Church, Stafford John Firth, third son of Edward Fernie, M.D., of Stone, Staffs., to Catherine Middleton, eldest daughter of John Harding, Stone, Staffs.

Hazell—Dalgleish.—On April 27th, at St. George's Cathedral, Capetown, Frederick Hazell, M.R.C.S., L.R.C.P.Lond., to Edith Haynes, third daughter of the late William Dalgleish, of South Hampstead.

Death.

Wilson.—On April 26th, at Denham House, Goldhawk Road, London, Enid May, youngest daughter of James Wilson, M.D., aged two years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, MAY 8, 1907. No. 19

NOTES AND COMMENTS.

Imperialism and Medicine. THE visit of the Colonial Premiers has naturally re-awakened that sentiment of affection for the Colonies which as a rule slumbers so heavily that some occurrence out of the ordinary is needed to bring it to activity. All parties in the State are united in the pleasure of welcoming the representatives of their kinsfolk, and each tries not to obtrude its politics too much lest it should hurt the feelings of the other. But it is inevitable that the words "Empire" and "Imperial" should be on everybody's lips, whatever may be the precise meaning implied by the different persons using them. It has struck some folk that as the British Medical Association is applying for a Charter, this would be a happy moment to change its name from the domestic one by which it is known to the high-sounding designation of the "Imperial Medical Association." Indeed, the advocates have not confined their arguments to their medical brethren, but have even overflowed into the ordinary daily journals to find sympathy with their proposal. If their desire in changing the name be to please the colonists, we fancy that they are mistaken, as the colonist feels his proudest title and nearest link with the old country coincides with the word "Britisher," and anything more at variance with the spirit of medicine, which is catholic, cosmopolitan, and world-wide, than to introduce any idea of imperial exclusiveness, it is difficult to conceive. Medical men of course have their own individual political views and aspirations, but the spirit of medicine is quite apart from and vastly superior to the passing political phases of the moment, and in its common and indiscriminating regard for all, irrespective of nationality, birth, or wealth, medicine should be quite untrammelled by imperial or national associations.

Cerebo-Spinal Fever and Secrecy. A CURIOUS statement, attributed to Dr. Gordon, has been widely circulated during the last few days, namely, that a new treatment for cerebro-spinal fever had been discovered, but that it is of a "confidential nature." This he is reported to have said in evidence before the Belfast Health Commission, and the remark was followed by an offer to put some of the substance, which appears to be a bacterial derivative, at the disposal of the health authorities in that town, if they care to give it a trial. Now in this world it does not do to be as harmless as a dove without being at the same time as wise as a serpent, and we can imagine what misunderstandings are likely to be raised by interested parties if it goes forth to the world that some secret serum, vaccine, or other "pestilential juice" is being injected into the veins of the innocent children of Belfast. Moreover, the idea of any secret remedy being used for treatment is against the traditions of the profession and, if the health authorities are to use this method of treatment, the nature of what exactly they are employing should be revealed to them and their *confrères*.

Vaccination Bill. WE suppose it is impossible to grumble at Mr. John Burns' new Bill substituting a statutory declaration of conscientious belief that vaccination would be harmful to the child's health, for the present personal appearance of the parent before a magistrate. When the conscientious objector was first brought on to the stage, Mr. Balfour purposely made his progress a little difficult in order that the merely idle or careless parent might not take advantage of the privilege in order to save himself trouble in nursing or looking after the child. The conscientious objector was admittedly an impossible person to argue with or to convince, and the easiest administrative method of getting rid of him was thought to lie in giving him his way without more ado than was absolutely necessary. But the magistracy throughout the country, stirred to righteous indignation against the perversity of these individuals, have made their path as thorny as possible, and by so doing have certainly done vaccination an ill turn, for they have given the grievance something to feed on, and have kept alive the spirit of discontent; whereas had the certificate been granted with business-like despatch the anti-vaccinationists would have had no cause to grumble. It is now pretty clear that the action of the magistrates was a mistake, and the new Bill is the natural sequence of it. But the temptation to evade primary vaccination will now be correspondingly greater.

Paying the Substitute. AN extraordinary case involving the interests of a medical man was tried towards the end of last month in the South Shields County Court. The guardians of that place employed as medical officer to one of their districts, Dr. Drummond, who had held the position for twenty-five years. Last year they suspended him from duty because his assistant, a qualified man recognised by the Local Government Board, had seen a larger proportion of the patients than usual, the reason for which was that there happened to be a number of cases of sickness in the vicinity of his (the assistant's) house. Dr. Drummond appealed to the Local Government Board, who very properly ordered the guardians to reinstate him, which of course they were bound to do. Now during the period of suspension, the guardians had employed another doctor whom they paid at twice Dr. Drummond's rate of salary, and when the latter was reinstated they actually had the effrontery to deduct half the amount payable to him towards the expense of this compulsory substitute. He therefore brought an action against them for the return of the sum, and for once in a way the judge gave the clerk who appeared for the guardians a smart dressing-down. He asked if the defence seriously put forward as the reason why they refused to pay the plea that Dr. Drummond had not fulfilled the duties which they would not allow him to fulfil, and characterised it as a "most extraordinary idea." Finally, he gave judgment for the plaintiff with a special order as to costs and counsel's fee. In this case at least we may congratulate Judge O'Connor on perspicacity and good sense.

Tests for Drunkenness.

WHEN giving evidence before the Police Commission last week, Mr. Plowden, in recounting the difficulties of a police magistrate's life, said that many of his troubles would be relieved if medical men would agree on some common sign of drunkenness. We pity Mr. Plowden from our hearts, but he must know well enough that the difficulty is not with the medical men but with the law. It is impossible to frame a law that will define what degree of alcoholic intoxication amounts to punishable drunkenness, and the evidence of drunkenness must rest entirely on a medical man's judgment. All poisons are variable and affect different persons differently, and every "test" for drunkenness from "British Constitution" to "toeing the line" is only *ballona d'essai* at the best, and is liable to be vehemently disputed by the defence. Magistrates would find the complexity of their task in such cases considerably lightened if they discarded the shibboleth of tests and relied on the testimony of an experienced police-surgeon. The reproach, let us repeat, is with the law and not with medicine.

LEADING ARTICLE.

MR. HAFFKINE AND THE INDIAN GOVERNMENT.

THE British Empire, which sways the destinies of a great proportion of the population of the world, is naturally vexed with many problems arising from the complexity of conditions existing among her Crown colonies and dependencies. The results are seen on every hand in the grotesque and often incongruous patchwork of laws and of administration that figures under our flag both at home and abroad. A limited Parliamentary franchise in the United Kingdom, for instance, stands side by side with adult suffrage in New South Wales. The jealously guarded civic magistracy of our insular system, again, stands out in vivid contrast from the wide and autocratic powers vested in Indian magistrates, who as a rule combine civil with military functions. Of all incongruities, however, there is perhaps no single one more apparent than that involved in public health. The value and sacredness of man's life have attained such an exalted place in the estimation of our modern humane Government, that the occurrence of a few extra deaths from enteric fever in any Little Peddlington village is followed by official investigation and report from the Local Government Board. On the other hand, in India, with its two hundred and ninety millions of inhabitants, the Government appears to view with resigned indifference deaths from a purely preventable disease like plague at the rate of many thousands a week. Professor Ronald Ross states that in the nine years up to the end of 1905, more than 4,000,000 deaths from bubonic plague occurred in our Indian Dependency, and quite recently Professor Simpson said that 20,000 deaths were occurring weekly from the same cause. These facts constitute a severe indictment against British sanitary rule in India. Dr. Ronald Ross, at any rate, does not blink matters in his recent letters to *The Times* about Mr. Haffkine's prophylactic serum and the Mulkowal disaster. He maintains that the whole story of the plague in India in recent years illustrates the disregard for science that often stamps British administration. Though plague had been raging in Hong Kong for two years before the outbreak in Bombay, the Indian authorities nevertheless appear to have organised no system of sanitary intelligence, to have investigated few of the cases, and to have equipped themselves with no adequate bacteriological and other indispensable preventive machinery. History has taught us that this disease, which for centuries devastated Europe, can be ousted by the influences of an average standard of sanitation. The great plague of London never recurred, because the contributory precedent conditions were not reproduced after the Fire of London. In modern times the whole question has been brought under the control of science by the isolation of the specific bacillus by Kitasato and Yersin during the Chinese epidemic of 1894. The supreme outcome of a curative serum has not so far reached us from the medical bacteriologists, in whose hands the future conquest of disease to a great extent unquestionably rests. On the other hand, the immunisation of persons who have been exposed to the infection in a plague-stricken district has been given to the world by the brilliant researches of Haffkine. There can be no question as to the prophylactic efficacy of his sterilised bouillon culture of the *bacillus pestis*. India has reason to be proud of

Haffkine, who in this particular matter of the prophylactic serum has proved himself worthy of a place among the great benefactors of the human race. For all that, he has been called upon to face the whips and scorns of fierce contemporary criticism, because, forsooth, one of his serum bottles was contaminated by tetanus bacillus, probably long after it had left his laboratory, and a handful of deaths from lockjaw ensued. The Indian Government, whose incompetent sloth and indifference had led to 4,000,000 preventable deaths, appear to have left Haffkine, the one man in all the world who has shown the way to scientific salvation, to public reprobation. Rather should the Government have erected statues of brass throughout India in honour of his great achievement. It is not the way of British Administration, however, to bestow recognition of that kind upon civilians, especially in India, where military methods reign supreme. The authorities in that country have still to learn that disease must be fought by scientific men and not by soldiers. The results of their mistaken policy are writ large in the terrible mortality from preventable disease that has always drained the life-blood of British population, civil and military, in that great dependency. It is recorded in more lurid characters in the millions of natives that are sacrificed year by year to visitations of a similar kind. Some day, possibly, the British Government will adopt a wiser and more humane view of their responsibilities towards the bodily welfare of the people who are subject to our rule. Meanwhile, we may safely trust the Secretary of State for India to take efficient steps for the protection of Mr. Haffkine and for the furtherance of his prophylactic work. In this hope we are strengthened by the recollection that Mr. John Morley is himself a medical man, and it is mainly to that profession that we must look for the ultimate banishment of plague, pestilence, and disease generally from off the face of the earth. The life-work of men of the stamp of Haffkine will do much to hasten the day of that most desirable millenium.

CURRENT TOPICS.

King Edward's Hospital Fund Bill.

It is with extreme regret that we notice that the Council of King Edward's Hospital Fund are pushing forward their Bill for incorporation in spite of the general feeling of disapproval expressed by the profession through its organs. The Fund aims at becoming absolutely autocratic and irresponsible, even more so than it is at present, whereas such a body should essentially be representative of subscribers, hospital authorities, and the medical profession. The powers sought are at variance with every principle valued by a free and democratic country, and the most unhappy part of all is that this authority is to be vested in the Prince of Wales, who will thereby incur all the odium which action by the Fund may excite at any time. The proposed constitution is the last that should be sought, and the Prince of Wales is the last person who should have been chosen to be the responsible officer under such a constitution. The Royal Family should be kept strictly out of all controversial matters and should never be made, even in appearance, the stalking-horse of individual interests. The present Bill has been passed through the House of Lords up to its third reading, and is being taken as an unopposed measure. We hope some sturdy Commoner may be found to oppose it when it goes to the Lower House, as the Bill jeopardises not only all the hospital interests of London, but is liable to bring the Prince of Wales, through his benevolence, to occupy an invidious position. The subject was fully dealt with in the Medical Press and Circular of January 23rd last.

Domestic Compensation and Hospital Patients.

The advent of the extension of workmen's compensation to domestic service raises many points with regard to medical practice. So far as the general practitioner is concerned, we have already advised him to fix a uniform fee to be charged for all consultations involving compensation claims, whether to the master or servant. Medical men in hospitals, both of the salaried and of the honorary staff, will be wise to form some plan of dealing with these cases. Otherwise the medical profession will find itself taken advantage of on all sides by solicitors and their clients who wish to get medical evidence free. Hospital authorities, and hospital residents, too, will do well to make up their minds that under no circumstances will information as to the nature of accidents or sickness be given in compensation cases without adequate fees. In point of fact, the proper course would be to exercise the rights of a medical witness in Court, and to demand prepayment of fees before giving any evidence whatever. Without such precaution those who give evidence in cases which are settled out of Court will run the risk of getting no fees at all. In important cases an endeavour will doubtless be made to secure the testimony of the assistant or full honorary surgeons or physicians, who doubtless will demand fees as expert witnesses.

The Proposed Registration of Plumbers.

The proposal to register plumbers compulsorily has been before the public for some time. It has been actively advanced in London by the wealthy and powerful City Company of the Plumbers, who naturally wish to resume and extend their authority over the trade in question. There is much to be said on both sides of the matter, and it would be well for all concerned to inform themselves of the various issues involved before committing themselves to any scheme of the kind. The Edinburgh Public Health Committee recently declined an invitation from the Worshipful Company of Plumbers of London asking the Corporation to authorise a representative to take part in a proposed deputation to the Local Government Board "with the object of seeking recognition and support in securing the

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lated to excite strenuous opposition. We think
the Division might have gone further, and asked
that the case in favour of demanding a Charter
at all should be made out before proceeding
to discuss the terms of any particular Charter.
Charter without a very careful system of checks
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Should Medical Men have a Day of Rest?

Possibly one of the wisest of the world's dispensations has been that which provides man with a seventh-day rest. Prehistoric man in all likelihood first learned the lesson, since crystallised in the famous classic phrase which intimates that even Achilles cannot always stretch his bow. Of all sorts and conditions of men, members of the medical profession come nearest to that impossible feat, for they work early and late, week in and week out. Nor is there any possibility of the State coming to their aid with an Eight Hours Bill, unless, indeed, it would be possible at the same time similarly to restrain within a time limit the matronly labours whereby the population is recruited to an average and a progressive level. Of all classes that minister to the welfare of mankind, the medical man deserves most tender consideration, for the health not to say the lives of the community lies in the hollow of his hand. As things go, he is for the most part overworked and underpaid; he is exposed to the unfair competition of quacks and quackery of all kinds, notwithstanding that the State has compelled him to undergo a long and costly education, and after granting him a licence to practise, fences him in with a thousand-and-one iron-bound regulations. Most medical practitioners make some sort of a living, but few stumble on fortune, and the general experience is that of the old song, inasmuch as "they work all day for too little pay." There can be little doubt that if anyone deserves a Sunday rest it is the hard-working medical practitioner. In some parts of the Continent, the profession has agreed to nominate a weekly batch of their brethren for Sunday duty, while the others enjoy a well-earned rest. Last week in Paris the proposition was seriously discussed whether a double fee should not be charged for Sunday visits. That practice is already unofficially in vogue in some parts of the United Kingdom, nor is it easy to see how it could be at all strenuously opposed by a community that recognised the necessity of maintaining a proper standard of health and energy among their medical attendants. Granted some plan for dealing with pressing sickness and emergencies, there is no clear reason why medical men should not have, at any rate, an occasional Sunday to themselves.

Practice by Companies.

The reception in the House of Lords of Lord Hylton's Bill for the Prohibition of Medical Practice by Companies, was distinctly encouraging, and we hope that the Earl of Crewe's statement of the views of the Government may be taken as forecasting the granting of facilities for getting the Bill through the Lower House. As he put it, the Bill is designed to meet what nearly approaches a public scandal. By a defect in the law it has been possible for those who could not individually practise as physicians or surgeons, to obtain freedom so to do simply by registering themselves as a company. If the Bill pass into law this evasion will be prevented, and the formation of companies for the purpose of medical practice will be prohibited. As Lord Crewe explained, the measure is somewhat drastic, prohibiting all medical practice by companies, even where the company would employ legally-qualified practitioners to carry on the practice. His lordship's remarks showed a proper appreciation of the personal relations subsisting betewen medical man and patient, and of the desire of the better class of medical men that such personal relations should continue. We trust that every exertion will be used to pass into law Lord Hylton's Bill, as well as the similar measure prohibiting dental practice by companies.

PERSONAL.

H. R. H. the Prince of Wales has graciously consented to take the chair at the dinner of the National Association for the establishment of sanatoria for workers suffering from tuberculosis, to be held on Tuesday, May 14th, at the Hotel Cecil, London.

At a meeting of Barry Parish Council, on April 26th, the resignation of Dr. Paton, who had held the office of medical officer for the northern district of the parish for the long period of thirty-one years, was submitted and accepted.

Dr. Archibald, the assistant medical officer of Glasgow, who contracted cerebro-spinal meningitis, is making progress, and it is now confidently expected that he will make a good recovery.

Three lectures on the pre-historic and early historic inhabitants of England will be delivered before the Royal College of Surgeons of England on May 6th, 8th, and 10th at 5 p.m., by Mr. William Wright, M.B., D.Sc., F.R.C.S.

Dr. Frederick Taylor has been elected a representative of the Royal College of Physicians of London on the Senate of the University of London in place of Dr. W. H. Allchen, whose term of office has expired.

From Paris the death is announced of Dr. Paul Poirier, the well-known surgeon. Dr. Poirier was Professor of Anatomy at the Faculté of Paris.

Inspector-General H. M. Ellis, Director-General of the Navy Medical Department, has been unanimously appointed first President of the newly-formed "United Services Medical Society," to which reference is made in our "News" column of present issue.

Dr. Frederick Taylor has been unanimously appointed consulting physician to Guy's Hospital on his retirement from the acting staff. Dr. Lauriston E. Shaw is promoted to fill the physiciancy, and Dr. A. F. Hertz has been appointed an assistant physician.

Dr. M. J. McQuoid, of Ballyjamesduff, has been appointed to the Commission of the Peace for the County of Cavan.

The Wightman Lectures of the Society for the Study of Disease in Children, will be delivered on Friday, May 17th, in the rooms of the Medical Society of London, at 5 p.m., by Dr. Frederick Taylor, the subject being "Pneumonia in Children."

During the past fortnight seventy-one cases of epidemic cerebro-spinal meningitis have been notified in Glasgow as against eighty-one in the previous two weeks, while the deaths have fallen from sixty-three to fifty-nine.

A CLINICAL LECTURE
ON
THE USE AND ABUSE OF SKIAGRAPHY IN FRACTURES AND DISLOCATIONS. (a)

By JOHN POLAND, F.R.C.S.Eng.,

Senior Surgeon to the City Orthopædic Hospital, London; Senior Surgeon to the Miller Hospital, Greenwich.

One is often asked whether skiagraphy has afforded us generally a clearer knowledge of fractures, a better diagnosis, and, consequently, better and more efficient methods of treatment. To each and all of these questions I can unhesitatingly answer in the affirmative, provided that a proper and scientific observation has been made.

I hope to be able in this lecture to point out some of the uses and abuses of this method of diagnosis.

Without the increased experience in technique which we now possess, and with the many abuses with which the earlier days of the Röntgen process was beset, and which I am sorry to say too often still exist, the use of skiagraphy must assuredly be more harmful than useful. Any practitioner can set up an X-ray apparatus with a Crookes' tube and fluroscope, and use it. But there will always be a field for an X-ray specialist who can always be available and competent in the use of the X-rays for every class of case beside fracture—one who has a wide knowledge of anatomy and is skilful in the proper interpretation of skiagrams. Such a person must necessarily be a qualified medical man. It is monstrous to suppose that all this can be efficiently performed by an unqualified chemist. Yet everywhere we still see advertised in chemist's shops, hydropathic establishments, at instrument makers, and in other places that an X-ray apparatus is on the premises and available for their customers. The abuse of powerful apparatus in hands such as these will be apparent to you all. Yet medical men are not blameless in this matter; they still send their cases to chemists, instrument makers, &c.

I strongly advocated this view of the matter many years ago—soon after the Röntgen method was first used. At that time I was asked the following questions, among others, as to the establishment of an X-ray department in the hospital of a very large and important provincial town:—

1. Should not the hospital have the apparatus necessary to apply the Röntgen rays to the patients therein, many of whom are men engaged in large works in the district and who constantly meet with accidents?
2. Can an ordinary medical man in the borough properly use it?
3. What is the cost of a first-rate apparatus?
4. If the medical man cannot use the apparatus, can a competent photographer use it?

What, I replied, was: *First*, In short, that a photographer was certainly incompetent as was also an electrician, unless the latter was under the supervision of a medical man, and did only the manual or operative work; and *Second*, That there were always excellent medical men in every district who could readily acquire the proper technique, and that a post for the medical man should be created at the institution, which was especially one for the diagnosis and treatment of fractures and other injuries and urgent cases. I think you will agree with me that these replies hold equally good at the present day.

In the first place, as to the use of the X-rays in *Clinical Diagnosis*. Fractures are no longer—or should no longer be—mistaken for dislocations, sprains, or severe contusions, and *vice versa*, although pain and swelling exist in all these conditions. However, Lynn Thomas (*British Medical Journal*, May 5th, 1906) has given us some startling limitations of the usefulness of the X-rays, especially with regard to the treatment of fractures. In his opinion the rays are of no value in modifying the ordinary methods, and to form a correct diagnosis they are, in nearly all cases, unnecessary. One is almost persuaded on reading the conclusions he draws up that it is a great misfortune that the rays were ever discovered, at any rate, so far as these injuries which we are considering to-day are concerned. He only admits that in a few cases they may be of value in clearing up a doubtful point, but says, "the evidence afforded by X-rays is deceptive, misleading, and should only be submitted to and acted upon by those who understand their value." To the last part of the paragraph all must agree; but with regard to his other conclusions, I cannot imagine that he has many sympathisers.

I am sure that the Röntgen method has established a clearer and more extended scope in our diagnosis, and, as a consequence, our methods of treatment are daily becoming much more definite, less severe, less complicated, although it must be admitted that they are rendered wider in range and more exacting on the care and attention of the surgeon; indeed, already in many instances our methods of treatment have become most exact and perfect and are carried out with great precision.

Mere palpation, although most serviceable in detecting the various signs of fracture or dislocation, cannot—even when combined with large experience—do now, and could not do in the past what we now accomplish with the assistance of the X-rays. Skiagraphy must be employed in fractures by every conscientious and careful surgeon, however great may be his skill in diagnosing these lesions by the older methods. I cannot do better than repeat what I stated in 1901:—"The use of the X-rays does not supersede the ordinary methods of clinical diagnosis; it supplements them in a most valuable way, especially where great swelling of the soft parts exists. It makes the presence of a fracture clear where otherwise doubt might exist." It is now common knowledge that many fractures of the carpus, phalanges, metatarsus, and elbow joint were almost entirely unknown before Röntgen's discovery.

INTERPRETATION OF SKIAGRAPHS.

All of us as surgeons are quite cognisant of the normal characteristics of bones and joints as seen by the naked eye, but it is quite another thing in interpretating skiagraphs, where we have to consider only shadows. These shadows are often printed as a permanent record of the shortcomings of the surgeon, but this I will allude to later on. These shadows can be distorted to any extent, and will vary according to the distance of the sensitized plate from the bones and according to the position of the tube. Take the hip joint, for instance. If the tube be placed below the joint, the shadow of the neck of the femur will give the appearance of considerable deformity, whilst the pelvis itself appears to be considerably distorted.

The shadow of a bone is an entirely different thing from a photograph or from the naked eye appearance of the same bone. Therefore the interpretation of shadow is unquestionably more difficult than that of a photograph. If we could always compare the shadow of a normal bone in the same position as that of an abnormal shadow of an injured bone, our task would be lighter; but, unfortunately, no one has yet attempted a complete skiagraphic atlas of the whole body. Probably the task is too immense for any individual worker. To render the interpretation of skiagraphs easy, and to avoid as much as possible distortion of the parts, Mr. Chisholm Williams has suggested the following points :—

(a) Delivered at the Medical Graduates' College and Polyclinic, Wednesday, March 20th, 1907.

1. That there should be certain points on the human subject over which the anode should be placed, and that on the skiagraph a small mark should denote the position of the anode.

2. That the distance from the tube to the plate or film should never be less than 18 inches.

3. That in the lower extremities they should be placed at a right angle with a line drawn between the two anterior superior spines, and that the spine be absolutely at right angles to this also. In the case of one hip joint being fixed in, say, adduction, then the sound limb should be placed at a right angle.

4. In the upper limbs, for the shoulder-joint the arm should make with the mid-line an angle of 45°, and the hand rest with the palmar surface downwards. The opposite sound parts should always be shown for comparison, taken, of course, under exactly the same conditions. In the elbow-joint the internal condyle being on the film, the anode should be placed over a point about an inch below the external condyle in the line of the forearm. This is for the purpose of opening up the joint as much as possible.

5. For the trunk, it should be placed as symmetrical as possible, and in the case of the neck vertebræ I have found the best position is with the occiput well over the end of the film or plate, and the chin high up, exactly in a straight line with the sternal notch.

Now what are the conditions where we find the X-rays of great importance? I would enumerate them as follows :—(1) Sprains. (2) Fractures accompanied with great swelling. (3) Fractures and dislocations about joints. (4) Fracture with great displacement. (5) Separations of the epiphyses. (6) Ununited fractures.

Take first of all that large class of injuries called *Sprains*, which were formerly regarded as a laceration of a ligament of a joint or other soft tissue. We now know by the X-rays that these usually comprise a detachment of a small fragment of bone. Indeed, a large number of sprains should be classed under the heading of fractures, and, of course, have appropriate treatment. I maintain that, fracture of a small portion of bone being so often co-existent with sprain, all cases of sprain should be examined by the X-rays. How often in the past has the complication of fracture in sprains been undetected on account of the absence of the supposed characteristic sign of crepitus? Very often the complication of fracture is only revealed some time after the receipt of the injury and its treatment by the doctor, the patient consulting some non-medical radiographer to the discomfiture of the surgeon.

In sprains of the phalanges of the finger, this undetected complication is very frequent.

A French surgeon has lately discovered by means of the X-rays that a fracture of one or other of the smaller metatarsal bones occur in soldiers on the march. The injuries had been previously considered as sprains.

The value of the X-rays where *Immense Contusion and Swelling* from rupture of superficial vessels leading to complete obliteration of every bony prominence, is very great. A complete and satisfactory examination by palpation in such cases is quite impossible. One good instance of this occurred in the early days of the X-ray. A young man had fallen off his horse and injured his elbow. An eminent surgeon who was called in by the doctor to see the case was quite unable to make a diagnosis, and rather discountenanced the use of the rays. However, the practitioner on his own responsibility took an X-ray picture, which revealed a complete dislocation backwards of both bones at the elbow. An anæsthetic was at once given and the dislocation reduced with a most favourable result.

In the case of fracture the very fact of severe contusion and swelling might, as of yore, tempt the surgeon to make attempts at reduction and cause displacement where none existed, were it not for the knowledge obtained by the X-rays. The X-rays, having no consideration for any amount of swelling, reveal the simple condition of affairs in the injured bone and instruct us that no manipulations are necessary, and a simple splint or dressing is applied.

The study of *Injuries to the Epiphyses* in children and youths entails an accurate knowledge of the normal ossification of the bones as seen by the naked eye; but also more especially of ossification as seen by the X-rays. As regards the ossification of the hand, I have endeavoured by my "Skiagraphic Atlas of the Hand and Wrist" to give a complete account of this latter process.

In the early days of the Röntgen era, the non-recognition of the unossified or partially-ossified epiphyses failing to produce a shadow, led to many deplorable mistakes.

I hope not to be thought egotistical when I state that I was the first (in February, 1906) after the introduction of the X-rays in this country, to point out the importance of skiagraphy as an aid to the diagnosis of epiphysial lesions in children. I then described and figured (*British Medical Journal*, March 7th, 1906), the case of a boy, æt. 17, where the X-ray photograph confirmed the diagnosis of a separation of the distal epiphysis of the metacarpel bone of the index finger. I also drew attention to the great importance of obtaining skiagraphs of certain forms of recent complicated injuries to the epiphyses in children.

You will agree with me that my remarks over eleven years ago, were justified, and that we are now fast gaining this knowledge of these important injuries.

However, there is a very important class of injuries in which skiagraphy does not help us; in fact, the negative findings of this method of examination may lead to disastrous results. I allude to *Epiphyseal Separations without Displacement.* I have drawn attention to it elsewhere.

Common situations of this form of injury exist at the lower end of the radius, and lower end of the femur. I show you a skiagram of one of these latter injuries in which backward displacement of the femoral epiphysis has subsequently taken place. The absence of diagnosis and consequent neglect of treatment are liable to be followed by arrest of growth of the bone. This absence of treatment I have shown to be the most frequent cause of interference with the proper growth at the epiphyseal junction.

TREATMENT OF FRACTURES.

Accurate apposition of the fragments being the most serious item in the treatment of fractures, the X-rays give us the greatest assistance. The bringing of the fragments of the bones into apposition under the X-rays in recent fractures is an important step. In this way the surgeon can see as well as feel whether the bones are in position. It is only, however, in a few situations that this method can be satisfactorily employed, because of the difficulty in carrying the patient to the X-ray department with all the necessary apparatus for fixation of the fragments. At the shoulder, elbow, and wrist this method is particularly useful. The Röntgen process cannot, however, always determine the *cause* of the displacement or rotation of the fragments of the bone, although it often gives us valuable points in the display of comminution of fragments of the broken ends, or of the rotation of one or other fragment or rotation of a separated epiphysis. It cannot show us the hindrance to reduction, through muscular spasm, or the interposition of muscle, periosteum, or other soft structure between the fragments. Still, recently, with improved technique, these interposed tissues have been detected in some instances.

If the interposed material be a small portion of bone, the method, of course, is of value.

All fractures should be taken by the X-rays after being "set." The stereoscopic method should, if possible, be always employed. Indeed, this method is becoming quite popular, and will be more so in the future, more especially as the requisite extra apparatus is very inexpensive.

It is easy to watch the position of the fragments and to rectify it, if malplaced, as far as possible during the process of consolidation.

Even after an operation on the bones, as well as before, I may here remind you that a little overlapping of the fragments may look very bad in skiagrams. Such skiagrams have been produced in the Law Courts as evidence of want of skilful treatment. The overlapping frequently does not affect the functional result in the least, so that perfect functional results may be obtained, although the findings of the skiagraphs in no way agree with this.

In malposition of the fragments in *old fractures*, the Röntgen rays enable us to make a complete diagnosis of the anatomical conditions and to work out our operative measures exactly. This method is especially useful in deformed oblique fractures of the femur and at the malleoli of the ankle, where, in the latter, we are able to resect a wedge from the diaphyseal ends and correct the deformity.

Passing now to a few of the *Medico-Legal aspects* of the Röntgen method. In a fracture in the neighbourhood of a joint the displacement may be slight, and the practitioner look upon the injury as not particularly severe; but the X-rays would have shown him that the fracture is really intra-articular or comminuted—a very different condition from the patient's point of view. Contrast this with another case of simple fracture with displacement further away from the articulation, which may be easily reduced and rapidly get well without untoward result. The patient would contrast the adverse results in the first case, supposing the intra-articular lesion undetected by the X-rays, with the favourable result in his neighbour's case treated by another practitioner, and we see the beginning of much criticism on his part.

So many skiagraphs have lately been produced and admitted in evidence in Courts of Law in suits for damages after accidents and in cases of malpractice, that I should like to add my protest against the custom as it obtains at present. The Southern *v.* Lynn Thomas and Skyrme case last year was a case in point. The skiagraphs in that case showed that even under most favourable conditions some overlapping of the fragments very frequently persists, but that this faulty position in very many respects does not interfere with the ultimate results in a strong and functionally useful limb. Fortunately in this country we have not had the frequent charges of malpractice or claims for damages in Courts of Law which occur in the United States of America and on the Continent. Yet these actions at law, based, upon the abuse, as I must call it, of the X-rays, have become sources of annoyance and financial loss to surgeons. There are some solicitors only too ready to act in collusion with X-ray offices conducted by electricians or photographers or others.

The remedy is in the hands of the surgeons, as I have hinted at the beginning of my lecture. The X-rays may show a fracture when none exists, or fail to show a fracture which is clearly manifest by clinical signs. This latter is rare except, as I have mentioned above, in epiphyseal separations. Again, the deformity from a fracture may easily be exaggerated to an enormous extent. It is also well to remember that in recent fractures in which union has taken place with formation of good callus, the condition presented is often indistinguishable from that of non-union of a fracture on account of the non-deposition as yet of the lime salts.

I am not one of those who entirely question the advisability of admission of skiagraphs into a Court of Law. I do not consider it right to say that skiagraphs are inaccurate; they are perfectly accurate if they have been taken under the superintendence of the surgeon, and taken and considered in combination with the clinical signs present.

The improper use of skiagraphs in Court is quite another matter. No surgeon should be asked in Court (or, indeed, out of Court) to pass an opinion on an X-ray picture without an examination of the patient taken at the time of the picture and without the guidance of an accurate interpretation of the same.

In concluding these general remarks I would emphasise the fact that, especially as regards deformity, skiagraphs by themselves without surgical interpretation and, moreover, taken under proper conditions, and considered with the clinical signs, are absolutely of no value—indeed, must often be positively misleading.

I would, in conclusion, briefly point out how great is the value of skiagraphy in regard to *injuries in various joints and bones*, as it has presented itself to me during the past eleven years (*a*). I am positive that the ideal method of diagnosis is, that every care should be submitted to the X-rays, whether uncertainty as to diagnosis exists or not, and that the Röntgen process should be used as a scientific adjunct to clinical methods and in no other way.

Many apparently simple cases display some comminution, obliquity, or rotation, and *vice versa* an apparently severe fracture with great swelling and contusion will turn out to be a very simple one through the co-operation of Röntgen's process. But each case should be made a complete study in itself.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor Alfred J. Smith, M.B., M.Ch., F.R.C.S.I., Gynæcologist to St. Vincent's Hospital, Dublin, Examiner in Midwifery, Royal University of Ireland. Subject: "Climateric Floodings."*

ORIGINAL PAPERS.

A CASE OF

ULCERATIVE COLITIS—APPENDICOSTOMY—CÆCOSTOMY—COMPLETE RECOVERY. (*b*)

UNDER THE CARE OF

ARTHUR LATHAM, M.D.Oxon., F.R.C.P.Lond.,
Physician to St. George's Hospital.

AND

FRANCIS JAFFREY, F.R.C.S.Eng.,
Surgeon to St. George's Hospital.

On March 10th, 1906, Edward O., æt. 48, was admitted to St. George's Hospital with a history of passing mucus and blood from the bowel daily since the beginning of February. The bowels had acted several times a day from the commencement of the illness and in each motion blood and mucus was present. Gradually the number of motions passed a day had increased until the bowels were opened as often as sixteen times in the twenty-four hours. In many instances the motion consisted of pure blood. On February 25th, there

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(*a*) The lecturer then set forth the utility of skiagraphy in individual joints and bones and presented in illustration of this a large number of skiagraphs from his own practice.

(*b*) Read before the Harveian Society of London, April 18th, 1907.

was a definite rigor, which was followed by much debility together with fever to the extent of 103° F. for a few days.

There had been no previous illness, and the man had always been temperate.

On admission.—The man was obviously very ill, being markedly anæmic, and drowsy. The temperature was normal; the pulse 100, of low tension; the tongue dry and dirty. There was some tenderness in the right iliac fossa, but no rigidity or abnormal dulness in the abdominal area. On examination of the rectum by the finger no marked tenderness or other abnormality was discovered. On examination with the sigmoidoscope no ulceration of the rectum or pelvic colon could be seen.

The stools were frequent, ten, fourteen, sixteen in the twenty-four hours. They consisted chiefly of blood mixed with a little mucus and pus.

The patient was kept absolutely at rest, in bed, on a light spare fluid diet. Various drugs by the mouth, such as calcium chloride, opium, liquor ferri pernitratis, tannalbin, were given without effect. The colon was washed out daily by large injections of boracic acid (ʒi to a pint) and later by injections of silver nitrate (10 grs. to two pints) without effect. Starch and opium and other enemata were given with the hope of controlling the hæmorrhage, but failed to diminish this symptom.

As the man was in a precarious condition, Mr. Jaffrey was asked to perform appendicostomy, so that the bowel might be flushed out more thoroughly.

Operation, March 30.—Mr. Jaffrey operated by the incision used for the removal of the appendix. The appendix was small, and a partial division of its mesentery was necessary before it could be brought out of the wound, and stitched to the abdominal wall. It was not opened until the following day, when the protruding portion was removed. It was found impossible to pass any catheter, even a probe, through the lumen of the appendix owing to swelling of its walls; however, a few days later the swelling having subsided, a No. 5 olivary was passed and some saline solution was injected into the cæcum. Owing to the small size of the appendix, it was impossible to irrigate the colon properly, and the condition of the gut did not improve. There was no diminution in the amount of blood, mucus and pus passed or in the number of times the bowels acted. On further consultation with Dr. Latham it was decided to remove the appendix and perform a cæcostomy.

On May 5th, Mr. Jaffrey opened the scar of the former wound, removed the appendix, and sewed the cæcum to the abdominal wall, but did not open it till the following day. When the cæcum was opened it was seen that the mucous membrane was very much thickened and that the slightest touch caused it to bleed. It was now freely irrigated each day by means of a fountain syringe from a height of three feet above the patient, with a pint to two pints of a solution of listerine of a strength of 1 oz. to a pint of water. Occasionally adrenalin of a strength of ʒi to the pint of water, or Liq. hammameledis ʒii to the pint was used with the hope of lessening the amount of blood passed. The result of this treatment was truly wonderful, for in less than a fortnight practically all the symptoms had disappeared, and there was no blood, mucus or pus, in the stools. It was also noticed that the thickened mucous membrane had very nearly returned to its natural thickness.

After a few days of this treatment the patient was given ordinary diet, together with cod-liver oil and malt; and a quinine and strychnine mixture was prescribed. He rapidly regained flesh and was anxious that the cæcum should be closed. The closing of the opening in the cæcum was, however, delayed as it was thought that possibly the colitis would return when the man resumed his ordinary way of living. A colotomy belt was ordered and the patient was sent to the Atkinson Morley Convalescent Hospital at Wimbledon on June 13. He remained there a very short time, as the fluid fæces caused a troublesome irritation around the colotomy wound. He returned to St. George's Hospital. The eczematous condition was intractable at first, but yielded to the application of boracic acid mixed with lanoline. An attempt to close the opening in the cæcum was made on September 18th. This was not completely successful as slight discharge of fæcal matter continued. On a second attempt on October 9th, the wound healed finally, and the patient returned to his work and has remained in good health since. He has had no further symptoms of colitis.

Remarks by Dr. Latham and Mr. Jaffrey.

This case shows the beneficial results of prompt resort to the performance of cæcostomy when medicinal measures have failed in the treatment of ulcerative colitis. No doubt the fact that complete rest was given to the colon through the operation of cæcostomy being performed within three months of the initial symptoms accounts to some degree for the rapid recovery. There can be little doubt that if the colon had not been opened the patient would have rapidly succumbed to the disease. There are several points of interest in the case. The condition of the cæcum suggested acute inflammation of the mucous and muscular coats, and although no ulceration was seen, yet hæmorrhage followed on the slightest manipulation. The fact that pus was present in nearly every motion shows that definite ulceration must have been present in the colon. The inflamed condition of the colon entirely subsided within ten days of the opening of the cæcum, and the tendency of its mucous membranes to bleed ceased within six days of the operation.

The operation of appendicostomy for the purpose of allowing the bowel to be flushed out failed entirely. It was performed in view of the favourable reports given by various operators of this procedure in the treatment of colitis. In this case the swollen condition of the appendix prevented the passage of a fine probe. Even in an healthy appendix the lumen will seldom allow the passage of a catheter larger than a No. 10. Flushing out of the bowel by means of a No. 10 catheter cannot be so effectual as flushing out by means of a large-sized glass nozzle after cæcostomy, and this may account in part for the fact that when appendicostomy is performed, flushing of the bowel has not infrequently to be continued for many months. Another advantage of cæcostomy over appendicostomy in cases of colitis is that by its means real rest is obtained for the diseased colon. The fact that the closure of the colotomy within four months of the operation was possible may in part have depended on the fact that the case was not of long standing. In closing the cæcum it is necessary to first wash out the bowel just before operating and to pare the edges of the wound with great care.

EPITHELIOMA INVOLVING THE HEAD AND FACE WITH GREAT DESTRUCTION OF TISSUE.

By Professor JOHN P. SHOEMAKER, M.D., LL.D.

Professor of Skin and Venereal Diseases in the Medico-Chir. College and Hospital, Physician to the Philadelphia Hospital for Diseases of the Skin.

The patient, Mr. R. B——, æt. 47, born in the United States, came under my observation three months ago. He is fairly intelligent, and gave the following history: He stated that eleven years ago, a small, hard, indurated pimple appeared on the helix of the left ear. It annoyed him to some extent by a constant itching pain, which caused more or less scratching. The effect of this was to cause the lesion to become sore and bleed. This condition was always followed by a tendency to ulceration, which on healing formed a scab. Every time the scab came away the ulceration would become more marked. This state continued for three years without much variation His physician at this time advised him to have the spot removed, because he thought it to be an epithelioma. This the patient refused to do and consulted a "cancer doctor," who applied a caustic paste or salve which removed the spot or ulceration with a portion of the ear as well. The wound produced by the application of the caustic paste did not heal, but ulcerated more decidedly, and gradually "ate," as he expressed it, the entire ear away. After the ear was destroyed, more caustic paste was applied to remove the infiltration, supposed to be cancerous skin. The second application removed not only the skin but also large masses of the underlying tissues.

The ulcer was now over two inches in diameter, and the disease was over six years standing. Gradually the ulceration spread, the eye became involved, and was finally removed. Two years ago X-ray treatment was instituted, but it was of no avail. The patient stated that the ulceration continued and to-day it involves the entire half of the head, giving the patient a most horrible deformed appearance, part of the lip being destroyed, so one can look right into the mouth and throat.

His family history is entirely negative. As a child he had measles, varicella, whooping cough, diphtheria, and mumps, and influenza fifteen years ago. He is married, but has no children. His habits have always been good; he never used either tobacco or alcoholic liquors. The patient is greatly emaciated, but otherwise presents no abnormal physical signs. Even the glands of the neck are not enlarged. He is nervous and very irritable, which is due to the fact that he is unable to sleep without a hypnotic or anodyne. The pain is worse from eight to twelve o'clock at night. I made the diagnosis of epithelioma from the history, the age of the patient, and the appearance of the ulcers, which involves the entire half of the head and face, including the mouth. The edges of the ulcer are sloping, indurated and slightly elevated. The base is reddish, granular, and covered with a viscid yellowish secretion. The ulcer bleeds easily, is painful, and for the past year has been increasing in size very rapidly.

No microscopic examination of the tissue could be made, as even at this late date the patient will not permit a specimen of the tissue to be removed under any circumstances. I had great difficulty in inducing him to permit either a history or his photograph to be taken.

The present ulceration has the appearance of what has been described as a rodent ulcer, but the bone or even the periosteum is not involved. Some of the deeper muscles are likewise not involved, consequently the diagnosis of rodent ulcer is ruled out.

A differential diagnosis lies between lupus vulgaris and epithelioma; my opinion inclines decidedly to the latter. The following table will briefly show the difference of the two diseases:

Epithelioma.	*Lupus vulgaris.*
1. Develops after 35 years.	1. Develops before puberty.
2. Lesion, a single papule.	2. Lesion, multiple, gelatinous tubercles or papules.
3. Ulcer is deep with sloping edges and surrounding skin is infiltrated.	3. Ulcers superficial and sharply defined, no inflammatory areola.
4. Secretion is viscid and scanty.	4. Secretion usually abundant, yellow, and purulent.
5. Pain is a marked feature.	5. Pain usually absent or very slight.

It is only fair to suppose that the immense slough, in the absence of enlarged lymphatic glands and other symptoms usually present, is entirely due to the caustic action of the "cancer plasters or pastes" that were applied. The composition of most of the so-called "cancer plasters" employed by the "cancer doctors" is nothing more than the old Vienna paste, with or without arsenic. The escharotic and destructive action of such caustics is well known to every physician who employs them even with the greatest care and caution. In truth in many of the cancers and especially in epithelioma the ulcerative and destructive action of the malignant growth may be increased by the application of the caustic agent or agents, and such is particularly the case after the application of arsenic. Again, in employing arsenic over a large surface the systemic action of the drug often develops. I have had several cases in the hospital in the past few years which presented marked systemic arsenic poisoning due to the local application of the drug to ulcers and malignant growths. In these instances the applications were usually made by the quack or so-called "cancer doctor" who applies one of the many pastes or plasters to draw out, as they say, the cancer by the roots.

In one patient the poisonous action from the arsenic was so severe as to jeopardise the patient's life for many days.

The application of the X-rays to some of the malignant growths, especially if pushed too rapidly or too severely, will often produce a most destructive action and increase the disease instead of ameliorating it, as in one case that I have had and which I propose to report, where the molecular destruction was so great that it resulted in sepsis followed by death.

FRIEDREICH'S ATAXIA. (a)

By FREDERICK S. PALMER, M.D., M.R.C.P., Lond.,

Physician to the West-End Hospital for Diseases of the Nervous System.

The disorder, which bears the name of the distinguished Professor, formerly at the head of the Heidelberg School, from whence so many eminent physicians and scientists have come, was first recognised by Friedreich in 1861.

Historical note.—(1) At the Congress of German naturalists and physicians, held at Spire, (the ancient cathedral city and capital of the Rhine Palatinate, in Bavaria), on September 18th in that year, he presented (and afterwards published the notes of) six cases of ataxy in the members of two families, presumably running on lines of consanguinity, whose symptoms-complex did not conform to the masterly description of locomotor ataxia given by Duchenne, of Boulogne, in 1858–9. From a careful study of these cases, Friedreich believed they belonged to the same group, but there were special points in their clinical history which had been overlooked in Duchenne's account of the malady. For several years afterwards, in France, under the influence of the teaching of Charcot, Vulpian, Bournville and Guerard, cases of ataxie héréditaire were regarded as one of the irregular types of insular sclerosis—a disease at that time attracting a great deal of attention—the main facts recorded by Friedreich were either ignored or lost sight of. (2) The next case reported was one by Carre, in 1865, and, after a pause of nearly six years, Bradbury published another, and Carpenter two, of evidently the same class, in 1871. These were followed by two cases reported by Kellog in 1875, three by Dreschfield in 1876, and three more by Friedreich in 1877, making nine of his series. Eleven other cases were recorded by Kahler and Pick, Schmidt, Seeligmüller, Hollis, Gowers and Fraser in 1880. At the end of that year the total number of cases reported was only thirty-one. (3) In August, 1882, Marie wrote a memoir in competition for a resident hospital appointment, in which he collected the various facts recorded by authors, and the results of his own observations on the subject, describing the disorder, like all the other writers, as a form of tabes. Auguste Brousse, of Montpelier, inspired by Grasset, in an excellent thesis published the same year, first claimed for the disease a separate entity, and proposed to bestow on the malady, the name of the distinguished observer, by which it is now so commonly known. This thesis may be said to mark the second stage of progress, in the evolution of our knowledge of the disease. Two years later (1884) the first case was recognised in Paris. A young lad was brought to Charcot at the Salpêtrière by a physician attached to the hospitals, deeply interested in the progress of medical science, as a probable example of juvenile tabes—a clinical condition then, much in dispute. Before submitting his diagnostic acumen to the searching criticism of a learned society, he desired with praiseworthy modesty, to have his opinion confirmed by that eminent neurologist. Marie, who was then acting as a clinical assistant at the Salpêtrière, relates in his thirtieth lecture, how Charcot at once detected the nature of the disease the boy was suffering from, rescued his confrère from the probable, and humiliating consequences of an unfortunate conclusion, and a few days afterwards, devoted a lecture to the consideration of the special features of the case, which definitely established the separate existence of Friedreich's ataxy.

Since then, a number of valuable, and important contributions have been made to the literature, notably the writings of Rütimeyer, Musso, Massalongo, Gilles de là Tourette, Blocq, and Huet, Letulle and Vaquez, Crozer Griffith, Dana, Marinesco, Achard and Weigart Dejerine, the remarkable thesis of Soca, published in 1888, and the valuable contributions to *Brain* of Everitt Smith, Ormerod, Mackie Whyte and Ladame, of Geneva.

At the present time, the disorder which Friedreich discovered, constitutes an accepted, and well-defined malady, and its position in the nosography of nervous diseases is due unquestionably to the thesis of Brousse, written under the influence of Grasset, and to Charcot's lecture delivered in 1884. It is essential, as Osler remarks, that in speaking of this (4) affection, its prominent symptom, ataxy should be expressed, to avoid any confusion, with another clinical condition, paramyoclonus-multiplex or myoclonia, described by Friedreich twenty years later, in 1881, which has a strong resemblance to Henoch's chorea electrica, sometimes called lightning spasms, and is occasionally spoken of as Friedreich's disease.

Definition.—A disease occurring usually in several members of a family during the developmental epochs, characterised by ataxy, wide spread paresis, impairment of speech, nystagmus, deformities and other less constant symptoms.

The co-existence of the disorder in more than one member of the same family and its common appearance in childhood, or at puberty, stamps it as one of the so-called familial type, and clearly points to its origin in some inherited morbid developmental tendency. In both these respects the affection in question presents a striking analogy to the group known as the muscular dystrophies or myopathies.

Isolated cases are undoubtedly encountered, and many have now been reported, especially in small families, but these sporadic examples. are open, as Soca admits, to the argument, that if the number of children were greater, more might have suffered from the disorder. Although it is not an uncommon circumstance to find three, four or even five brothers and sisters affected consecutively with the disease, it is absolutely certain, that the others who are not so afflicted, may remain in perfect health.

Ætiology.—(5) Strümpell asserts that the disease is rarely seen "in members of the same family in different generations," but there is little, if any doubt, that heredity in the broad sense of the term, is the prime factor in Friedreich's ataxia. (6) It has been traced through several, as many as four generations in one family. (7) Ten cases in three generations of a single family have been reported. The family proclivity was strongly insisted on by Friedreich, who appreciated its importance, and the prominent position it occupies as a distinguishing feature of the malady.

Predisposing causes.—Apart from the question of direct or indirect inheritance, the following are believed to exercise predispositional influences.

1. Neurotic diseases in ancestors, or collaterals.
2. Alcoholism in the parents.
3. Syphilis in the parents.
4. Consanguinity in the parents.
5. Over-production, prolonged lactation and disparity of age in the parents.

The part which a neuropathic inheritance plays in the history of all nervous disorders, is too well known to require any comment.

Intemperance—In the ancestry, as a probable factor in hereditary ataxia, was suggested by Friedreich, who attached considerable weight to it. In his first series of six cases in two families, both of the fathers were habitual drunkards, and one of the mothers after the death of her husband remarked, "the children were conceived in drunkenness."

Evidence of syphilitic transmission has been rarely traced, and there are few facts recorded to support the connection. The children of tabetic parents seldom, if ever, present the symptoms of Friedreich's ataxia.

Consanguinity, according to Gowers, appears sometimes to intensify the morbid tendency. Two families have came under my notice within the last four years afflicted with this scourge, and in both instances the parents were first cousins. The unhappy results, certainly as regards nervous and mental diseases which so frequently follow inter-marriage, must be familiar to everyone, who has been engaged in medical practice for many years.

(a) **Lecture delivered at the West-End Hospital, November, 22, 1906**

Over-production, prolonged lactation and disparity of age in the parents.—The arguments in favour of these influences are probably based on the facts, previously mentioned, that in the majority of the cases reported the disorder had attacked the members of large families. In one of the two just quoted, there were thirteen children, including two sets of twins, and in the other, ten; brothers and sisters. It is conceivable that the early marriages, rapid rate of reproduction, and the social surroundings of the less prosperous, and cultured classes of the community, may be to a certain extent responsible for the degeneration of stock.

Race and environment.—(8) The largest number of cases have been reported from America, and the smallest from France. (9) Collins, of New York, has recorded eight in his clinic in five years. There is good reason to suppose, that the disorder is more prevalent among the labouring, and agricultural population, and in rural, rather than in urban districts.

Proximate causation.—The immediate cause of the disease is unknown, but there are two antecedent conditions, which stand out with considerable prominence and frequency,

1. The acute infective disorders,
2. Trauma.

Many parents date the commencement of their children's nervous instability from one of the acute specific fevers, and of these, diphtheria and smallpox have the credit of being (10) "peculiarly efficacious in evoking the early symptoms."

Trauma has been blamed for precipitating the disorder, and the evidence produced appears to be trustworthy.

Sex.—The sexes are nearly equally affected, males slightly preponderating, albeit Friedreich held the opposite opinion.

In Soca's series the proportion was 68 males to 47 females.

Gowers gives the proportion at 35 males to 30 females.

In the eight cases reported by Collins, there were five males and three females.

Age Incidence.—The age at onset varies between two and twenty-four years. (11) "Out of 143 cases tabulated by Crozer Griffith 30 per cent. developed the disease before the sixth year of age, about 60 per cent. before the tenth year, and only 3 per cent. between the twentieth and twenty-fifth years." In these cases direct inheritance was traced in thirty-three.

Distribution of cases.—The number of cases in a single generation is very variable. Gowers records sixty-five in nineteen families (12) "giving an average of rather more than three to each." Certain clinical characteristics are observed in some families, and absent in others. In some the males are attacked, and the females escape; in others the contrary obtains. There is some foundation for Soca's law, that the onset of the disease occurs about the same age in the case of each member of the family affected, and the symptoms follow on similar lines.

Symptomatology.—The cardinal features of Friedreich's ataxy are, progressive weakness, and inco-ordination of the limbs, most marked in the legs, hypotonia, staggering ataxic gait, absence of deep reflexes, speech impairment, nystagmus, tremor, scoliosis, pes cavus, involuntary muscular movements, the extensor type of plantar response and certain other subordinate manifestations which will now be discussed in detail. Motor symptoms predominate and constitute by far the most important group of symptoms.

Ataxia.—The inco-ordination which, as a rule, is first noticed in the lower limbs and trunk, is both of the ordinary and static types. It commences with clumsiness or uncertainty in walking, and there is considerable difficulty in maintaining the erect position. Closure of the eyelids frequently increases the unsteadiness, but the symptom of Romberg is an uncertain quantity. Later the arms are affected, or the disease may start with inco-ordination of the upper limbs, (13) as in the case recorded by Besold, quoted by Mackie Whyte. The ataxy is slowly but steadily progressive, all four limbs becoming sooner or later involved, until the power of directing voluntary movement is lost.

Paralysis.—(14) Some degree of muscular weakness is associated with the ataxy, but it is neither general nor considerable until the later stages are reached; the muscles are inactive, their strength reduced, but the tonus is not diminished to the same extent as it is in tabes. The condition is therefore one of paresis without any serious paralytic state being present, until quite late in the disorder. Atrophy is observed in some cases of long standing, chiefly in the muscles of the shoulder girdle, pelvis, arms and hands. Two cases exhibited at the meeting of the Neurological Society in Queen's Square, on July 14th, showed a well marked main-en-griffe.

Attitude.—The position of patients in the early stage of Friedreich's ataxy is quite characteristic—they stand on a wide base, with the feet far apart, and turned outwards, the head and trunk inclining forwards, slightly in advance of the legs.

Gait.—The gait is swaying, and unsteady, resembling that of a person under the influence of alcohol. It was described by Charcot as the démarche tabeto-cérébelleuse.

Reflexes.—As a rule the knee-jerks are annulled early in the disease, but they (15) may be normal, or in very rare instances exaggerated. Crozer Griffith in the analysis of his 143 cases, found that abolition of the knee jerks was very early and constant. The ankle jerks are usually diminished, the superficial cutaneous reflexes are indefinite, generally retained, but the plantar response is nearly always of the extensor type, on one or both sides. The sphincters are rarely affected, except it be in the late stages of the malady.

Speech defects.—Articulatory impairment is not commonly an early feature, it is most frequently observed two or three years after the disease is recognised, or even later in its course. Like the limbs, the speech is ataxic, irregular, mangled or jerky, but in some cases it is blurred, explosive, monotonous or hesitating.

Deformities, scoliosis, kypho-scoliosis, pes cavus and contractures often occur. The spinal curvature occupies the dorsal and lumbar regions, and is usually one of the later symptoms. (16) Two cases have, however, been reported, one by Brock, and the other by James, both quoted by Mackie Whyte, in which the spinal deformity gave the earliest clue to the nature of the disease. The foot deformity is bilateral, and also one of the more advanced symptoms. It has been admirably described by Dr. Ormerod in *Brain*, January, 1888, and as it has been quoted elsewhere, no apology is needed for its reproduction here. "The instep becomes prominent, and the metatarsals appear to be shortened at the metatarso-phalangeal joints, the toes become over-extended, and the first inter-phalangeal joints flexed. The foot looks humpy and shortened. Below, the plantar arch (at least as seen from the inner side) is abnormally high, and the balls of the toes are very prominent. The foot also tends to assume the position of equino-varus."

Involuntary muscular movements.—Head swaying, coarse rhythmic tremors, choreiform, and salutation movements are frequently noticed; they may be provoked by attempts to move the extremities, and twitchings are sometimes seen when the body is at rest, or when the child begins to talk. In the advanced stages of the disorder the head not infrequently nods, or rolls from side to side in an extraordinary manner.

Cranial nerves.—The special senses of taste, hearing, and smell are seldom, if ever, affected, paralysis of the ocular muscles has rarely been noted, but diplopia, strabismus, and some degree of ptosis have been reported in a few of the cases; nystagmus is a frequent, but not constant sign. Strümpell says it is rare and not characteristic. It can, however, be discovered in most of the cases on lateral or upward deviation, particularly after fixation on a given object. Pallor of the discs, and optic atrophy, are rarely but occasionally observed. (17) Snell reports three cases in one family presenting some degree of it. At the Neurological Society's meeting in July one patient was shown by Dr. James Taylor with double primary optic atrophy, and concentric contraction of the visual fields, who was unable to count fingers beyond one or two feet, and another by Dr. Ormerod whose discs were markedly atrophic. In a third, exhibited by me—a sister of Dr. Ormerod's patient—there was distinct pallor of the discs, without any apparent impairment of sight. The pupillary reflex as a rule is normal.

The sisters are here this afternoon and I hope to show them to you presently. They are typical examples of the disease in different stages.

Facies.—The aspect of the victims of Friedreich's syndrome may be described as expressionless, with a peculiar appearance of hebetude; the drooping features, and partially-closed mouth are very typical, and so are the facial contortions, which precede the effort of speech or follow emotional excitement.

Intelligence.—Some grade of mental retardation is frequently noticed in these cases, especially in the late stages of the disorder, and memory may be impaired.

Vaso-motor and trophic changes are not usually observed. Some of the authors have reported coldness, and even cyanosis of the affected extremities (18) but the skin, and joints, as a rule, preserve their normal appearance, and the muscles do not waste until the disorder is far advanced.

Sensory symptoms.—Subjectively and objectively, alterations in tactile sensibility do not commonly form part of the clinical picture, nor is the muscular sense disturbed; (19) cramps and rheumatoid pains are sometimes complained of, and very rarely lightning pains have been reported. (20) Charcot showed that true tabetic pains have been encountered. In a certain number of the cases, anæsthesia, analgesia, paræsthesia and delay in conduction have been noted.

Visceral crises are said not to occur. This is not strictly correct—a girl, æt. 16, who was in this Hospital last May, under the care of my colleague, Dr. Outterson Wood, had a severe gastric crisis lasting thirteen days. It is interesting to relate that her elder sister, afflicted with the same disorder, who was in Westminster Hospital, under the care of Dr. Donkin, ten years ago, had a precisely similar crisis which lasted exactly the same time.

Electrical reactions.—Sir William Gowers quotes two cases reported by Dejerine, a brother and sister with great atrophy of the muscles, and altered electrical reactions. In the two cases I have tested there was no polar change.

Cardiac (21) *Tachycardia and a basic murmur* have not infrequently been observed in Friedreich's ataxia.

Menstruation is said to be often delayed. In the case of the girl just mentioned, the menstrual function was performed very regularly, but the tachycardia continued all the time she was in the hospital, the pulse rate was seldom, if ever, below 112.

Course and duration.—In the majority of the cases the ataxy first noticed in the lower limbs, extends to the arms in the course of four or five years, and by that time the patient is either unable to walk without assistance, or confined to bed or a chair. The symptoms which first attract attention in the order of frequency are: 1, the disorders in the gait; 2, the loss of the patellar reflex; 3, speech defects; 4, nystagmus; 5, scoliosis and hyperextension of the hallux. Any of these abnormalities occurring in a member of a family affected with the disorder, should at once raise a suspicion of a probable addition to the list.

The course of the disease, although essentially progressive, is measured by years of disability. Twenty or thirty years' duration is not exceptional. (22) "Long remissions may occur, and sudden aggravations take place." Death usually results from some intercurrent disease, seldom directly from the disorder. (23) The longest case on record is forty-six years, and the shortest only two years.

In sixteen autopsies recorded by Dana the duration of the disease was as follows: Thirteen cases lasted over ten years; two cases lasted over eight years; one case lasted two years.

Morbid anatomy.—The *post-mortem* changes in Friedreich's ataxia are extensive, and well marked. To the naked eye the cord appears to be undersized throughout its entire length (particularly in the dorsal region) and may present only two-thirds of its usual thickness. The lesion is a combined system degeneration of the postero-lateral tract. Sclerosis, not of the ordinary connective tissue type, but gliosis, or neurogliar sclerosis (ectodermal) of these regions. In its distribution the morbid process invades the columns of Goll and Burdach, the crossed pyramidal, direct cerebellar, Lissauer's and Gower's tracts, and the cells of Clarke's vesicular column are frequently atrophied.

Degenerative changes have also been found in the posterior horns, and rarely (Friedreich and Rütimeyer) in the anterior cornual cells. In a very few of the cases, lesions of the medulla, and cerebellum have been reported. (24) The cranial nerves usually escape, but the hypoglossus, and the optic nerves have been found diseased." Very little is known about the condition of the posterior ganglion cells, but the peripheral nerves do not appear to be concerned in the degenerative process.

Closely allied to the syndrome of Friedreich is the other form of hereditary ataxy, called the cerebellar, or Marie's type, with which it has many features in common. It commences later in life, seldom before the twentieth year, with paresis and inco-ordination of the lower limbs, articulatory defects, pronounced choreic movements, exaggerated knee kicks, and frequent ankle clonus, but nystagmus and deformities are rare. In this type, optic atrophy, amblyopia, diplopia, colour blindness and the Argyll-Robertson pupil are often encountered, together with sensory disturbances of various kinds; spasticity of the limbs develops later. Atrophy of the cerebellum has been found in some of the few cases reported. It seems probable that the co-ordinating mechanism is attacked in the cerebellum in Marie's type, and in the spinal cord in Friedreich's. The points of distinction between the two types of hereditary ataxy are briefly expressed in the following table:—

Friedreich's Syndrome.

Early onset, at or before puberty.
Reflexes diminished or absent.
Optic atrophy rare.
Choreic movements frequent.
Deformities common.

Marie's Syndrome.

Late onset, at or after twentieth year.
Reflexes increased.
Optic atrophy common.
Choreic movements very marked.
Deformities exceptional.

Regarded from a clinical standpoint the difference is not very great and there is evidently a disposition in both these types to meet each other more than half way in irregular cases.

In both forms of family ataxy, by whatever names they may be called, the fundamental factor is their probable dependence on some embryological defect in the nervous organisation, leading to premature exhaustion, and decay in certain parts of the cerebrospinal axis, chiefly of the columns of Goll, pyramidal tract, and cerebellum, whether it be, as Gower suggests, that these structures are endowed with a lower degree of vitality than normal, and are incapable of discharging their functions beyond a limited period; or that the demands made on the nervous mechanism during the developmental epochs are too severe, it is impossible to say.

The interesting series of cases published by Sanger-Brown indicate that the hereditary ataxias follow the general rule of familial nervous diseases in two important points.

1. Transmission by the female line.

2. The tendency to preponderance in the male sex.

His genealogical diagram in the summer number of *Brain*, 1892, shows a remarkable inclination of the disorder to attack the children of successive generations at a progressively earlier age, and is well worth a careful study.

Diagnosis and differentiation.—In well marked cases with a family history of other victims the diagnosis is almost self-evident, but in the sporadic examples, they may have to be distinguished from: 1, Marie's type of hereditary ataxy; 2, ataxic paraplegia; 3, hereditary tabes; 4, chorea; 5, insular sclerosis; 6, cerebellar neoplasms.

1. The first has already been discussed in detail.

2. From ataxic paraplegia, the diagnosis may be difficult, if not impossible, some assistance may, however, be obtained, from the presence of exaggerated knee jerks, and ankle clonus, which are not usually observed in Friedreich's syndrome.

3. From the inherited, or juvenile form of tabes, the disorder is distinguished by the absence of syphilitic stigmata, skin diseases, Hutchinson's teeth, choroiditis, and loss of the iris-reflex; a history of parental syphilis may also be useful. The tabetic gait lacks the staggering quality of the family ataxias, and the sphincter of the bladder is frequently affected.

4. *Sydenham's chorea* is a disease of abrupt onset, marked by general motor restlessness and irregular distribution of the movements, chiefly affecting the upper limbs. The reflexes are normal, or slightly exaggerated. Rheumatic taints in the parents or child are common and cardiac complications are frequent.

Huntingdon's chorea is seldom or never encountered in childhood, and only rarely at puberty. Its onset is much later in life, commonly between the thirty and forty-fifth years. The mental state, forced attitudes, and progressive depression which either accompanies, or in some instances precedes, the malady are signs of diagnostic value to be remembered.

5. *Insular sclerosis*, which Charcot said in 1868 "he believed was unknown in England," assumes so many disguises, and presents such a variety of masks, more particularly in those irregular types known as the "formes frustes," that the confusion of the French authors before Friedreich's ataxy had attained to the dignity of a separate existence is not to be wondered at. Even now, with our advanced knowledge of this disorder, and with broader views of its cardinal features, it is the one most likely in the earlier stages to be mistaken for the disease under consideration. We must recall the spastic gait, exaggerated reflexes, scanning, staccato speech, volitional tremor, frequent early sphincter trouble, nystagmus, disturbances of sensibility, occasional optic atrophy and the fact that disseminated sclerosis is seldom seen in children, and is most commonly a disease of early adult life, to help us in arriving at a correct conclusion.

6. *Cerebellar neoplasms* are distinguished by their prominent head symptoms, occipital pain, perhaps accompanied by tenderness or bulging of the cranium in that region, vertigo, vomiting, optic neuritis, neck rigidity, forced attitudes, the true cerebellar staggering gait, the distribution of the paralysis, and the involvement of any of the cranial nerves.

Prognosis.—The outlook in both forms of hereditary ataxy is always serious. No case yet reported has ever been known to recover. Some of them, however, appear to remain in a more or less stationary condition for considerable periods. (25) One, a tradesman, mentioned by Gowers, attended to his business for many years. Beyond the disability, the disorder is not usually associated with any marked or acute suffering—the victims bear their affliction with surprising calmness and resignation from onset to its natural goal.

Therapeusis.—From what has been said, very little improvement can be expected from treatment. There is no known remedy which influences materially the progressive course of the disease. Ladame suggests (26) "the application of continuous currents, stabile and labile to the vertebral column by means of large electrodes, 10 to 14 milliampères, three times a week." Some good results were reported by Charcot at the Salpêtrière from suspension. Phosphorus, silver nitrate, arsenic, ergot and antipyrin have been tried with indifferent success. In some cases they appear to have retarded for a time the progress of the malady. Bodily exercise should be avoided, but massage may be employed. It is conceivable that ultimately some serum may be discovered to arrest the retrograde process in the nervous mechanism on which the disorder depends. In the meantime, our chief reliance must be placed on a more careful and intelligent observance of the principles of hygiene, and the strenuous advocacy of prophylactic measures to combat those predispositional influences which are believed to be potential factors in the development of degenerative changes in the neuronic system. To wit, the encouragement of habits of temperance, the prevention of inter-marriage among blood relations, and to oppose the nursing of children by mothers whose history as regards familial nervous disorders is not irreproachable.

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OPERATING THEATRES.

ROYAL EAR HOSPITAL.

Radical Mastoid Operation.—Mr. Macleod Yearsley operated on a woman, æt. 27, who had been admitted for recurrent discharge after ossiculectomy. When first seen in 1905 she gave a history of right purulent discharge since childhood, and stated that an operation for adenoids had been done fourteen years earlier. The ear was full of very foul débris and pus and there was a large perforation The ear was carefully cleansed and treatment carried out for several weeks; at the end of that time, as syringing caused vertigo, it was decided to remove the ossicles and outer attic wall. This was accordingly done and the patient made an uneventful and uninterrupted recovery. About a year after she contracted a very severe cold, experienced pain in the ear with vertigo; this latter was of horizontal character, was accompanied by nystagmus, and objects apparently moved towards the affected ear. There was a recurrence of discharge, and after cleansing the ear it was found that the tympanic opening of the aditus was partially occluded by a fibrous cicatrix. As treatment did not reduce the amount of discharge, it was decided to perform the radical operation. The patient was therefore anæsthetised and the usual incision made, the antrum was quickly reached, and on removing the posterior meatal wall it was found that there was considerable caries about the external semi-circular canal; there was also some caries about the entrance to the aditus and the facial nerve was exposed. The operation was concluded in the usual way, and a superior posterior meatal flap was fashioned and the wound sutured, packing being performed via the meatus. Mr. Yearsley pointed out that this was an instance of failure of the operation of ossiculectomy, and the case was interesting because it illustrated one of the ways in which this operation might fail, namely, partial occlusion of the tympanic opening of the aditus by scar tissue, whereby the drainage of the antrum would be interfered with. Had it not been for this it was quite possible that the re-infection of the ear by the severe catarrh of the upper air passage would not have been attended by such a grave result. This did not, however, reduce the value of ossiculectomy as an operation. In his experience it was a most useful method to adopt where there was caries of the ossicles as it provided for the removal of an irritating agent and also established good drainage. He thought that it was successful in at least 10 per cent. of cases, and it had the advantage of in no way interfering with the mastoid operation should this latter be required later. In this particular case the re-infection of the ear had resulted in an acute inflammation ofthe mastoid antrum with retention of products owing to the cicatricial obstruction he had already alluded to; this was accompanied by caries about the external semi-circular canal, which had given rise to the serious symptoms which necessitated the major operation.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of State Medicine.

Meeting Held Friday, April 19th, 1907.

The President F. C. Martley in the Chair.

The State and Syphilis.

Dr. **Seymour Stritch** read a paper on the above subject, and discussed the matter from its financial, vital, hygienic and legislative aspects. He endeavoured to show that the time had now come for an active crusade to be formulated by the Government and people against syphilis. He adduced figures to prove that the cost to the nation of venereal diseases in the army, navy and Government departments amount annually to no less a sum than £3,000,000, and that making allowances for superannuations and for sick leave occasioned indirectly through these diseases, though not appearing in the returns as such, he personally considers the more accurate estimate of this loss would be £7,000,000. The loss to the nation from death and disablement should be considered, not only from the point of view of syphilis only, but also from all those scrofulous and tubercular diseases which may be traceable from its origin (cancer of the tongue, throat, leucoplasia, &c.) The hygiene of syphilis might be dealt with from the basis of a trihedron supporting the principle of morality, sociality and legislation. The first of these was, he believed, more within the province of the church than that of medicine, and, therefore, resigned it into their hands. Socially, the disease might be combated by improving the environment of young men in business and in the services. Domestically, an endeavour to make the home attractions more pleasant than the seductions of the city should be the anxious endeavour of parents. By fathers retaining the confidences of their sons they could observe the bent of their minds, and by tactful insinuations create by suggestions the necessary antidote. The *morale* of the nursery should not be neglected owing to morbid curiosity of young nurses. Circumcision he believed worthy of being adopted universally. Boys should be encouraged to acknowledge any slip to their fathers. Lectures should be given in schools and ambulance classes on the dangers of venereal disease. He considered the question of legislation, as including a review of the Contagious Diseases Acts, could only be studied, like certain plays, in one's own room. He believed the Acts fulfilled their purpose, but for the general good should not be applied piecemeal or patchy-like to secluded areas, but rather throughout the empire. He believed that "given free dispensaries for men in each quarter of a city, the notification of the disease and punishment of those to whom its spread was traced, together with the compulsory detention and segregation of prostitutes whilst in an infectious condition, and also by the General Medical Council including dermatology and syphilis as a subject requiring evidence of special study during the curriculum of students"—given these, he believed that syphilis would become of but sporadic importance.

Colonel Butt, R.A.M.C., said his experience of the disease had been limited to the army, but he had often thought that the medical profession did not look at the matter as it ought, and that they, in common with the general public, did not look facts in the face and recognise that, notwithstanding all sorts of moral and educational influences, things were much the same as they had been in the past. Legislation was required for a section of the community who would not submit themselves to self-control. The State would be guided in the matter largely by the opinion of the medical profession, and yet the whole subject bristled with controversy largely as the result of ignorance. He was convinced that no advance could be made towards stamping out the scourge until every member of the profession took a whole-hearted interest in it. His own experience of his last three years in India had led him to the conviction that the disease could be stamped out. During that period, in a garrison of one thousand men, he had not one case of syphilis, although there were many prostitutes living on the confines of the garrison, and none of these contracted syphilis, although the number of syphilitics in the garrison never fell below one hundred. He admitted that the accomplishment of this was made easy for him by the magistrates, officers commanding, and his brother medical officers working with the one desire of stamping out the disease. They induced the soldiers to believe that they could benefit them by submitting to treatment. There was no stigma attached to women who suffered from venereal diseases going into cantonment general hospitals, and the native women attendants were got to explain to the women the benefits of treatment. The result was, he thought, strong presumptive evidence in support of his contention, that so long as local manifestations of the disease had been removed and the treatment was continued the disease could not be communicated. It had occurred to him that in order to get to influence the prostitutes to submit to treatment use might be made of the Salvation Army. That society had done immense good in other directions, and if it were shown that the profession was anxious to combat the disease on humanitarian grounds he believed the society would assist them. He believed that by treating syphilis patients as sufferers rather than offenders they could be got to submit to treatment, and that thus they would go a long way towards controlling what he considered a preventable disease.

Dr. **Henry FitzGibbon** said the difficulty which had always existed in dealing with patients in the

Lock Hospital had been the absence of controlling power to get the patients to remain under treatment. The tendency with the patients was to think that they were cured as soon as the disease was out of sight. Power was required to keep prostitutes in hospital as long as there was active syphilis present, and to keep them under observation and treatment as extern patients afterwards. There was also a difficulty in connection with young men who had not the means to pay for treatment, and who had no encouragement to go to general hospitals.

MAJOR BROWN, R.A.M.C., said that although he had never been able to connect syphilis and tuberculosis, as suggested by Dr. Stritch, he had always found that when syphilis was contracted by a patient with tuberculosis he went from bad to worse, no matter what the treatment was, unless he was seen early. As regards prevention, keeping boys at home was an excellent method, if it could be done; but a better plan was to protect them when they went abroad by legislating for them, and legislation meant bringing back the Contagious Diseases Act. The majority of those who indulged in that particular vice were not open to moral persuasion. Syphilis, of course, could be contracted in many ways, and there should be some place where it could be cured. Women, however, who practised as prostitutes were not open to moral persuasion, and the only way was to compel them to remain in hospital or to report to a doctor until they could be certified as free from the disease. Their efforts to stamp out the disease in the army did not seem to have had much effect. In Dublin, in 1906, the constantly sick from syphilis were 2.93 per 1,000, while in 1866 it was 1.72.

Dr. **PUGIN MELDON** said that one of the first difficulties in curtailing syphilis was the difficulty of diagnosing it early. He thought, however, that that would be only temporary, and that the bacteriologist would aid them in telling the patients definitely whether they were suffering from syphilis or not. A further difficulty was that of keeping prostitutes in the hospital. They went in readily enough as long as they were sore, but they went out in a short time and became infectious. This was the case with the very large percentage of patients who were also heavy drinkers. Soliciting in the streets should, he considered, be made illegal, and the punishment should depend on whether they were suffering from venereal disease or not. If suffering from disease, they should be confined in a lock ward or hospital, or in special prison wards, until cured, or allowed out on a ticket-of-leave principle. He considered also that any man who held connection with another individual while suffering from syphilis ought to be severely punished. The great difficulty in the way of legislative measures was the opinion of the public that the more syphilis was stamped out the more prostitution there would be. Their business, however, as medical men, was to check disease in every form. The presentation of the financial side of the question, as mentioned by Dr. Stritch, might smooth over the obstacle of public opinion. Seven million pounds lost to the nation meant twopence or threepence off the income tax. That was a fact which the general public would appreciate.

Dr. **KIRKPATRICK** said the question of State interference was as old as history. So far back as 1162 Parliament interfered for the regulation of brothels. If the public knew more of the history of the disease and the efforts which had been made to stamp it out the work of the medical profession at present would be much lessened. There seemed to be a general idea among the public that there was no regulation for State interference with venereal disease in Dublin. That was a mistake. Under the Act of Parliament, 5 Vict., c. 24, the police dealt very severely with prostitutes and soliciting, and in the Act, 48 and 49 Vict., there were very stringent regulations for the suppression of brothels. He had received from the Commissioner of Police a table showing the number of women proceeded against during the last five years, 601 being dealt with in 1906. During the same period twenty brothels had been suppressed in each year. This afforded them a starting-ground for an active crusade against the disease. It was not always, as was urged, a merited disease, and he had only recently seen the case of a woman who had been infected by her husband as the result of his contracting the disease during her pregnancy, and she had infected her child. The morbidity and mortality of the disease justified them in urging the State to interfere in the matter just as it was interfering in diseases that cost the State insignificant number of lives compared with syphilis. The sentiment of the country was against the official registration of prostitutes, and he would rather follow the suggestion that the laws at present in force should be used against solicitation, and a man who could be proved to have infected a woman with syphilis should be liable to similar punishment.

COLONEL BURTCHAELL said he had been in several American cities where prostitution was rampant, although the police arrangements absolutely prevented soliciting. If the prostitutes did not find the men, the men would find the prostitutes. The State legislated for zymotic diseases, but they were diseases of innocent people. Syphilis, however, was due to a voluntary act. If legislation was enacted it should be equally severe on the man and the woman, and he thought there should be some restriction on the marriage of syphilitics.

Dr. **WINTER** said that the debate showed that the profession were not of one mind. Their policy should go along three main lines—(1) They should educate the people, and to do so they must first educate themselves; then (2) they could proceed to agitate for State interference; having agitated sufficiently they could then (3) proceed to try to get the State to act. In the prevention of the disease there was the difficulty that young men could not get away from their employment continuously to attend hospital, and it occurred to him that a possible aid would be for some of the hospitals to start an evening dispensary for men. He believed they would remain under treatment if allowed. He did not think the police could be very active against soliciting.

Dr. **STRITCH** replied.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD THURSDAY, APRIL 18TH, 1907.

The President, Dr. **SIDNEY PHILLIPS**, in the Chair.

MR. **F. JAFFREY**, F.R.C.S., read a joint paper by himself and Dr. A. **LATHAM**, entitled,

A CASE OF ULCERATIVE COLITIS; CÆCOSTOMY; COMPLETE RECOVERY,

which will be found fully reported on page 502 of the present issue.

In the discussion that followed,

Dr. **ALEXANDER MORRISON** spoke of the value of turpentine or terebene in these cases of ulcerative colitis, laying stress upon their styptic and antiseptic action.

Mr. **T. CRISP ENGLISH** referred to the relative merits of cæcostomy and appendicostomy.

The **PRESIDENT** said that only a few cases of ulcerative colitis require operation, among other indications being obstruction from atony and hæmorrhage. He referred to the value of adrenalin injection for hæmorrhage, and recommended mercury as being one of the best drugs for this disease. He pointed out the fact that hiccough is a frequent symptom, that embolism may occur, and that leucocytosis is present.

Dr. **ARTHUR LATHAM** said that in the great bulk of acute cases of ulcerative colitis, medicinal treatment does not control the disease, and he suggested that in the really acute cases surgical measures should be advised earlier than is the usual practice. Cæcostomy acts chiefly by resting the colon, and the washing out is probably of comparatively little use.

Mr. **JAFFREY** replied.

Dr. **Leonard Guthrie** read a paper on

FUNCTIONAL NERVOUS DISORDERS IN CHILDHOOD.

He suggested that all depended upon individual instability of the nervous system, and not upon the normal physiological instability common to all young subjects. Such instability was manifested in (1) *Derangement of co-ordination*, shown in nystagmus, head-rolling, and nodding, some cases of strabismus, congenital stridor, dysphagia, enuroesis, and stammering. (2) *Defective control* by higher over lower centres was instanced in chorea, the tics, some cases of recurrent pyrexia, and cyclic vomiting. (3) *Explosiveness* of higher centres accounted for epilepsy and eclampsia. (4) *Explosiveness* with readily induced exhaustion of psychical, sensory, and motor realms characterised hysteria. (5) *Irritability* and exhaustibility of all parts of the nervous system explained neurasthenia. (6) *Derangement* of the lymphatic and vaso-motor system was the cause of many functional ailments such as pseudo-angina palpitation, tachycardia, Graves' disease, dead fingers, atonic dyspepsia, entero-spasm, entero-ptosis, mucous diarrhœa, constipation, cyclic albuminuria. The sympathetic system was at the mercy of the mind, and most functional nervous disorders were the outcome of the neurotic or emotional temperament. The neurotic child was the father of the neurasthenic adult. The various types and characteristics of neurotic children were described. The importance of recognising such early signs as unusual timidity, tendency to brood, fret, and worry; hypersensitiveness of special senses, and of sensory organs in general, was emphasised. The influence of neuropathic inheritance and the effects of environment were considered in relation to neurasthenia. It was held that the neurotic temperament itself is in no sense morbid, though likely to become so under injudicious management. Educational over-pressure was attributed chiefly to fact-cramming, strain of defective memory, enforced concentration on uncongenial tasks, fear of failure and disappointment at want of success. Precocious children were no more liable than dullards to die young.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, April 18th, 1907.

Mr. Frank T. Paul, F.R.C.S., President, in the Chair.

CHRONIC SUPPURATIVE OTITIS MEDIA.

Mr. **E. M. Stockdale** read a note on the above with special reference to surgical treatment, based upon a series of cases which included sixty radical mastoid operations. He drew attention to the importance of skin grafting in certain cases, and mentioned the case of a bleeder in which frog skin had been used with excellent result. A case was related in which a baby, æt. 8 months, had suffered from a discharge from the left ear for seven months. Exploration revealed the fact that almost the whole of the mastoid and petrous portions of the temporal bone were necrosed. Removal of the diseased bone brought into view an extensive surface of dura mater covered by unhealthy granulations, both in the middle and posterior fossæ. A considerable portion of the lateral sinus was exposed and the internal carotid artery could be seen as it ascended to enter the skull. His experience showed that the hearing was often improved by the radical operation. The dangers of the disease and of the operation respectively were reviewed. His cases demonstrated that the danger of allowing the disease to run its course was much greater in every respect than the risk of even the radical operation.

Mr. **C. G. Lee** said he had watched the development of aural surgery from the time when a free incision into a post-aural abscess was thought to be all that was requisite; through the period when the mastoid was opened with a gimlet, the lateral sinus occasionally being opened accidentally up to the present when systematic and thorough surgical procedures happily held sway. Mr. Lee considered that the radical mastoid operation must rank as one of the most difficult in surgery.

Dr. **W. Milligan** remarked that the great difficulty was to determine the point at which local treatment should be given up and operative treatment instituted. For localised disease in the epitympanum and in the antrum removal of ossicles and the outer attic wall or Stacke's operation was as a rule sufficient. The great difficulty in practice was to determine the extent of the disease in the accessory cavities of the ear. An exploratory operation followed if need be by a complete radical operation was frequently indicated in chronic cases. He found, as Mr. Stockdale had said, that after many radical operations the hearing power was distinctly better than prior to operation.

EXTRAVERSION OF INTESTINAL MUCOUS MEMBRANE.

Mr. **G. P. Newbolt** showed this case after operation, having described and shown the case in its original condition before the Society on October 23rd of last year. The abdominal wall was now completely restored with the exception of a small sinus from which a little mucus sometimes escaped.

Mr. **R. W. Murray** advised leaving the sinus open.

COMPOUND FRACTURE OF THE HUMERUS.

Mr. **Rushton Parker** read a note on the above subject and showed a patient whose upper arm had been severely lacerated and the humerus broken transversely. Mr. Parker explained by means of lantern slides the way in which the ends of the bone had been kept in position by means of a sheet-iron twisted back-splint and two smaller lateral ones without having recourse to wiring. An excellent result had been secured. Radiographs were shown exhibiting the stages of callus formation.

THREE CASES OF EMPYEMA OF AN UNUSUAL NATURE.

Dr. **W. B. Warrington** read notes of, and commented on, the following cases:—(1) Empyema latent for over a year in a boy, æt. 17 years. There were very few symptoms, and spontaneous cure followed rupture of the empyema through the lung. (2) Empyema limited to the upper part of the thorax following pneumonia occurring in a patient who had six years previously had an empyema, which had been opened in the usual infra-scapular site. (3) Empyema in a boy, æt. 8 years. The physical signs were unusual, extended hyper-resonance, with amphoric breathing, coin sound and metallic tinkling, depression and rotation of the liver. An area of movable dulness in the lateral and basal regions of the right thorax. Dr. Warrington considered the symptoms were such as could be caused by air and fluid in the pleural cavity, though evidence as to the cause of a pneumothorax was wanting.

THREE CASES ILLUSTRATING SOME POINTS IN THE DIAGNOSIS OF ABNORMAL CONDITIONS WITHIN THE CHEST WALL.

Dr. **John Hay** read notes of these cases. (1) Actinomycosis of the lung simulating pulmonary tuberculosis, embolic pyemia, death. A girl, æt. 16, suffered from great dyspnœa, cough and anæmia and had been losing weight for six months. Pulse 160 per minute; signs of consolidation at the apex of the right lung. Three weeks later numerous abscesses had formed. Actinomycosis of the lung was diagnosed with a secondary actinomycotic pyemia. This diagnosis was proved to be correct by subsequent examination of the pus. (2) Centrally placed empyema not discovered by frequent exploratory aspirations. A woman, æt. 35, was admitted into the Stanley Hospital five weeks after a difficult confinement suffering from pain in the chest, pyrexia and cough. Ten days before admission she had a rigor and pain in her left side. Exploration of the chest gave a negative result. Later, the spleen was enlarged, the temperature remained elevated, and there was leucocytosis. Widal reaction negative. Exploration on two more occasions failed to locate pus, but finally it was found below the costal margin and the abscess was drained. The patient died the next day. The autopsy revealed an empyema in front of the root of the right ung adjacent to the pericardium. The pus had travelled down through the diaphragm and formed a sub-phrenic abscess. The recent delivery, the rigors, continued temperature, the normal position of the apex beat, the enlarged spleen, severe anæmia and the failure to strike pus all added to the difficulties. (3) A man, æt. 36, with marked dyspnœa, recurring hæmoptysis, cardio-pulmonary murmur audible at the mouth, but with slight physical signs, had contracted syphilis when aged 27. He first began to suffer from lung symptoms five years ago. The X-rays showed some fibrosis, especially at the root of the right lung, the apices were clear, the right side of the diaphragm limited in its movements. There was no history of night-sweats nor any abnormal temperature and there was no expectoration. Under treatment by mercury and potassium iodide the dyspnœa had greatly diminished, the cough had almost disappeared, the man's weight had increased, but the cardio-pulmonary murmur remained unaltered.

Dr. T. R. **Glynn** referred to a case of actinomycosis apparently commencing in the lung which he had seen with Dr. Thacker King. The victim of the disease was an elderly gentleman. The early symptoms were harrassing cough with the expectoration of blood and sanguineous mucus, later the development of a tumour on a leg in which the ray fungus was found. The mode of infection was not discovered.

Dr. T. R. **Bradshaw**, in discussing Dr. Warrington's cases, drew attention to the difficulty of distinguishing between empyema at the apex and a pulmonary abscess, pointing in the same situation. He narrated the case of a man who had pneumonia of the right apex. After a week fœtor was noticed in the breath for one day. A few days later a prominence was noticed below the right clavicle found on puncturing to contain fœtid pus. Operation showed that the abscess was in the lung and that it contained a large slough, which was removed. Recovery was satisfactory.

Dr. P. **Marsh** had seen a large number of cases of empyema at the infirmary for children, but never one with the physical signs as depicted in Dr. Warrington's case of pyo-pneumothorax. He had only seen two cases of pyo-pneumothorax, one of which was a tubercular case and the other followed the bursting of the empyema into a bronchus. He was astonished that so large a collection of fluid should cause so small an area of dulness as was shown in Dr. Warrington's diagram, and he doubted whether the pleural activity of a child of eight years would have a capacity to hold much air in addition to 40 ozs. of pus and compressed lung. He would like to ask two questions: (1) Whether there had been any escape of air when the pleural cavity was opened by the surgeon, and (2) whether an exploratory puncture had been made before the signs of pneumothorax had appeared as this operation had been known to cause pneumothorax. (Both these questions were answered in the negative).

Sir Chas. Barr, Dr. R. J. M. Buchanan, Dr. Grace-Calvert, Mr. R. M. Murray, Mr. T. Littler Jones, and the President also took part in the discussion on Dr. Warrington's and Dr. Hay's cases.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, May 5th, 1907

The Cries of Infants.

Two great varieties distinguish the cries of infants—the physiological cry and the pathological cry.

Children are frequently brought to the consulting-room because they cry unceasingly, and that is the only symptom complained of. The point is to be able to classify the cry under one or the other of the categories above-mentioned.

The most frequent cry is that produced by hunger, but more from a defect in the quality of the food than from the quantity; consequently, the consultant should examine closely the nourishing quality of the food given to the infant. Examine the breast of the nurse, or, if bottle fed, the quality of the milk; weigh the child before and after feeding to see if the quantity given is sufficient; every decrease in weight, unaccompanied with fever or diarrhœa, is due to a fault in nutrition.

Once the cries of hunger are eliminated, says Dr. Carriere, the cause must be pathological; the child cries from pain, and should be undressed, when frequently the cause is found to be a pin or a flea.

Generally the parents attribute the uneasiness of the infant to dentition. The eruption of the teeth might be incriminated if the little patient bites his fingers; the nipples of the feeding bottle or of the breast, if the gums are swollen and tender to touch. In such cases the gums should be rubbed by some sedative preparation.

Erythema of the thighs always provoke cries from the infant, and only cease when it is undressed and the parts powdered with talc or anointed with vaseline.

Another frequent cause of incessant cries is abscess developed in the cellular tissue, and especially in the folds of the umbilicus.

In osseous affections the cries are of extreme intensity and exasperated by the slightest movement. Consequently the different segments of the limbs should be examined one by one. It is thus that may be recognised osteo-myelitis, fractures, luxation, sprain, sub-periosteal sanguineous tumour of Barlow's disease, acute rheumatism (not rare in infants), or synovitis.

The glands should also be passed in review for possible adenitis.

If the examination has still given negative results, and that the mother says that the child cries especially after taking the breast or while it is sucking, attention should be drawn to the mouth and the throat, where aphthous stomatitis or tonsillitis may be discovered.

The public generally, and frequently with good reason, attribute the cries of infants to colic, which may be due to dyspepsia, dilatation of the stomach, enteritis, worms, &c.

There remains two other frequent causes of infant cries—otitis and meningitis.

In disease of the ear, they are inceasing and accompanied with high temperature. The suffering is increased when the ear or the mastoid process is touched. By the aid of the otoscope the cause of the pain is discovered, which is generally a boil or an abscess behind the tympanum. If a few drops of a solution of cocaine and oil (1—100) are poured into the middle ear, the boil or the drum can be incised, when all pain ceases.

The cries of meningitis are acute, short, monotonous, penetrating, and intermittent; they are accompanied by grimaces and pain which nothing relieves.

Treatment of External Tuberculosis.

The treatment by salt water of external tuberculosis is to-day of common practice. Dr. Regnier read a paper on it before the meeting of the Surgical Society a few weeks ago. The treatment is simple: Application of absorbent wool moistened with salt water, made with an ounce of the salts of chloro-sodic waters to a quart of boiled water.

A man suffered from suppuration of the shoulder for four months; through two fistulæ about five ounces of pus flowed out daily. He was greatly emaciated. The cause was tuberculous disease of the head of humerus. In spite of resection of the diseased bone and the filling of the cavity with iodoform gauze, the suppuration continued and amputation was thought necessary. However, M. Regnier, as a last resource, decided on irrigating the wounds with salt water and covering them with absorbent wool moistened with the same liquid. Gradually the suppuration ceased, the fistulæ closed, and the man recovered with a useful arm.

Another patient was also tuberculous. He coughed and presented several suppurating fistulæ, two on the sternum, one on the shoulder, one on the upper extremity of the humerus, and two on the elbow (resected a year before).

Over all these fistulæ, M. Pegnier applied the compresses of salt water during nine months. The fistulæ closed by degrees and to-day the patient is cured of all the external signs of tuberculosis, while the condition of the lungs has considerably improved.

GERMANY.

Berlin, May 5th, 1907.

A RUSSO-GERMAN Medical Society has recently been founded in Berlin, the object of which is the drawing together in fraternal intercourse the physicians of the two nations by means of personal intercourse and meetings of the Society in various places. The first presidents of the new Society are Prof. von Leyden, Berlin, Prof. Bechtereff, St. Petersburg, and Prof. Hildebrand, Berlin. The secretary is Dr. Lipleawsky, treasurer Dr. Weissbein, and librarian Dr. Kossmann. It is intended further to form a library, a polyclinic for poor Russians, and a Russian Hospital in the city, to be the headquarters of the Society.

The late Oberlandesgerichtsrat, Dr. Rothschild, the founder and president of the Köln Cremation Society, has left the whole of his fortune, amounting to a million marks, to the city of Köln. The condition on which it is left is that the city shall at once build a crematorium at a cost of not less than 100,000 marks. At a meeting of the city council on the 21st ult. the bequest, with its conditions, was unanimously accepted.

The thirtieth meeting of the German Society was held from April 3rd to the 6th. The president, Hr. Reichel alluded to the great loss the Society, the surgery of Germany, and of the whole world has sustained in the death of Ernest v. Bergmann. He took the opportunity of correcting certain incorrect reports that had been permitted to spread regarding the cause of his death. The deceased had suffered from dysentery during the Russo-Turkish war, but had apparently completely recovered from it. During the past few years several attacks of obstruction of the bowels had come on, the cause of which could not be made clear. They were, however, always overcome. A short time ago Prof. v. Bergmann had visited Wiesbaden on account of sciatica, the attack subsiding in a short time. Then suddenly a very violent attack of illness came on with vomiting, so much so that it became necessary to open the abdomen on the right side where there was violent pain. This operation was performed by Prof. Schlange, a former assistant of the deceased's. On account of the patient's great weakness only a cæcal fistula was formed. Then the most violent pain set in on the left side and Prof. Schlange (and not another surgeon as had been stated), at the express wish of his patient operated a second time on that side. It was evident that general peritonitis had already set in, and death rapidly took place. The autopsy showed a kink in the intestines caused by adhesions, a result of the old dysentery and fatty necrosis of the pancreas. We knew the speaker said how deleteriously the latter condition acted on already existing morbid conditions—hence medical art was powerless. The late professor was one of the founders of the Society, and was the thirteenth on the list; he also stood thirteenth on the list of those members that had died, the Society having lost thirteen of its members by death during the past year.

The president then turned to a more agreeable subject. On April 5th of the present year Lord Lister had completed his eightieth year. The management, in the name of the Society, sent a congratulatory address, drawn up by Hr. Körte and artistically engrossed to the benefactor of mankind, to whom many thousands of people every year were indebted for their lives and health.

The President then opened the professional part of the meeting, and observed that as the first meeting was usually attended by numerous ladies the first theme for discussion would be the heart.

Hr. Rehn Frankfort then introduced the subject of

THE SURGERY OF THE HEART AND PERICARDIUM.

He remarked that when he brought before the Society ten years ago the successful case of suture of the heart the majority of surgeons had been very sceptical on the matter. To his great joy they had now become confident. No case was known in which definite cessation of cardiac movement had taken place in consequence of the operation, even if death had taken place on the operating table from the excessive exhaustion of the patient. But we did occasionally observe when manipulation was prolonged or severe a temporary arrest of movement. Such was a warning to the surgeon to be exceedingly careful. Recent anatomical investigations had made distinct progress as regarded the centre for cardiac movements. Experiments made in the Aschoff Institute showed that when His's bundle was completely cut through the heart always ceased to contract, but not if even only a few fibres remained intact. This knowledge permitted us to operate on the heart quite energetically.

External inspection only rarely gave certainty as to wound of the heart. For the future an X-ray examination would often allow a conclusion to be reached. The situation of the external wound often indicated the existence of a wound. Symptoms were rarely absent in wounds of the heart; usually there was severe shock and free bleeding. The chief danger lay in bleeding to death and pressure from blood in the pericardium. When this was filled with blood the heart rotated on its axis in proportion to the degree of filling. Smaller effusions into the pericardium might prove fatal from causing over-fatigue to the heart. Characteristic symptoms following wounds of the heart were: pains in the left arm, precordial pain, pain in the abdomen, shortness of breath, cyanosis and torpor. One symptom that pointed to the injury was a systolic squirting sound.

If the weapon causing the wound was a knife, it should not be removed at once, as it dammed the route of the canal and acted as a tampon. If on opening the pericardium the blood squirted out the flow should be checked by pressure on the auricle. Contraction would begin again after pressure had been kept up a minute and a half, and after incomplete pressure for four minutes.

For the human heart these periods could be considerably lengthened. The vena cava was best compressed at the right auricle by a fork-like grasp with the second and third fingers.

The most unfortunate occurrence in suture of the heart was the cutting through of the sutures. All these patients died.

He advised that the pericardium should be sutured along with the heart itself, he would not pass the suture right through all the structures. Neither wire nor catgut should be used for sature material, but only fine silk. One hundred and twenty-four cases of suture of the heart had been published; of these 40 per cent. had recovered and 40 per cent. had died from septic infection.

AUSTRIA.

Vienna, May 5th 1907.

TEMPORAL ABSCESS FROM OTITIS.

ALT showed a case to the "Gesellschaft der Aerzte." In January the lad took influenza, followed by an acute inflammation of the right middle ear, with otorrhœa. A week later meningitis developed, and the lad was removed to hospital, where he appeared to suffer a good deal of pain in his stupor. The temperature ranged between 30.0° and 39.8° C., with a pulse of 84.

About this time the otorrhœa was very profuse, with perforation of the tympanum posteriorly and inferiorly, while the parotid and mastoid were very tender on pressure.

The left ear was quite normal; the right could detect whispers at one metre; the Weber test lateralised the right, while the Rinnie test was negative on the right, with prolonged osseous conduction—high tones being better heard than low.

Trepanning the right mastoid was then performed, relieving a large quantity of putrid pus extending vertically down the mastoid almost to the point, which was removed to give free vent. Eight days later the temperature was still at 39.6°, with stiffness of the neck, facial paralysis on the left side, fundus of left eyes normal, but the vessels of the right fundus were greatly enlarged and serpentine, while the temporal section of the papilla was adherent. These symptoms favoured an intra-cranial complication, as the left-sided facial paralysis would be expected from implication of the right temporal lobe of the brain.

This suggested another operation into the temporal lobe on the right side, where an abscess 1½ centimetres deep was found about the size of an apple. This was kept open for three weeks and carefully dressed with the insertion of a drainage tube. Everything prospered after this; the present shows a fine granulating wound nearly closed except the bony structure.

RHINOLITH.

Glus showed a patient from whom he had removed a calcareous mass that was situated below the lower turbinated bone over the eye-tooth.

After an attack of pleuro-pneumonia which the patient had last October, vomiting with a nasty fœtid smell commenced. The stomach and bowels were found to be healthy, which excited the presumption of the cause being buccal. The sputum was examined and purulent matter sometimes found. The patient was then taken to Chiari's Clinic, where the rhinoscope was used and the rhinolith discovered below the lower turbinated bone after a long examination, as it was surrounded with pus and a broken mass of tissue from the septum, as in all foreign bodies when long detained in the nasal cavity. After its removal the parts healed rapidly.

The most interesting points in this case are (*a*) the unusual anatomical position of the rhinolith, and (*b*) the anomaly of the circumstance. He must have carried this morbid body for years without trouble, till the influenza aggravated the surroundings and precipitated the morbid changes.

LUPUS VULGARIS EXULCERANS.

Freund presented a young woman whom he had cured by means of the rays. The lupus had destroyed a large part of the nose from the point backwards. Within two months after twelve sittings the nose was quite healed. Six applications had been added since as a prophylactic preparatory to a cosmetic operation to restore the outline of the nose.

PARALYSIS OF LOWER EXTREMITIES.

Moszkowicz next presented a boy, æt. 7, on whom he had operated for a contracted condition of the muscles of the leg resulting from paralysis in youth of both legs. Before the operation the boy was able to move like a four-footed animal. The knee-joints were stiffened from synarthrosis, while the tendons of the feet and hips were greatly shortened. The glutei maximi were useless as extensors, but the semitendinosus, semi-membranosus, and biceps were removed from the tuber ischii and attached to the os ileii. The knees were then straightened and the parts allowed to heal. With the assistance of two sticks the lad is now able to walk upright.

CHRONIC RHEUMATISM AND FIBROLYSIN.

Zuppenger presented a boy, æt. 12, who had typical articular rheumatism in 1899, which left him unable to move or turn himself, while the chin was so fixed on the sternum that he with difficulty took fluids. In this state he was received into hospital and after three weeks' treatment with fibrolysin injections the patient is able to move his head and freely open the mouth. He considers this a marvellous result after six years' fixation.

HUNGARY.

Budapest, May 5, 1907.

HYPEREMESIS GRAVIDARUM.

Dr. Odön Tuszkai, Gynæcologist in Marienbad and Budapest, concludes his investigations, carried on through several years, in the following summary:—

I.—Hyperemesis produced solely by gravidity, is one of the rarest complications of pregnancy.

II.—We have strictly to distinguish between vomitus gravidarum occurring during gestation and between hyperemesis gravidarum specifica. Also, we have carefully to discern by exclusion those diseases which cause vomiting in pregnant women, too; such as gastric troubles, meningitis, peritonitis, hydrops, &c.

III.—The diagnosis of hyperemesis gravidarum can be made with certainty under the following conditions: (*a*) If we were able certainly to exclude the diseases mentioned under II., viz., with the adoption of all the diagnostic and therapeutic methods and means; (*b*) If after these we find all the characteristic clinical symptoms, viz., great local tenderness of the peritoneum and of the uterus, which tenderness not only increases on bi-manual examination, but also gives rise to vomiting or violent retching and nausea; (*c*) If the frequent and severe vomitings occur also without taking food, and show within a short period the symptoms of inanition, and we find:

1. The quick decrease of the body weight, the daily quantity of urine, its chlorides and the red blood corpuscles of the blood.

2. The increase of the quantity of urine, its specific gravity, also the alkalinity of the blood and the pulse-rate.

3. The appearance of albumin and kidney elements in the urine and the presence of normoblasts and uninuclear megaloblasts in the blood.

(4) The sudden fall of the morning temperature, and in opposition to this, the febrile or subfebrile rise of the same.

IV.—The symptoms of hyperemesis gravidarum were explained from the irritation of the perimetrium, which most probably originates on account of its individual and occasional properties from a local atrophy, and thus is in causal nexus with gravidity.

V.—Prognosis is evidenced from the degree of inanition, in relation to the bodily condition of the individual. Evidence is gained by the above-described bio-chemical reactions.

VI.—On these grounds we shall be in the position to employ causal treatment, which in the forefront is conservative (local cold, heat, complete rest, large doses of opium), and only in cases of entire failure to interrupt pregnancy, when the life of the mother is endangered. This operation can be performed very easily and comfortably.

At the recent meeting of the Royal Society of Physicians of Budapest, Dr. Pandy exhibited a child that strikingly resembled a monkey. The head, attitude, manner of moving and walking of the child (a boy, æt. 10) reminded one of a monkey. His height was 103 cm., weight 16 kgr. The largest horizontal periphery of the skull amounted to 39 cm., forehead low, and bent backwards. The upper portion of the ears were narrowing; the chin was not prominent; the feet were loo long, the calves undeveloped. Thirty years ago, Dr. Vogt described similar small-headed children in order to prove that man originates from the monkeys. This statement has proved faulty, inasmuch as the resemblance affected only the head, and even here it was only superficial.

As for the treatment of small-headedness, which pathological condition involves also the smallness of the brain, some surgeons attempted to trephine the skull, in order to yield space to the brain for growth. But all these operations were futile. There is one medicine against small-headedness, that is, careful attention, thorough education, and systematic teaching of the child.

The commonest cause of small-headedness is excess in drinking. We all very well know that we are able to breed dwarf animals by giving them alcoholics. The habitual drunkenness of the father can produce small-headedness likewise epilepsy in the children. A drunkard, whom Dr. Pandy has known, had six hydrocephalic, and four microcephalic, idiotic children.

Dr. Tynatz Feldmann, prosector of the County Hospital in Békés-Gyula, read a paper on

Intestinal Obstruction as Complication of Gonorrhoic Epididymitis.

He could state from necropsy and from the results of bacteriological examinations, that gonorrhoic epididymitis} recte deferentitis was followed by the formation of a subperitoneal abscess on account of the perforation of the spermatic cord. The abscess produced a circumscript peritonitis, and this led to the adhesion of the bowels and finally to intestinal obstruction. The consecutive acute general peritonitis was caused by the obstruction.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

The Health Commission.—For some days past the Health Commission has been hearing evidence on the Belfast water supply, much of the evidence being of great interest in view of the doubt which exists as to how far typhoid, epidemic and endemic, can be attributed to bad water, and how far to defective sanitation. The fact that the Water Commissioners are responsible for the one, and the Corporation for the other is, in this instance, an advantage, for each body has produced the best expert evidence available to help to elucidate the problem. Among the witnesses heard were Professor Lorrain Smith (late Professor of Bacteriology in Queen's College and now of Owen's College), Professor Symmers (the present professor at Queen's), Professor Letts (professor of chemistry at Queen's), Professor Frankland, and Drs. Gordon and Houston, of London, three experts retained by the Water Commissioners, Mr. Macassey, engineer and legal adviser to the same body. The water is derived chiefly from three sources: Stoneyford, near Lisburn; Woodburn, on the hills above Carrickfergus; and from the Mourne Mountains. The two first are agricultural land, with some population, and the last, which is intended eventually to be enlarged to supply the whole city if necessary, is wild mountain land. Professor Lorrain Smith said that he had investigated the typhoid question in Belfast in 1898 and in 1903. He did not consider the housing in Belfast worse than Manchester or Liverpool, which had about one-sixth as much typhoid. The disease did not occur where one would expect it, if due to bad sanitation, nor did he think milk could be blamed. But he looked on the presence of typhoid in the catchment area at Stoneyford as a very serious factor. He strongly advocated isolation. In Belfast there were only about 50 per cent. of the cases treated in hospital, while in Glasgow there were 91 per cent. Professor Symmers stated that he had entered into an experimental arrangement with the Corporation to make 100 analyses of water and milk per annum, for this year at any rate. He had examined eleven samples of water, but had not found any B. coli in any of them, in 100 c.c. In one sample he had found a bacillus which he regarded with extreme suspicion; it was very like the typhoid bacillus, but not identical with it, and he had never seen anything quite the same before. He believed there ought to be a bacteriologist to devote his whole time to the examination of the water, as the question of the typhoid infection was such an important one. The experts retained by the Water Commissioners described various investigations they had made, the result of which was that they admitted that the Woodburn and Stoneyford supplies were not quite satisfactory, in view of possible pollution of the catchment areas: but they did not consider that water stored as long as Belfast water is—200 days—ever produced typhoid. They also urged the fact that typhoid occurred all over the town, and not in the district supplied by any one of the sources, and also that it did not occur in the gaol, which is supplied with town water. Professor Letts said that on the ground of repeated chemical analyses he believed the water supply unsatisfactory. He strongly advocated the extension of the Mourne Mountains supply as an ideal one. Several other witnesses gave technical details about the working of the filtration beds, the distribution of the different supplies, &c. It is not easy to sum up the whole matter, but the general opinion would seem to be that while the Belfast water supply is open to grave suspicion, it can hardly be held entirely to blame for the constant presence of typhoid in the city.

LETTERS TO THE EDITOR.

MILK AND TUBERCULOSIS.

To the editor of The Medical Press and Circular.

Sir,—Dr. Granville Bantock's letters appear to me amusing in virtue of his standpoint, which seems somewhat that of Bantock *contra mundum* in all questions of modern bacteriological science. I am sorry if this displeases him. I admit it is not to the point. My point, like his as he avows it, is entirely practical. I would respectfully suggest to him that objective symptoms of tuberculosis rarely, if ever, appear until the lapse of a prolonged period after infection, and that this renders vain, in most cases, a search for the source of the poison. This is not the case in typhoid. Ten thousand instances could be adduced in which the contagium has been clearly followed to its course. A striking illustration was given in the High Court a year or so ago. An outbreak of typhoid was traced to the milk supplied by a leading London dairy company. The milk was derived from one of a number of farms whose produce the company dispensed. At the farm in question typhoid cases had occurred, and defective drains led the poison into the wells from which the water supply at the farm was drawn. The whole case was proved with scientific exactitude. I don't know what practical moral Dr. Granville Bantock wishes to draw from his argument, He seems to make light of the suggestion that we are to take any pains to guard our patients against poisoning from sources which the whole scientific world, except himself, seems to recognise. The case has been fully stated during the progress of bacteriological research; we all know it; you, Sir, certainly would not afford me space, if I were willing to tell the long story over again.

I am, Sir, yours truly,
A Family Doctor.

Bristol, May 3rd, 1907.

P.S.—It would be interesting to learn whether Dr. Bantock believes in a prophylaxis of tuberculosis, and if so, how he describes or formulates it.

PHARYNGO-KERATOSIS TREATED BY APPLICATIONS OF SALICYLIC ACID IN SULPHO-RICINATE OF SODA.

To the Editor of The Medical Press and Circular.

In the report of a case illustrating the above, which I brought before the Laryngological Society at its last meeting, a very important fact—and, indeed, the one which gave the main value to the case—was omitted. This was to the effect that the condition—best known as pharyngo-mycosis—was well marked on both tonsils, but that after the patient had made a daily application of a 10 per cent. solution of salicylic acid in sulpho-ricinate of soda to her right tonsil only, a slow but steady diminution in the size and in the consistency of the spots on it was observed after a few weeks. The other tonsil remained as before, until the same application was made to it also. This rigid experimental test showed incontrovertibly that the improvement was due to the application and not to any co-incidental spontaneous disappearance such as we know to take place from time to time in this disease. It is generally agreed that the condition is really one of no importance, and if a patient can be persuaded to disregard it, so much the better; for those, however, who are impatient of the condition, it is gratifying that there should be a method of treatment which has an unmistakable action on the keratotic condition and which can be placed in their own hands. The action is, of course, analagous to that of salicylic acid upon warts, corns, and similar conditions, and the sulphoricinate of soda seems to be the vehicle with which it can be incorporated as as to be as unirritating as possible. In view of the policy I have above described of dissuading patients from submitting to treatment for this condition, the opportunities for observing the effect of such treatment are obviously very few.

Thanking you for allowing me space for this communication,

I am, Sir, yours truly,
DUNDAS GRANT.

Cavendish Square, May 7th, 1907.

OBITUARY.

EDWARD MARKHAM SKERRITT, M.A., M.D.Lond. B.S., F.R.C.P.Lond.

WE regret to announce the death from pneumonia, after a short illness, of Dr. Edward Markham Skerritt, at his residence in Clifton, Bristol. Deceased was born in London in 1848, so that he was 58 years of age at the time of his death. His career has been one of brilliant success both at college and in after life. He relinquished the post of Dean of the Medical School only two years ago, having become first Dean of the Medical Faculty of University College, Bristol, in 1893. He was educated at Amersham Hall School, and University College Hospital, London, graduating B.A. at London University in 1868. He had a distinguished career as a student, taking many prizes and medals and the Atkinson-Morley scholarship at University College, London. He took the degrees of M.D. and B.S. (Honours) in 1873, and that of M.D. in 1874. He became a licentiate of the Royal College of Physicians, London, in 1873, member in 1876, and Fellow in 1885. He also became M.R.C.S., England, in 1873. He was gold medallist in medicine and obstetric medicine at the first M.B. examination, and obtained similar honours at the second M.B. examination.

He was elected physician of Bristol General Hospital in 1875, having at that time commenced practice there. He continued to serve the hospital for the rest of his life, being at the time of his death senior physician. He was a Fellow of University College, London, having previously filled the post of house-surgeon, assistant physician, and assistant in obstetrics there. He was a member of the Council of the Royal College of Physicians; vice-president (late treasurer) of the British Medical Association. For a period of some 26 years, Dr. Markham Skerritt, as Dean and joint professor of medicine, was prominently associated with medical education in Bristol. His loss will be deplored by a wide circle of friends and acquaintances, both social and professional.

The following comes from a personal friend and colleague:—

"I can supply a few details with regard to Skerritt. His latest appointment was that of Hon. Consulting Physician to the Cossham Memorial Hospital, Kingswood, a magnificent place to be opened in June next. Perhaps the chief characteristic of the man was the high standard he set in all matters of medical policy and medical ethics. In any matter of dispute between medical men, Skerritt was always sought for as referee, and his judgment implicitly relied upon. His medical consultation work was marked by rare common-sense. He never hesitated to say that a diagnosis could not be made immediately, and his diagnoses when made were nearly always correct. He had a firm belief in the curative powers of time and rest in bed, employing few drugs, and these of the simplest. His personality inspired great confidence both in patients and in medical men. He was a man of few words, and one whose shyness suggested, perhaps, sometimes a lack of sympathy, but his patients were firmly attached to him and the large attendance at his funeral (the largest I have seen in Bristol) were striking witnesses to the regard in which he was held. He was a strong total abstainer, a lover of horses and of fox-hunting. Latterly his wife's sudden blindness and his only child's premature death at the age of about 23, were heavy blows to him."

JOHN MACDOUGALL, M.D.GLAS.

THE death of Dr. John MacDougall, one of the oldest and best-known medical men in Greenock, occurred on Wednesday last with startling suddenness. At half-past five that morning, his wife noticed something wrong with him, but before anything could be done he expired. Although occupied the previous day, and in his usual apparent good health, with his duties, he expired suddenly in the bedroom in the presence of his wife in the early morning following. Deceased, who was over 70 years of age, graduated at Glasgow University in 1863, and had practised in Greenock ever since. He was police surgeon, a position he had held for about twenty-two years, and leaves a widow and a grown-up family.

SPECIAL ARTICLES.

THE NATIONAL SANATORIUM FOR CONSUMPTIVES, BENENDEN.

[BY OUR SPECIAL REPORTER.]

THE National Association for the Establishment and Maintenance of Sanatoria for Workers Suffering from Tuberculosis, justified its existence publicly on Tuesday April 30th, when Princess Christian formally inaugurated the opening of the portion of the Sanatorium at Benenden, in Kent, now available for patients. Visitors were conveyed by special train to Cranbrook, and thence for six miles by motors over the undulating hills of the Weald of Kent. Sir Clifton and Lady Robinson hospitably provided luncheon for the guests, among whom were Dr. Heron, Dr. Kelynack, Dr. T. D. Lister, Dr. A. Latham, and many well-known laymen. The new institution is a praiseworthy experiment to help the workers to help themselves. The Post Office employes and members of friendly societies are enthusiastically co-operating in the movement. The sanatorium is to be an example of the minimum of expenditure with the maximum of efficiency. It is estimated that the cost per bed will not exceed £100. The site is a good one, although the district is not easily accessible. An estate of 250 acres has been taken on which are two farms suitable as bases for the proposed Farm Colony, which is an essential part of the scheme. At present only a portion of the sanatorium is built. When completed, it will consist of a central block accommodating 68 patients, with scattered pavilions for ten patients in each, administrative block, dining hall, laundry, and electric light station. The buildings are being constructed as economically as possible. They are of steel framework, the intermediate space between the stanchions and girders being filled in with Frazzi cement rough-casted on the outside and plastered on the inside. The wards are floored with teak and the doors are of the same wood. The drainage is provided for by a septic tank system. Already there are a number of patients. Dr. Leonard Crossley is the resident physician. Mr. A. William West is the architect. Many have afforded the movement loyal support.

It is a rational attempt to secure effective co-operation and co-ordination of practical effort which will be watched in its future developments with sympathetic interest. Certainly the experiment should be carefully studied by all those desiring to render rational aid to the independent and self-respecting worker. The Prince of Wales is to preside at a dinner on the 14th inst., at which it is expected there will be ample practical evidence of the helpful interest taken by both medicals and laity in this praiseworthy national movement.

THE INFANTS' HOSPITAL.

[By our Special Reporter.]

The ancient and honourable City of Westminster on Thursday last, May 2nd, publicly recognised and accepted a unique addition to the many notable institutions which exist within its borders. H.R.H. The Duchess of Albany, the Patron of the new Infants' Hospital, formally laid the memorial stone.

The hospital, which has done much good work in a quiet way at Hampstead for several years, will shortly take up work in the new buildings, which already promises to form a most handsome institution overlooking Vincent Square, the playground of the Westminster schoolboys—an admirable position for such an institution. The hospital will provide accommodation for 50 infants. There is a well-designed Lecture Theatre with laboratory adjoining, and the institution may be expected to take a prominent part in that educational movement which seeks to arrest the deplorable wastage of infant life now so prevalent in London and all our large centres. Major-General Lord Cheylesmore, the Chairman of the Hospital, and Mr. J. S. Fletcher, M.P., its Vice-Chairman, detailed the work of the institution, and the Mayor of Westminster, who was accompanied by members of the City Council, also took part in the proceedings. Sir Lauder Brunton, one of the Consulting Physicians, and Drs. Ralph Vincent and T. N. Kelynack, the Physicians of the Hospital, with Mr. Mayo Robson, Dr. Sandwith, and Dr. F. J. Allan, were also present. The hospital is the munificent gift of Mr. Robert Mond, and forms a peculiarly fitting memorial of his wife. It is a greatly-needed addition to Metropolitan institutions caring for the young.

REVIEWS OF BOOKS.

THE RONTGEN RAYS IN MEDICAL WORK. (a)

Dr. Walsh's book, "The Röntgen Rays in Medical Work," hardly needs any commendation from us, for we venture to think that it is almost as well-known as the rays themselves; at any rate, to everyone who uses them therapeutically or skiagraphically this book has been guide, philosopher, and friend for the last ten years. The lawyer, too, finds it invaluable, and hardly a compensation case comes before the court without appeal and counter-appeal to its pages and illustrations. Its success is sufficiently demonstrated by the fact that frequent editions have been called for; indeed, the author more than hints in his preface that the present one has been due for some time, and would have been brought out earlier but for the demands that a complete survey of X-ray work necessarily made on his time. To this reason, too, is due the fact that Dr. Lewis Jones's lucid and interesting introductory series of chapters on Electrical Apparatus are found to contain one or two points which are disputable in the light of recent work, but of this first part generally it may be said—and we could give no higher praise—that it forms a complete and fitting introduction of the main thesis. For anyone unskilled in X-ray manipulations who wishes to render himself proficient, these first nine chapters will be found to supply all that he need know, set out with skill and clearness, and they will save any amount of heart-burnings if he keeps to them when at work, and eschews other and more loquacious guides, for the pictures are sufficiently numerous and well-set-out practically to allow a tyro to find his way by himself through all the intricacies of apparatus and machinery. Of Dr. Walsh's own chapters, which constitute three parts of the book, we can only say that they have been brought quite abreast of the newest facts and latest knowledge on the subject, without losing anything of their old freshness and charm. They are written with that clear knowledge and literary skill which enable the author in the course of each paragraph to present a pen-picture, precise and finished, of the condition he is describing; there is no redundancy, tedious detail, or vain repetition. Yet in the course of some three hundred pages he succeeds in covering the whole immense field now occupied by the X-rays in medicine, surgery, and therapeutics—certainly a highly-creditable achievement. The bulk of the work naturally is devoted to the various appearances of the bones and viscera in health and disease, but there are also sections on Dental Surgery, Nasal and Throat Surgery, Obstetrics and Gynæcology, Legal Medicine, Anatomy, Physiology, and Veterinary Surgery, all containing much valuable observation and instruction. One of the best parts of the section on Surgery is that dealing with the localisation of foreign bodies and injuries, in which the author is able from his wide experience to give many hints as to how to avoid the pitfalls which beset the expert witness who unwarily enters the box to give evidence based on X-ray photographs. Of the illustrations themselves, a hundred and seventy-two in number, it is hardly possible to speak without using terms that savour of exaggeration. They are by far the most beautiful, accurate, and artistic reproductions of X-ray photographs that we have seen, and we can only congratulate the author and publishers on having enriched surgical literature with such a unique and fascinating collection. It is difficult indeed, to know which takes our fancy the most. The photos of foreign bodies, especially Fig. 74, Three Bullets in the Head of a Cadaver; Fig. 77, Pin in Larynx; Fig. 80, Watch and Chain in Œsophagus, swallowed by "Ostrich Man"; Fig. 85, Stone in Kidney, are of first-rate excellence; but on the whole we prefer the photographs of the bones, especially those showing the absorption of lime-salts, and Fig. 155, Charcot Knee in a Woman, for to the practical worker they represent an even higher standard of technical skill. But there is nothing like a weak illustration among the collection, and some of the medical ones reach a high degree of excellence. We may then conclude this brief notice by saying that Walsh's "Röntgen Rays" well deserves its reputation as a standard authority on its own subject, and that in this new and improved edition we can predict for it even greater popularity and usefulness than it has attained in the past.

It is reported that owing to an outbreak of enteric fever Chelmsford Hospital has been closed to all but a few urgent cases. So far as can be ascertained at present the source of the mischief is an old sewer that passes beneath the building. The Hospital Committee have sent back to their homes all patients fit to be moved.

(a) "The Rontgen Rays in Medical Work." By David Walsh, M.D.Ed., Senior Physician Western Skin Hospital, London, and Hon. Physician Kensington General Hospital. Part I.—Electrical Apparatus. By H. Lewis Jones, M.D., F.R.C.P., Medical Officer in charge of the Electrical Department, St. Bartholomew's Hospital. Part II.—Medical and Surgical. By the Author. 4th Edition. 172 Illustrations. 15s. net. London: Bailliere, Tindall, and Cox, 8 Henrietta Street, Covent Garden, W.C.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Tuberculosis of the Kidney.—Charles P. Noble (*Surg. Gynæ. and Obst.*, March, 1907). Ten years ago it was believed that tuberculosis of the kidney was frequently, if not usually, bilateral, and it was held that where it was not a part of a general tuberculosis it was usually a secondary condition due to tuberculosis of the bladder with ascending infection. As is well known, when not due to pyæmia or bacteriæmia, urethritis, pyelitis and pyelonephritis are commonly due to ascending infection from a primary cystitis, No evidence has ever come under my observation that tuberculosis of the kidney in women is ever due to ascending infection. On the contrary, in 50 per cent. of the cases the bladder was but little, if at all, infected, and in all the cases the ulceration of the bladder or cystitis has undergone either spontaneous recovery or has recovered after local treatment subsequent to the removal of the primary focus of the disease in the kidney by nephrectomy Cystitis existing as a complication of tuberculosis of the kidney is usually due to infection from the pus entering the bladder through the ureter. In a considerable percentage of the cases, however, there is a mixed infection, and the cystitis is due, not to tubercular infection, but to infection from some other organism.

Diagnosis.—The diagnosis of tuberculosis of the kidney is usually difficult except in late cases in which the kidney is much enlarged by pus contained within its capsule, or in which the presence of a perinephritic abscess, together with the history of the patient indicates the probable nature of the malady. In the majority of cases referred to the writer the diagnosis was cystitis. The first symptom, in most cases, is increased frequency of urination. Examination of the urine shows the presence of pus and the urine is usually acid, and these, combined with evidence of failing nutrition and discomfort in the region of one or the other kidney, are a combination of symptoms which should always raise one's suspicions. Blood in the urine is a frequent symptom, usually microscopical in amount, and pain, when present, is usually one of the evidences of extensive involvement of the kidney. The diagnosis is made positive by examination of urine for tubercle bacilli, by injection of urine into guinea pigs and by cystoscopy. F.

Pathological Changes Caused by the Gonococcus.—Auspach (*Amer. Jour. Obst.*, April, 1907). The gonococcus is a pus-producing organism, but it differs in many ways from the streptococcus or the staphylococcus. Although it usually affects mucous surfaces, it may burrow beneath them and cause a suppurative lesion (Wertheim). Besides the direct pus-producing action of the organism itself, whether it remains localised or is transported to distant joints or synovial sheaths there is another factor in the symptom complex. This factor is a toxine, called gonotoxin, which exists in the body of the diplococcus and is not set free till the organism dies. It is an endo-toxin—a bacterial protein. Wasserman found that the death of the gonococcus, after sterilising a culture, made the body of the organism exquisitely poisonous. The smallest quantity of this poison produced inflammatory symptoms at the point of applications, fever, swelling of the nearest lymph glands, and severe pain in the muscles and joints. There is no immunity to gonorrhœa in man, either naturally or by reason of a previous attack and in chronic gonorrhœa the individual is quite susceptible to a new super-imposed gonococcus infection. The gonococcus attacks an individual by means of the mucous membranes and usually by those of the genital organs. Upon the horny stratefied epithelial surface of the skin it has no effect; upon the squamos epithelium of the vulva and vagina it is less capable of harm than when it gains access to the transitisual epithelium of the urethra, or the columnar cells of Bartholin's glands or the cervix. What the organism lacks in its powers of invasion it makes up in persistency. According to many observers it never disappears spontaneously. It is quite common for the infectious process to leave the urethra and be hidden in the periurethral crypts. Here it slumbers, but is capable of being aroused into new activity by finding fresh grounds for invasion or by congestion of the tissues in its immediate vicinity. These peculiarities explain the clinical fact that an individual having no symptoms of gonorrhœa, but harbouring the gonococcus in his person, may produce an active infection in another, and this infection, after developing new activity in the second individual will cause a violent attack if returned to the first. F.

Management of the Adipose Layer in Suturing.—Robert T. Morris (*Jour. Obst. and Gynæ.*, March, 1907). All sutures which enter the adipose layer set free a certain amount of fat, and this free liquid fat leaves channels which must be closed by reparative processes, in a tissue which is badly equipped for carrying on repair. The principal of depending upon atmospheric pressure for keeping adipose tissue surfaces in contact is not universally employed by surgeons. The wet leather disc used by boys as a toy for lifting stones demonstrates the principle. The method adopted by the writer for many years is as follows:—(1) A continuous suture of very small catgut for the peritoneum; (2) a continuous suture of small or large catgut for the posterior and anterior sheaths of the abdominal muscles, allowing atmospheric pressure to close out "dead spaces" evenly in the muscle tissue; (3) a continuous catgut suture through the skin only, carefully avoiding the adipose layer. If the adipose faces of the wound are pressed snugly together before the last knot is tied, they will adhere so firmly and evenly that it will be difficult to separate them twenty-four hours later. F.

The Relations of Diseases of the Sigmoid Flexure to Diseases of the Female Genital Organs were discussed by Albrecht at the November meeting of the Munich Gynæcological Society (*Zentralbl. für Gyn.*, 1907 Nr. 17). The points which he brought forward were as follows: Firstly, owing to the over-filling of the flexure in cases of habitual constipation, fæcal tumours may arise which, under some circumstances, may be mistaken for tumours of the genital organs. Further, these fæcal accumulations are made responsible for a series of disturbances, for example, displacements of the uterus and ovaries, passive congestion of the pelvic plexuses, dysmenorrhœa and uterine hæmorrhage. The inflammatory processes which arise in the flexure itself are of importance as regards differential diagnosis and treatment. They may be (*a*) acute sigmoiditis, which may exactly resemble an acute pelvic peritonitis or an appendicitis; (*b*) chronic hyperplastic sigmoiditis with pains to the left of the hypogastrium resembling chronic inflammatory oöphoritis; (*c*) chronic pseudo-carcinomatous sigmoiditis with progressive stenosis of the lumen of the intestine, abscess formation, and perhaps perforation peritonitis. These conditions may just as easily be mistaken for pyosalpingitis as they may be for real carcinoma of the intestine. Perisigmoiditis may arise from extension of inflammation of the pelvic organs to the flexure, and, on the other hand, primary diseases of the flexure may extend to the ovaries, tubes, and uterus. Various adhesions, stenoses, kinking of the intestine, &c., may thus be produced. Finally, when considering the retroperitoneal lymphatics, the clinical picture of meso-sigmoiditis arises with a consequent parametritis or periproctitis.

G.

A Contribution to the Statistics of Placenta Prævia is recorded by Bürger and Graf (*Monatssch. für Geb. und Gyn.*, Bd. 25, Hft. 1) from the material of Schauta's Klinik in Vienna. They bring it forward on account of the recommendation by Dührssen and Bumm that vaginal Cæsarean section should be employed for the treatment of placenta prævia. They do not favour this method of treatment, because their own results with other methods are very good, and also because there is an unavoidable loss of blood during the performance of this operation among these cases, which may cause grave danger when much blood has already been lost. They also believe that the wounds produced in the richly vascular tissue of the lower uterine segment can be particularly easily infected. They, of course, allow that the prognosis for the child is better when this operation is performed, but they do not consider this of very great importance since the infants are frequently non-viable. They recommend the combined method of version which must not be followed by extraction. The results which they obtained are relatively good compared with other statistics, when one considers what a very dangerous complication of labour, from hæmorrhage and infection, the placenta prævia is. As regards the fœtal mortality the authors wish that it could be improved, but they do not consider that methods of improving it should be adopted which may cost the life of the mother.

G.

A Case of Supravaginal Amputation of a Fibroid Uterus between Four and Five Months Pregnant is recorded by Kayser (*Monatssch. für Geb. und Gyn.*, Bd. 25, Hft. 1). The patient, a nullipara, æt. 43, had been under treatment with ergot for a year on account of the myoma. During the last four months the abdomen had greatly increased in size, but in spite of this the patient had lost a good deal of weight. Examination revealed a tumour reaching to a hand's-breadth above the umbilicus. It felt extremely solid. The cervix was very high up. Some colostrum could be pressed out of the breasts. The legs were very much swollen. Severe dyspnœa and intestinal symptoms forced the author to operate, the diagnosis varying between a sarcomatous degeneration of a uterine myoma, or the combination of pregnancy with the myoma. The operation was easy, and the convalescence normal. The tumour removed weighed 13 lbs. When incised it was found to be pregnant between four and five months, the placenta situated on the upper portion of the posterior wall. A myoma larger than a man's head was situated with a broad base on the anterior wall of the pregnant uterus. It was only a little softened in the centre. Microscopic examination showed that the rapid increase in size of the myoma during the pregnancy was not due to an œdematous infiltration, but to genuine growth.

G.

The Treatment of Puerperal Mastitis.—The advantages of Bier's method of treatment are given by Thorbecke (*Med. Klinik*, 1906, Nr. 37, n. 38) as follows: In the first place, its power of removing the pain. The pain brings the patient to the doctor, and the result produced by the hyperæmia is wonderful. Generally, immediately after the first sitting there is a complete cessation of the pain, the patients feel much better, and trust in this unknown method grows. The patient's second question, "How long will the treatment take?" can also be answered. A few days when the inflammation is not severe; two to three weeks if it is severe. The temperature falls in about two days. If pus had already formed, its extension is prevented by the suction hyperæmia, its formation stopped, or the pus is altered into a serous fluid. Instead of the long incisions or complicated operations, to-day we only require punctures. The cosmetic effect is excellent, and the breast remains capable of performing its functions. The glandular tissue is not destroyed.

G.

MEDICAL NEWS IN BRIEF.

The Milk Supply and Sick Children.

A Conference on the subject of Milk Supply was held in London last week in the Board Room of the Hospital for Sick Children, Great Ormond Street, under the presidency of Mr. Arthur Lucas, chairman of the Hospital, at which representatives from the following hospitals were present:—The Hospital for Sick Children, Great Ormond Street; the East London Hospital for Children; the North Eastern Hospital for Children; the Victoria Hospital for Children; the Evelina Hospital for Sick Children; the Paddington Green Hospital for Children; the Royal Waterloo Hospital for Children and Women; the Alexandra Hospital for Children with Hip Disease; the London Hospital. The Conference, after discussion, passed the following resolutions, subject to the confirmation of the Committees of the various hospitals interested:—Recommendations adopted at a Conference of the United Children's hospitals of London. (1) The milk shall be pure, genuine, and with all its cream as yielded by the cow, and absolutely free from any and every kind of adulteration, including preservatives. It shall be of such quality as will produce at least 3.50 per cent. of butter fat. (2) It shall be supplied from a farm or farms whose name or names and locality are notified to the hospital. (3) It shall be permissible for an authorised representative of the hospital to inspect such farm or farms at any reasonable time. (4) The cows supplying the milk shall be in a good state of health, and a veterinary surgeon shall give a certificate to that effect once a quarter. (5) The milk shall be strained and refrigerated at the farm, and there canned and sealed. (6) The milk shall be delivered, sealed, at the hospital. (7) It shall not be "pasteurized," or treated otherwise than as mentioned in Clause V., without the written sanction of the hospital authorities. (8) It is advisable that the milk be tested bacteriologically and chemically once a week by the hospital. (9) That the name of the medical officer of health of the district in which a supplying farm is situated be furnished by the contractor, and that he be informed of the relations between the farm and the hospitals, and that he and the clerk of the urban or rural district council be supplied by the hospital, for their information, with a copy of these recommendations. (10) This Conference invites the committees of the various hospitals interested to adopt the resolutions passed at this meeting.

Royal Opening of Tottenham Hospital New Wards.

Yesterday (Tuesday) was quite a gala day in the North of London, as H.R.H. the Prince of Wales honoured the governors and medical staff of the Tottenham Hospital by being present at the opening of the new wards and theatre, and also by Her Royal Highness the Princess of Wales graciously consenting to receive purses towards defraying the debt on this very useful institution and to meet some of the current expenses for the new buildings. In the evening the medical staff of the North-East London Post-Graduate College held a conversazione, which was largely attended by members of the profession. The new wards and theatre were greatly admired. There was also a medical and surgical exhibition, at which music and refreshments were provided.

The United Services Medical Society.

A largely-attended meeting of officers of the medical services of the Navy, the Army, the Indian Army, and the Auxiliary Forces was held last week at the Royal United Service Institution, to consider the advisability of creating a United Services Medical Society. Inspector-General H. M. Ellis, director-general of the medical department of the Navy, presided, and explained that there were so many points where the interests of the different services met that it was desirable to form a society which would help towards co-operation. The present was a peculiarly fitting time, as the R.A.M.C. had now got a home in London, and it was from the Army Medical Department that the inception of the movement had come. He then explained the proposed constitution of the society, to be known as "The United Services Medical Society," ordinary meetings of which are to be held monthly in London. The scheme was unanimously adopted, and the Chairman elected its first President. The following were elected officers, representing the different services:—Fleet Surgeon Craig, Fleet Surgeon Dalton, for the Navy; Major Holt and Lieutenant-Colonel Cottell, for the Army; Lieutenant-Colonel Sir R. Havelock Charles, Lieutenant-Colonel Freyer, for the Indian Army; Lieutenant-Colonel Sir J. Clark, Lieutenant-Colonel Valentine Matthews, for the Auxiliary Forces. There will also be four *ex officio* members of the council—the directors-general, Navy and Army Medical Services, the president of the Medical Board at the Indian Office, and the commandant, Royal Army Medical College.

Action for Slander by a Medical Man.

During the past week, in the Nisi Prius Court, Dublin, Dr. David Turner, of Rathmines, near Dublin, claimed £1,000 damages from Mr. R. D. P. Darby, a retired Post Office official, for slander. Among other statements made by the defendant was one to the effect that if an inquest had been held upon his wife, Dr. Turner "would swing for it." There was also a suggestion that Dr. Turner had improperly obtained possession of a sum of money belonging to the defendant. Defendant denied that he ever spoke falsely or maliciously or published the words attributed to him, but admitted that he stated he was going to summon plaintiff for an account of the moneys entrusted to him and which he refused to pay. Defendant further in reference to some of the words complained of pleaded privilege, submitting that he was entitled to speak of what he considered the negligence of the plaintiff in attending on his wife. Dr. Wallace Beatty and Dr. J. H. Glenn gave evidence on behalf of the plaintiff to the effect that his treatment of Mrs. Darby was right and proper. The jury, after a short consultation, returned a verdict for the plaintiff, Dr. Turner, and assessed the damages at £100. The defendant further gave an undertaking that he would not hereafter directly or indirectly annoy Dr. Turner by publishing any defamatory matter.

Midland Medical Union.

At the Sixth Annual Meeting of the Midland Medical Union held at Chesterfield last week, Dr. J. G. Shea in the Chair, the Annual Report for the year 1906 was presented, and adopted, the accounts showing a balance in hand of £19 8s. 7d. Mr. A. Chawner, of Clay Cross was re-elected President for the year. The other officers elected were: Hon. treasurer, F. R. Mutch, M.D.; Hon. auditors, A. Fulton, M.B., and J. H. Cox, M.R.C.S.; General secretary, G. S. O'Rorke, M.A., LL.D. Council: Representing the Nottingham Branch, A. Fulton, M.B., J. Holmes Thompson, M.B., J. H. Cox, M.R.C.S.; representing the Mansfield Branch, T. Tate, M.D., J.P., E. H. Houfton, M.D. (hon. sec.). Representing the Belper branch, R. G. Allen, M.R.C.S., G. G. Macdonald, M.D., J.P., W. Brownlow Smith, M.D. (hon. sec.). Representing the Chesterfield branch, J. G. Shea, M.D., J.P., S. Worthington, M.D., F.R.C.S., G. Booth, M.D., J.P., W. Duncan, M.B. (hon. sec.). After the meeting the annual dinner of the Chesterfield branch was held at the Hotel Portland, Chesterfield.

Medical Sickness and Accident Society.

At the Monthly Meeting of the Executive Committee of this society, held last week, Dr. de Havilland-Hall in the Chair, there were present Dr. J. Brindley James, Mr. F. S. Edwards, Mr. H. P. Symonds (Oxford), Dr. Walter Smith, Dr. J. W. Hunt, Mr. J. F. Colyer, Dr. W. Knowsley Sibley, Dr. Frederick S. Palmer, Mr. Edward Bartlett, and Dr. J. B. Ball. The accounts presented showed that the number of claims now being received on account of influenza is rapidly lessening, and there is reason to hope that the epidemic which appreciably added to the sickness experience of the early part of the year has now nearly subsided. The annual general meeting of the Society will be held at the rooms of the Medical Society of London on the 23rd inst., and the Report then to be presented to the members shows that, in 1906, the business was very successful and produced a considerable increase in the large reserves of the Society.

Medical Defence Union.

We are asked to announce that the Annual General Meeting of this Association will be held at the Midland Hotel, Manchester, on Thursday, May 16th, to receive the Annual Report of the Council and the Statement of Accounts, together with the Auditor's Certificate, for the year 1906; to elect three members of Council, Dr. J. Roche Lynch, L.R.C.P., Dr. A. A. Mackeith, M.B., C.M., and Dr. F. J. Wethered, F.R.C.P., hon. treasurer, retiring by ballot under Rule 28, but offering themselves for re-election; to appoint an auditor and to fix his remuneration, and to vote for the payment of railway fares as expenses incurred by provincial members of the Council attending Council meetings.

A Liverpool Injunction.

In the High Court, on April 24th, Mr. Rutherford moved before Mr. Justice Neville, on behalf of the plaintiffs, a Liverpool firm, in the action Evans, Sons, Lescher, and Webb, Limited, *v.* Ashford, for an injunction to restrain the defendant, a chemist at Northampton, from selling as Evans's antiseptic throat pastilles, pastilles not of the plaintiffs' manufacture. Mr. Hewitt appeared for the defendant, and agreed to treat the motion as the trial of the action, and submit to a perpetual injunction and to pay the costs of the action. Mr. Rutherford accepted the terms offered, and his lordship made an order on the terms agreed.

The Chemists' Exhibition.

The Chemists' Exhibition is being held at the Royal Horticultural Hall, Westminster, this week, from Monday to Friday inclusive, and is open each day from 11 a.m. to 10 p.m. The opening ceremony was performed by Mr. Idris, M.P. A novel feature in connection with the exhibition is that all London chemists residing within the four-mile radius will have their cab fares paid to the hall, while those from the country will get a rebate from the cost of their railway tickets.

The Irish University Scheme.

The principal, professors, and lecturers of University College, Bristol, have presented a memorial to the Chief Secretary for Ireland in which they state that they regard with serious apprehension any solution of the Irish University question that would deprive Trinity College of its autonomy, or limit its freedom by associating with it in the University of Dublin colleges differing from it in type and animated by incompatible ideals.

PASS LISTS.

Royal College of Physicians of London.

At the ordinary quarterly *Comitia* of the Royal College of Physicians, held on April 25th, the President of the college, Sir R. Douglas Powell, occupying the chair, the following members of the college were elected Fellows:—J. Barry Ball, M.D.Lond.; Edwin Bramwell, M.D.Edinb., of Edinburgh; E. Mansfield Brockbank, M.D.Vict., of Manchester; Daniel Colquhoun, M.D.Lond., of Dunedin, New Zealand; Andrew Duncan, M.D.Lond.; W. James Fenton, M.D.Camb.; H. Stanley French, M.D.Oxf.; Robert Jones, M.D. Lond.; Thomas McCrae, M.D. Toronto, of Baltimore, U.S.A.; G. Edward Rennie, M.D.Lond., of Sydney, New South Wales; Arthur Shadwell, M.D.Oxf.; and A. Thomas Wilkinson, M.D.Lond., of Manchester.

The following licentiates of the college, having passed the required examinations, were admitted members of the college :—J. M. Bernstein, M.B.Lond., of Owens College, Manchester; W. Edgecombe, M.D.Lond., Univ. Coll., Liverpool, and London Hospital; D. C. O. Finigan, M.D.Berlin, Berlin, Kiel, and St. Bartholomew's; A. M. H. Gray, M.D.Lond., of Univ. Coll. Hosp.; T. Lewis, M.B.Lond., Univ. Coll. Hosp.; N. Neild, M.B.Vict., Owens Coll., Manchester; C. S. White, M.D.Lond., Univ. Coll. Hospital.

Royal Colleges of Physicians and Surgeons Edinburgh and Faculty of Physicians and Surgeons, of Glasgow.

AT the April sittings of the Conjoint Board the following candidates passed the respective examinations :—

First Examination, Five Years' Course.—Tom Entwisle Ferguson, Bolton; Colin Hunter, Glasgow; Allan Ross Henry, Cape Colony; Hugh Francis Williams, Llanfyllin; Ishwar Das, Punjab, India; Patrick Walsh, Co. Limerick; John Scott, Dalry, Aryshire; Charles Stuart Ogilvy, Blantyre; William Woodburn M'Cowat, Transvaal.

First Examination, Four Years' Course.—Thomas Mitchell Jamieson, Co. Tyrone.

Second Examination, Five Years' Course.—David Lindsay Hutton, Glasgow (with distinction); Ernest Averell, Newcastle-on-Tyne; Robert Stobbo Watt, Glasgow; Arthur Duncan Macarthur, Pollokshields; Robert Miller Danks, Coatbridge; Michael Vincent Walsh, Cork; Hugh M'Ilroy, Co. Antrim; Robert Anderson, Beith.

Third Examination.—Abraham David Woolf, Birmingham; Henry William Turner, Glasgow; John M. Calb, Ulverston, Tasmania; James Thomas Gwynne Jones, Brecon, Wales; Abdul Majid Shah, Patiala, India; Ernest Gibson, Cork; David Welsh, Lanarkshire; Ishwar Das, Punjab, India; Archibald Davidson, Melbourne; Maurice Edward Kayton, Bagdad; George Noel Braham, Bath.

Final Examination and Admitted Licentiates of the Co-operating Authorities.—Shridhar Chintaman Jog, Edinburgh; Joseph Hume Patterson, Glasgow; Oliver David Gunasekara, Colombo, Ceylon; Fred Garnet Allan, Whaley Bridge, Cheshire; Hugh Ferguson Watson, Gartnavel; Edward Robert Harriott, Jamaica; Arthur Annesley Stork Kats, Ceylon; Effie Jemima Cassels, Glasgow; Charlott, Eliza Pring, Bristol; Phiroza Behranji Malabarie Bombay; Emile Hamel Smith, Edinburgh; Frederic James Breakell, Glasgow; Malcolm Ross Slack, Canada; Hugh Graham Anderson, Newlands, Glasgow; Ada Geraldine Boylette-Dias, Bombay; Hiralal Keshavlal Nanavati, Glasgow; Lennox Donald Napier, Egremont, Cheshire; William Frederick Fismer Durr, Glasgow.

University of Durham.

THE following candidates have satisfied the Examiners during the April examinations :—

FIRST EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

1. *Elementary Anatomy and Biology, Chemistry and Physics.*—William G. Bendle (Honours, second class). *Pass List*: Francis P. Evers, William J. Hickey, Carl J. V. Swahnberg, Harold F. Stephens, Robert W. Smith, Alfred T. Thompson, Thomas R. West.

2. *Elementary Anatomy and Biology.*—John E. Alderson, Richard M. Barrow, Roger Errington, D. Farquharson, Sarah L. Green, Thomas A. Hindmarsh, Arthur S. Hopgood, Tom M. Hopgood, Frank H. Kennedy, Richard B. Lilly, John Lumb, Benjamin B. Noble, Thomas A. Peel, Arthur H. Wear.

3. *Chemistry and Physics.*—Everard C. Abraham, Louis E. S. Gellé, Harold L. James, Hubert V. Leigh, George C. M. M'Gonigle, Oswald S. Norton, Henri R. G. Vander Beken.

4. *Elementary Anatomy.*—William Smith, B.Sc.

SECOND EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

Anatomy, Physiology, and Materia Medica.—Jabez E. Dainty (Honours, first class). Charles Marks (Honours, second class). *Pass List*: Hubert C. W. Allott, Wilfred Barkes, John A. Caulcrick, Francis H. Fawkes, Herbert E. Fullerton, Cyril J. Henderson, Francis F. T. Hare, Satyen Mozumder, William Reynolds, William Sacco, Dorothea M. Tudor, William R. E. Unthank, Charles L. Wigan.

The following candidates have passed the Third Examination for the Degree of Bachelor in Medicine :—

Pathology, Medical Jurisprudence, Public Health, and Elementary Bacteriology.—Braithwaite, Eldred Curwen (honours, first class).

Pass List.—Leonard F. Browne; Charles E. L. Burman; John Everidge; Reginald Francis; Arthur C. Greene; Hedvig C. Kellgreen; Raghunath V., Khedkar, L.R.C.P. & S., E L.F.P.S., G.; Herbert R. McAleenan; Friederike Rahtkens; Eric F. Waddington.

THE following Degrees have been conferred :—

Doctor in Medicine.—Robert Simpson Hindmarch, M.B., B.S., Durh.; Andrew Banks Raffle, M.B., B.S. Durh.; Norcliffe Roberts, M.B., B.S., Durh.; Frederick Riddle Scott, M.B., B.S., Durh.; Alan Fyre Smith, M.B., B.S., Durh.

Doctor in Medicine for Practitioners of Fifteen Years' Standing.—Edwin A. Bennett, L.R.C.S.E., L.S.A.; Joseph Buck, L.R.C.P.& S.E., L.F.P.S.G.; John M. C. Cole, M.R.C.S., L.M., L.K.Q.C.P.I.; Charles T. T. Comber, M.R.C.S., L.R.C.P.; Alexander Cuffe, F.R.C.S.I., L.A.H.; Harry Legh de Legh, M.R.C.S., L.R.C.P.; William C. Ellis, L.R.C.P.& S.E., L.F.P.S.G. L.S.A.; Charles J. Horner, M.R.C.S., L.R.C.P. L.S.A., Timothy Leahy-Lynch, L.R.C.P.& S., L.F.P.S. G.; Thomas McMillan, L.R.C.P.& S., F.L.P.S.G.; Edward Posnett, M.R.C.S., L.R.C.P., L.S.A.; Colamaranaucppi B. Ramarao, B.A., L.M.&S., Madras; Howard Slater, M.R.C.S., L.R.C.P., L.S.A.; Peter C. Smith, L.R.C.P.& S., L.F.P.S.G.; David T. Wylie, L.R.C.S.I., L.M.

Bachelor in Medicine (M.B.).—Harold H. Blake, Gilbert I. Cumberlege, William M. Emmerson, L.S.A., S.Havelock, B.Sc., Thomas D. Miller, M.R.C.S., L.R.C.P., David Ranken, Howard B. Stephenson, L.R.C.P.&S.E., L.F.P.S.G., Norman Spedding, Richard W. Swayne, Herbert H. Whaite, L.R.C.P.&S.E., L.F.P.S.G.

Bachelor in Surgery (B.S.).—Harold Henry Blake, Gilbert I. Cumberlege, William M. Emmerson, L.S.A., Sydney Havelock, B.Sc., Thomas Miller, M.R.C.S., L.R.C.P., David Ranken, Howard B. Stephenson, L.R.C.P.&S.E., L.F.P.S.G., Norman Spedding, Richard Swayne, Herbert H. Whaite, L.R.C.P.&S.E., L.F.P.S.G.

And the following received the Diploma in Public Health: Ernest G. D. Benson, L.R.C.P.&S.E., L.F.P.S.G.

The Royal University of Ireland.

THE following candidates have passed the Third Examination in Medicine :—

Upper Pass.—John A. Black,* James A. Brown, *Thomas P. Carroll, *John J. Gilmore, *James McCormick, *James M. O'Connor, Thomas Taylor. Those marked with an asterisk may present themselves for the further examination for honours.

Pass.—Charles Alexander, Francis Bradley, Joseph D. G. Burke, Bartley Byrne, Samuel Campbell, Samuel R. Campbell, Edgar N. Condy, Nicholas Cunningham, Elliot P. Dewar, James E. English, Edward Forbes, William A. Frost, John W. Garry, David J. Jackson, Thomas Kennedy, Caroline V. Lawe, Mathew J. McGrath, Harris Newman, Peter H. O'Connell, Arthur P. O'Connor, B.A., John P. J. O'Connor, Patrick C. O'Donnell, James J. O'Kelly, B.A., Robert H. Robinson, William H. Sheffield, Standish J. Watson.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

BRADFORD M.B.—Yes, since there are several such associations of ladies and disinterested layman, who place themselves at the disposal of the M.O.H. for the purpose of keeping an eye on, and giving a helping hand to, the poor, but the only one we know working solely in connection with infant mortality was formed last month at Glasgow. The ladies form committees and visit all slum infants born, and instruct the mothers in methods of feeding, &c. A letter to the Town Clerk would give you the information probably.

ODONT.—The London Counties Medical Protection Society is, we believe, the only one of the defence organisations that admits dentists to its membership; the Medical Defence Union consists only of doctors. You had, therefore, better apply to the Secretary of the former.

FILLET.—(1) The Monmouthshire C.C. is one of the authorities which has instituted its own training centre for midwives. (2) The address of the superintendent is Sister Barrett, 30 Herbert Street, Newport. (3) Last year's report looked very satisfactory, but we cannot say more at the moment.

AN ABERNETHY STORY.

AMONG the many Abernethy stories that are known to medical men, we doubt if the following occupies a foremost position. It concerns the time when the great surgeon was seeking election at St. Bartholomew's, the duties of which candidature included the canvassing of all the governors. Abernethy's uncompromising manners had already made him some enemies, and a greengrocer, one of the governors, had already made up his mind against him. When Abernethy on his round called at the shop, the greengrocer called out, "All right, Mr. Abernethy, I know what you're after. It's no good your coming to me. Now what do you want?" "Three pen'orth of your plums, please, and wrap them up quick," replied the ready surgeon, and left his antagonist to make the best of it he could.

AMERSHAM.—The soi-disant Medico-Electric Company is a sham, and has nothing medical about it; and the "medical attendant" referred to has, we have ascertained, purchasable diplomas which are not recognised in this country.

DR. MCCAW (Washington).—In reply to your enquiry the Pathological Society of Dublin was merged, together with the Surgical and other societies, into one corporate body under the title of the Royal Academy of Medicine at the end of 1882, since which the transactions have been issued in one yearly volume of the combined societies. This will explain why you have received no "Transactions of the Pathological Society" since 1882.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 8th.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street Cavendish Square, W.).—5.15 p.m.: Meeting.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Lecture:—Prof. W. Wright: The Prehistoric and Early Historic Inhabitants of England (with lantern slides).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. P. L. Daniel: Clinique. (Surgical). 5.15 p.m.:—Lecture:—Dr. J. Horne: Foreign Bodies in the Ear, Gullet and Air Passages.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, MAY 9th.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m.: Paper:—Dr. A. E. Giles: Observations on the Surgical Treatment of Inflammatory Diseases of the Uterine Appendages based on a Series of 120 Cases.

HARVEIAN SOCIETY OF LONDON (Hospital for Paralysed and Epileptic, Maida Vale, N.W.).—8.30 p.m.: Clinical Evening. Cases will be shown by Dr. L. Guthrie, Dr. W. T. Harris, Dr. C. Singer, and others.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. R. Hutchison: Mucous Colitis.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m. Demonstration of Medical Cases (Dr. Leslie).

FRIDAY. MAY 10th.

BRITISH LARYNGOLOGICAL RHINOLOGICAL AND OTOLOGICAL ASSOCIATION (11 Chandos Street, Cavendish Square, W.).—4.30 p.m.: Cases and Specimens.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W).—Papers:—Mr. Sherren: Gastro-enterostomy for Chronic Gastric Ulcer: Healing of Ulcer Verified at Post-mortem Examination 28 months later. Dr. H. French and Dr. M. G. Louisson: Upon the Extent to which Widal's Reaction persists after Recovery from Typhoid Fever. Dr. L. Guthrie and Dr. W. d'E. Emery: Precocious Obesity and Hirsuties with Hypernephrosis.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Lecture:—Prof. W. Wright: The Prehistoric and Early Historic Inhabitants of England (with lantern slides).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. StClair Thomson: Clinique. (Throat).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—9.30 a.m.: Clinique. Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon. Salary £20, washing allowance £2 10s., with board and residence in the Hospital. Applications to Stewart Johnson, Secretary. (See advt.)

Bradford Children's Hospital.—House Surgeon.—Salary £100 per annum. Applications to C. V. Woodcock, Secretary, Bradford.

West Suffolk General Hospital, Bury St. Edmunds.—House Surgeon. Salary £100 per annum, with board and lodging. Applications to the Secretary.

Cuninghame Combination Poor-house, Ayrshire.—Medical Superintendent. Salary £300 per annum, with house, fuel, light, vegetables, and laundry work. Applications to Wm. Gray, Secretary, 5 Montgomerie Street, Ardrossan.

Wandsworth Union Infirmary, St. John's Hill, near Clapham Junction.—Junior Assistant Medical Officer. Salary £100 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Appointments.

FINZI, NEVILLE S., M.B.Lond., M.R.C.S., L.R.C.P., L.S.A., Medical Officer in Charge of the Electrical Department, Metropolitan Hospital, N.E.

FISHER, H. R., M.B.Cantab, Certifying Surgeon under the Factory and Workshop Act for the Fillongley District of the county of Warwick.

GRIMBLY, RICHARD HENRY, M.R.C.S., L.S.A., Medical Officer for the Ippledon District by the Newton Abbot (Devon) Board of Guardians.

HARMER, JOHN D., M.B., Ch.B.Edin., House Surgeon at the Royal Devon and Exeter Hospital, Exeter.

HOWELL, ALFRED, M.D. Lond., Honorary Assistant Physician to the Cardiff Infirmary.

KELLAS, ARTHUR, M.B., Ch.B., D.P.H.Aberd., Resident Medical Officer at the Aberdeen Sick Children's Hospital.

MCELWAINE, THOMAS, L.R.C.S. and P. Edin., L.F.P.S. Glasg., Police Surgeon for the Borough of Devonport.

RUDGE, FREDERICK HENRY, L.R.C.P.Lond., M.R.C.S., House Surgeon at the Torbay Hospital, Torquay.

SHARP, ALEXANDER D., M.D. Brux., F.R.C.S. Edin., Consulting Surgeon for Diseases of the Ear, Nose, and Throat at Noble's Isle of Man Hospital.

STEWART, J., M.B., M.S. Edin., Certifying Surgeon under the Factory and Workshop Act for the Beith District of the county of Ayr.

TAYLOR, A. E., M.B., M.S.Edin., Honorary Physician to the Cardiff Infirmary.

Births.

DUNNETT.—On May 5th, at 7 Ascott Avenue, Ealing, Agnes Dunnett wife of Lionel Francis Dunnett, of a daughter.

HEGGS.—On April 30th, at Toronto House, West Bromwich, the wife of Raymond Mitchell Heggs, L.R.C.P.Lond., M.R.C.S., of a son.

MATTHEWS.—On April 30th, at Holly Lodge, Crawley, the wife of Sidney Philip Matthews, M.R.C.S., L.R.C.P., of a daughter.

THOMPSON.—On April 27th, at Riverbank, Sunbury-on-Thames, the wife of Frank Thompson, M.R.C.S., L.R.C.P.Lond., of a son.

VISGER.—On April 30th, at Elm Lodge, Clevedon, the wife of Charles Visger, M.R.C.S., of a daughter.

Marriages.

ATKINSON—BURD.—On May 1st, at Church Stretton, Thomas Dinham, eldest son of the late William Stephen Atkinson, M.A., to Emily Mabel, daughter of Edward Burd, M.D., of Shrewsbury.

DEWEY—WHITE.—On May 4th, at St. George's, Hanover Square, Edward William Dewey, M.R.C.S., etc., of Kingston Crescent, Portsmouth, to Annie Elizabeth Langley (Nancy), second daughter of the late Charles William White, of Northampton.

HARTHAN—SLATER.—On April 30th, at All Saints' Church, Evesham, George Ezra Harthan, M.B., B.C., only son of Ezra Harthan, of Sandbach, Cheshire, to Winifred May, eldest daughter of the late John Samuel Slater, M.R.C.S., of Evesham.

MORTON PALMER—RUSSELL.—On April 30th, at Streatham Parish Church, London, F. W. Morton Palmer, M.A., M.B., B.C. (Cantab), of Teignmouth, Devon, elder son of F. J. Morton Palmer, M.B., of Streatham, to Gertrude Eleanor, daughter of Alfred Russell, of Walsall.

Deaths.

DAVIDSON.—On April 30th, at 4 Streathbourne Road, Balham, Frederick Montgomerie D. Davidson, L.R.C.P., etc., aged 80.

HIDES.—On April 26th, at Teddington, Mary Rosa, wife of Henry Hides, M.R.C.S.E., L.S.A., late of Ham, Surrey, aged 83 years.

MACREADY.—On May 1st, at "Elmbank," Cumberland Park, Acton, Jonathan F. C. H. Macready, F.R.C.S., aged 57 years.

PATERSON.—On April 28th, at the London Hospital, from pneumonia, following operation, Walter Hugh Paterson, M.D., of Elmer House, Grantham.

WINKFIELD.—On May 3rd, at Hove, Brighton, Rosalie Anna, the beloved wife of Alfred Winkfield, M.A., F.R.C.S., of Beaumont Street, Oxford.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, MAY 15, 1907. No. 20

NOTES AND COMMENTS.

Prince of Wales' General Hospital.

THE trouble taken by the members of the Royal Family in supporting the many charitable institutions of the Metropolis, is real and genuine, and contrasts very favourably with the idle *bonhommie* of their predecessors. They give their work unsparingly and ungrudgingly, and it is not their fault if the funds available for hospital resources are not ample. Indeed, if the Royal Family had no other *raison d'etre* than that of keeping alive the charitable instincts of the nation, their existence in the most democratic State would be amply justified. An interesting instance of the progress of humanitarian sentiment in the community is supplied by the fact that whereas princes used to be chiefly honoured by having regiments called after them, now they are proud to have hospitals bear their name. The latest example of this tendency occurred last week at Tottenham, when the Prince of Wales, in opening the new wards of the hospital, graciously announced that at the request of the Princess Louise, the President of the Institution, and the Governors, he had given permission for the hospital to be rechristened after himself. In future, then, the Tottenham Hospital will be known as "The Prince of Wales' General Hospital," and under this proud style no doubt its supporters and staff will feel called on to make their most strenuous efforts to show that their young institution is in no wise behind its older compeers in vigour or usefulness. As a post-graduate school it has a good chance of going far.

Red Lung Balsam.

THE patent medicine duties, as we have frequently pointed out, are not only petty, in that they bring but an inconsiderable sum into the Exchequer, and misleading, in that people think that the Government stamp affixed to bottles guarantees the contents not to be injurious, but also are positively vicious in that they imply that the medicine is remedial as regards the complaints specified. The law, in fact, stipulates that the duty is payable for a preparation that claims by advertisement or label, to be beneficial for the prevention, cure, or relief of any disorder, ailment, or complaint incident to or in any way affecting the human body, and although, of course, the Government take no responsibility in the matter, the fact that they receive money in respect of the claim, and the claim only, makes them morally *particeps criminis* if an unworthy medicine is foisted off on the people. An amusing instance of the *impasse* to which this ridiculous law may lead was provided by an Excise case at the Keighley Police Court the other day, when a patent medicine vendor was summoned for selling his wares without a stamp. The defence was ingenious. The maker called his stuff "Red Lung Balsam," and he claimed that this description did not recommend the medicine for any specific complaint of the human body, and, indeed, it is likely he would have established his position if he had not put a label round the cork of each bottle, saying "Try our Poor Man's Friend for Coughs and Colds." After much deliberation the magistrates decided to convict, but on application have stated a case for the High Court.

Quack, M.B.

THE modern quack appears to be developing from the original stage of a vagabond in the market-place to that of the frock-coated and top-hatted scion of latter-day civilisation. A gentleman of this type was, thanks to the Medical Defence Union, brought within the clutches of the law at Hyde last week. True, he frequented the market-place and addressed the assembled multitudes, but his garb was said to be that of an "orthodox doctor," an expression which seems to imply that a doctor should be judged not by his fruits but by his coat. A woman who gave evidence said that she consulted the accused for indigestion, and paid him a guinea for two boxes of pills and a prescription. The latter certainly suggested the orthodox doctor quite as much as the coat, for it consisted of: "Tincture of gentian, 2 drs.; bicarbonate of soda, 2 drs.; sal volatile, 3 drs.; infusion of colombia (*sic*), 8 oz.; one tablespoonful three times a day." Indeed it would form an interesting matter for calculation as to how many guineas have accrued to orthodox doctors from that or similar prescriptions. However, the gentleman in question, it was said by counsel, so far exceeded the bounds of truth as to describe himself as "M.B." and "M.P.S.," and by his assumption of the former title, the Medical Defence Union were able to prove a clear violation of the Medical Act. The satisfactory penalty of £5 and costs was obtained in each of three cases, together with three guineas for the advocate's fee, so that it may be hoped a cold douche has been put on one more impostor's pretensions. From his own statements, however, he seems already to have amassed a comfortable fortune.

Fine for Family Prescription.

DEEP as is the moral responsibility entailed on medical men by the giving of misleading or faulty prescriptions, it would be very difficult, we fancy, to bring a doctor within the pale of the law for the commission of a pure error. Such, however, is not the case in Belgium, where, according to the *Pharmaceutical Journal*, a medical man recently prescribed fifty grammes of glycerine and carbolic acid, without stating the strength, or, apparently, the purpose for which it was intended. The pharmacist to whom the prescription was presented, was not able to communicate directly with the prescriber, and he, imagining that the preparation was wanted for dilution into a lotion, supplied a mixture containing equal parts of the constituents. As a matter of fact, the preparation was intended for the washing of an infant, and the wretched child was so badly burned that it died. The doctor and chemist were consequently both summoned in the police court, and each fined 300 francs. They appealed, but the verdict was confirmed by the higher court, and in the case of the doctor the fine was raised to 600 francs. Although the medical man's carelessness was culpable, the neglect of the pharmacist to obtain confirmation of the prescription before dispensing it, seems to us to form a far more serious fault. We hardly believe that under the circumstances the former would have been held criminally guilty in England, though his pocket would probably have been severely seared in a civil action.

Cats, Rats, and the Plague.

SINCE the relation of the rat to the dissemination of plague has become part of recognised knowledge, the Government of India have had some firm ground to go on in striving to prevent that disease. The question of rat extermination is now, it seems, to be taken up *con amore*, and as a first step an order has been placed at home for the expatriation of a hundred cats. When one considers the size of India and the number of rats to be dealt with, the hundred cats are likely to have a pretty busy time before they produce an appreciable impression. Or perhaps the spirit of economy that is abroad has taken the Indian Government also, and they have confined their purchase to a single hundred for the same reason that the Sheffield councillor advocated the restriction to two of the number of gondolas for the lake. Indeed, if the ordinary British animal be chosen for the purpose a very sensible addition to the feline staff should be realised before the end of the voyage.

LEADING ARTICLE.

A STANDARD FOR BREAD.

IT is somewhat curious that there is no fixed standard, either as regards its purity or its nutritive value, for so staple an article of food as bread. In view of its national importance the whole question seems not to have received the attention it deserves at the hands of the medical profession and of those concerned in the preservation of the national stamina. It is vain to deplore the physical deterioration of a people if at the same time we neglect the control of its staple foodstuff. An attempt to supply this lack of specific interest has been made by the Bread and Food Reform League, a purely uncommercial and non-political association organised to direct attention to the great importance of the questions involved and to provide the healthy nutrition of the people. Readers will learn with some amount of relief that in this particular instance the matter is discussed without the advocacy of any special system of diet. If in dealing with bread the reformers here and there lapse into the extravagance of enthusiasm, it nevertheless seems clear that in some points, at any rate, they are able to establish their claim to serious consideration. There is no need in a medical journal to remind readers that wheat flour is made from the interior of wheat grains and contains the greater proportion of the starch and most of the proteid. Whole flour, on the other hand, is made from the whole grain after exclusion of the husk, and thus contains not only the white interior of the grain but also its harder and browner outer portions. Whole meal contains one to two per cent. more proteid than the best white flour, but that advantage, under ordinary conditions of preparation, is counteracted by its less ready digestibility. Brown flour is a third variety which contains in addition a certain amount of bran, the cellulose of which irritates the alimentary canal, whereby it acts as a mild laxative. That there must be considerable difference in the nutritive value of bread made from these variously-prepared flours and meals is evident. Magendie's experiments long ago showed that dogs fed on white flour died at the end of fifty days, while those fed on whole-meal bread were healthy and vigorous. Miss May Yates, the devoted secretary of the League, has issued a pamphlet describing and commenting upon the certain experiments on the digestibility and nutritive value of bread carried out at the University of Minnesota, U.S.A. That lady is naturally somewhat jubilant at finding a confirmation of one of the League's previous statements that most people can digest the whole of the wheat grain if it be ground to a uniform very fine quality from properly selected wheat. Milling machinery has of late years been so perfected that there is now no difficulty in securing wholemeal flour in the requisite state of fine division. The results of the Minnesota experiments show similarly it is essential that the whole meal should be ground and re-ground until it will all pass through a fine sieve, and thus pass into a state of fine division which will enable the gastric juices to act in all the nutrients. It is not so much a matter of the varying digestive powers of different individuals as the form in which the grain is ultimately introduced into their stomachs. In addition to this highly practical step of advocating the use of finely ground whole wheat meal, the League has recommended the use of a bread containing the germ, middlings and sharps, or about 82 per cent. of the grain instead of about

75 per cent. It is obvious that the nutritive quality of the bread consumed by the poorer classes should be maintained at a good standard. The popular verdict at present is overwhelmingly in favour of white bread made from white flour. The reason for the preference is to some extent, as already pointed out, due to its more attractive appearance. The main objection to brown bread, however, is undoubtedly due to its indigestibility. If by the simple method of finer grinding advocated by the League the objection to more nutritive whole-meal bread can be overcome, a valuable service will thereby be rendered to the public by informing them on that head. It is in the power of the Government to initiate a simple but far-reaching reform in Poor Law dietaries by drawing the attention of local authorities to this point. Then, again, there is a large field in the bread supplied to our soldiers and sailors. Lastly, the Government will find a vast and valuable reform awaiting them in the substitution of a wholesome and scientific bread for the coarse product now supplied to the prisons of the United Kingdom. If there be one thing more than another out of touch with the humane and scientific tendencies of the age it is the neglected matter of prison dietaries. One of the laudable objects of the Bread and Food Reform League is to secure the standardisation of bread, whereby public analysts and health authorities may be provided with a proper basis of control. On that and other grounds the efforts of the League are worthy of cordial support in its single-minded efforts to promote the healthy nutrition of the people.

CURRENT TOPICS.

The Medical Defence Union.

THE annual report of the Medical Defence Union will be presented to members at the Annual General Meeting at Manchester on the 16th instant. It presents the record of progress and success to which the medical public has become accustomed. As the first of the professional defence societies the Union has triumphantly vindicated the necessity for its existence. In the year 1896 the members numbered 3,832 against 7,092 in 1906. It is perhaps not altogether satisfactory to find that in 1896, with 153 cases to Mr. Hempson, the solicitor to the Union, the law costs were £981 9s. 4d., while in the latter year with 193 cases the amount expended in that direction reached £2,208 13s. 3d. There may, therefore, be special reasons why, in spite of only a trifling increase of law cases in 1906 and with five hundred more members the average cost per head should have advanced to 6s. 1d. in that year as against 5s. 2d. in 1905. No Society, however strong and flourishing, can afford to disregard figures of that kind. Unless expenses are kept at a duly proportionate level there will be no chance of accumulating money. We by no means agree with the remark on page 9 of the report to the effect that "the Union can never hope to have a large reserve fund at its disposal; the very small subscription of members makes this impossible." The obvious criticism suggests itself that it will be impossible so long as law costs, a variable and controllable factor, are allowed to increase unduly in proportion to additions to income. Then, again, the holding of the Annual General Meeting of the Union in a provincial town is hardly calculated to secure a proper control of the affairs of the Society by members. Apart from these few points we have nothing but congratulations to offer the Union on its record of work for the past year. The Union, again, had the courage to protest against the unsatisfactory nature of the penal procedure of the General Medical Council. As the report observes, charges against practitioners are so carefully made that the fact that the complainants are the Medical Defence Union should be a guarantee of the seriousness of the complaint. It is disquieting, therefore, to learn that in one such case a member of the profession found guilty of infamous conduct in May had his name restored to the Register in the following November, without any further inquiry, by the General Medical Council. The report of this important professional body deserves the careful perusal of all who are interested in medicine in its social-legal aspects. The position attained by the Union after twenty-two years of strenuous and devoted work suggest that similar germs of practical organisation may be lying dormant elsewhere in the life of the medical profession.

Palatial Paupers.

THE Local Government Board appears to be awaking to a sense of its duties as regards the active control of Poor Law administration. Their auditor's inquiry into the West Ham Guardians' proceedings resulted in the disclosure of shameless peculation and jobbery that emulate the iniquities of the notorious Tammany ring in New York. The Whitehall authorities have followed up their success in the East End of London by a further investigation in a western suburb. On Thursday last an inquiry was opened by a London Government Board Inspector upon the cost of the new workhouse erected for the district mentioned at Wormwood Scrubbs. It was stated by counsel that the total expenditure had been £261,526, which worked out at the enormous figure of £335 per bed. The only instance that we can recall is that of one of the Metropolitan Asylums Board hospitals, but that did not approach the Hammersmith high-water mark by a long way. As counsel pointed out, thousands of hard working families of eight members, or even more, lived in small houses which had cost far less than the £335 expended on the space for each pauper in the institution under inquiry. The heating apparatus had cost at the rate of £3 per head, and the cost of supplying electricity was £2 to £2 10s. per pauper per annum. One of his most extraordinary allegations, however, was that a system of duplicate wiring had been introduced which was actually rejected some years ago at Buckingham Palace on the score of expense. While there is justification for the claim of decent and humane treatment of poor law inmates, it is nevertheless absolutely unfair to ratepayers to saddle them with the cost of providing palatial quarters for persons who are not benefited by a costly and luxurious environment. It is difficult to surmise what direct benefit can be conferred upon anyone by this sort of vicarious extravagance, unless, indeed, it be those whom it would not be well to mention at this stage of the proceedings.

The Sequel to the Ealing Scarlatina Case.

It is now nearly a year ago since Mr. and Mrs. Crier sued Dr. J. Hope and Dr. J. B. Currie, of Ealing, for negligence whereby Mrs. Crier contracted scarlet fever during her confinement. After a trial of five days a verdict was returned in favour of Dr. Currie, and this was confirmed on appeal to the higher courts. Recently the two medical men concerned brought an action in the King's Bench Division against Mr. Crier for £28 13s., being fees for attendance on Mrs. Crier while she was suffering from scarlet fever. The plaintiff's case was conducted by the London and Counties' Medical Protection Society. Dr. Currie stated that he had not been attending scarlet fever cases at the time, but had called in to see certain patients, and had notified them to the authorities and advised their removal to the isolation hospital. He disinfected himself before attending Mrs. Crier. The learned judge naturally refused to permit the question of negligence to be tried over again, and submitted the present question as simply one of contract. A verdict in favour of plaintiffs was given to the amount of £21 15s. The case is one of special interest and importance to general practitioners, inasmuch as a verdict against the medical men in the first trial would have rendered attendance upon confinements out of the question for those engaged in ordinary practice, to say nothing of the wider question of the communication of infection.

United Service Medical Society.

The formation of a Medical Society to include all branches of the Army and Navy services, including the Indian Army and the Auxiliary Forces, is an event of some importance. For one thing, it is quite in line with the spirit of reform that is now afoot at headquarters. At the beginning of the present month a United Service Medical Society was formally created at a meeting held at the United Service Institution, under the presidency of Inspector-General Ellis, Director-General of the Medical Department of the Navy. Its scheme is comprehensive, and includes :—(1) The furtherance of sciences which bear upon the preservation of health of forces afloat and ashore, at home and abroad, in war and in peace. (2) The study of diseases incidental to the life of sailors and soldiers under the varying conditions of climate, locality, and circumstances to which they are exposed in the performance of their duties, and the treatment of the same. (3) The study of organisations, methods, and apparatus for the amelioration of the condition of the wounded in war. (4) All matters which come within the scope of the technical duties of naval and military medical officers. The chairman was unanimously elected President of the Society for one year, and it was determined to hold the meetings at the Royal Army Medical College. Fleet Surg. W. W. Pryn and Lieut.-Col. C. H. Melville were appointed hon. secretaries, and Lieut.-Col. D. Wardrop hon. treasurer. It was announced that the Society's affairs would be managed by a council consisting of the president and the following officers elected by the Society :—Fleet Surgs. Craig and Dalton for the Navy; Major Holt and Lieut.-Col. Cottell for the Army; Lieut.-Cols. Sir R. Havelock Charles and Freyer for the Indian Army; Lieut.-Cols. Sir J. Clark and V. Matthews for the Auxiliary Forces. There will also be four *ex officio* members—the Directors-General Navy and Army Medical Services, the president of the Medical Board at the India Office, and the commandant, Royal Army Medical College.

Medical Men and Publicity.

In commenting recently on the manifesto on the use of alcohol which appeared in a contemporary, we expressed our surprise at its apparent spontaneity, and wondered for what purpose the document sprang into existence. As we guessed, it was not altogether as spontaneous as it appeared, and it has now been made known that its only begetter was Mr. Ernest Williams, a journalist specially interested in economic questions. The signatures were procured, it appears, and the manifesto issued in the interest of the alcohol industry. Innocent as the distinguished signatories may have been of this object, we can hardly congratulate them on the dignity of the position in which they have been landed. The views they have put forward may or may not be justified, but both the occasion and the manner of promulgating them are unfortunate. We regret to notice, indeed, of late years a greater tendency on the part of medical men to address the public through the columns of the newspapers, sometimes on purely medical matters, at other times pretending to express orthodox medical opinion on matters of general interest. The device adopted by a professional contemporary a month or two ago of distributing advance proofs of their issue to the daily papers, called forth from the contributors but very half-hearted disclaimers. This craving for publicity is an unpleasant phase of professional life, and we trust it is one which will soon disappear.

Motor-Car Taxation.

It is one of the minor injustices that medical men labour under that they should be compelled to pay the carriage-tax, for a vehicle is not only absolutely necessary for the pursuit of their profession, but also it can be clearly shown that for practical purposes its use is restricted entirely to business purposes. All trade-vehicles are exempt from this carriage-tax, and if a medical man were to paint his name on or attach a number to his brougham, there is no doubt he would be exempt from the tax. But even if the practice were sanctioned by the General Medical Council—

which is exceedingly doubtful—all tradition and usage would be against it, and in a practical work-a-day world it would be impossible. The Collectors of Inland Revenue know this well, and they trade on the necessities of the medical profession in a very mean way to procure them a regular source of revenue. It is all the more necessary that when the question of the taxation of motor-cars comes up in the near future, as seems more than likely, that strong representations should be made with regard to the medical man's position. Sir Henry Craik, who sits for the Aberdeen and Glasgow Universities has promised to see to the matter on behalf of his medical constituents, and if properly supported, it can hardly be doubted that he will obtain this small but important measure of justice.

The Health of Dublin.

THE death-rate of the Dublin Registration Area for the week ending April 27th, reached the extraordinary figure of 35 per 1,000 of the population per annum, being, in fact, equal to the latest recorded rate in Calcutta. In Calcutta, moreover, plague and cholera are both raging, whereas in Dublin there is no epidemic existing. The rate in Dublin for the week mentioned was by far the highest of any European city in the Registrar-General's list. Nevertheless, as far as the public can learn, the Public Health authorities remain inert, and we have been unable to discover in the daily papers a single reference to the present appalling mortality. The Dublin press and public seem to be in some strange way hypnotised so as to pay no heed to the condition of the city as regards sanitary matters. The Local Government Board Report, to which we referred some months ago, made clear that the recommendations of the Viceregal Commission of 1900 had been treated with contempt by the Corporation, but up to the present no steps have been taken to atone for this criminal negligence. The attitude of the health authorities toward the outbreak of cerebro-spinal fever also is not one to encourage confidence. Although deaths from the disease are still being registered, as far as the public can learn there are no cases being notified to the health authorities.

Milk for the Children's Hospitals.

A CONFERENCE was held a week or two ago between representatives of the various children's hospitals in London, in order to arrive at some arrangement which would safeguard the nature of the milk supply of the hospitals. Several resolutions were adopted providing, among other things, that the milk should be of a certain quality and should come from farms registered with the hospital authorities. The farms should be open to inspection at all reasonable times, and the cows supplying the milk should be certified as healthy every three months by a veterinary surgeon. Other precautions are to be observed as to the method and time of transit from the farm to the hospital. There is no doubt that it is of the greatest importance that children in the city hospitals should be provided with pure, good milk, and the restrictions the hospitals propose to impose seem well adapted for the purpose. The curious thing is, indeed, that such restrictions have not already been in force. It would appear, however, from the publicity given to the present movement as if this were the first time the question had been considered. If it be so, there has been a culpable slackness on the part of the hospital authorities.

PERSONAL.

IT is officially announced that Princess Henry of Battenberg has appointed Dr. Alfred James Rice Oxley to be a Physician-in-Ordinary to her Royal Highness.

SIR VICTOR HORSLEY has been elected honorary member of the Russian Surgical Society.

MR. BLAND-SUTTON, F.R.C.S., delivered an address on "The Problem of Cancer," at the Institute of Hygiene yesterday, the 14th inst.

OUR Scotch correspondent writes us that Lord Mount Stephen, whose previous acts of munificence will be remembered, has just given another £10,000 to the Aberdeen Royal Infirmary.

IN connection with the celebration of their golden wedding, Dr. and Mrs. Stretton were last week presented by the Kidderminster Infirmary Committee with a silver rose-bowl, in the presence of nearly 500 personal friends.

DR. DAVID LOWSON, M.D., late surgeon of the Hull Royal Infirmary, who was awarded the Albert Medal of the First Class for sucking the tracheotomy tube from a patient with diphtheria, left estates valued at £10,146.

DR. DONALD MACALISTER, President of the General Medical Council, will take the chair at the opening of the next session of the Council on Tuesday, May 28th, at 2 o'clock, when important business will be proceeded with.

MEDICAL men resident in Greenock have formed a new incorporation to be known as the Greenock Faculty of Medicine. Sir Hector Cameron, M.D., Glasgow, has been appointed president, and Dr. William Allan is secretary.

DR. HERBERT W. G. MACLEOD, who has travelled extensively in the Tropics, is announced to read a paper in London this evening at the Society of Arts, on "Sleeping Sickness." The chair will be taken at 8 o'clock, and members of the medical profession will be welcomed.

SIR ALFRED JONES, president of the Liverpool School of Tropical Medicine wired Dr. Kinghorn and Mr. Eustace Montgomery, on their departure:—"Again good-bye and best wishes. May you achieve the success of your heart, and so benefit the world by your great work of humanity." They replied:—"We thank you for good wishes, and will do our best." These gentlemen will be away in Central Africa for two years.

DR. F. M. SANDWITH, Lecturer on Tropical Diseases at St. Thomas's Hospital, who was appointed Gresham Professor of Medicine to Gresham College, London, in the place of Professor Symes Thompson, deceased, will deliver his first course of lectures at the College to-day, Thursday, and Friday, at 6 p.m.

A Clinical Lecture
ON
CLIMACTERIC FLOODINGS.

By PROFESSOR ALFRED J. SMITH, M.B., M.Ch., F.R.C.S.I.,

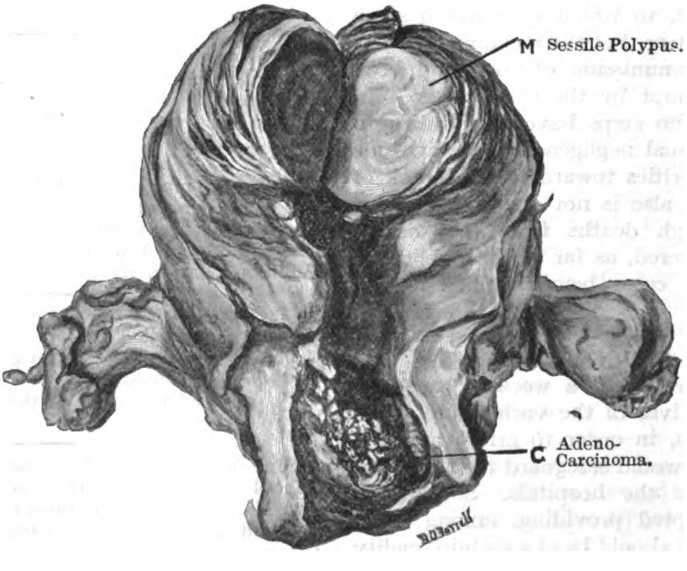
Gynæcologist to St. Vincent's Hospital, Dublin; Examiner in Midwifery, Royal University of Ireland.

There seems to be a more or less general impression that floodings or irregular hæmorrhage must of necessity occur at the climacteric.

Consequently when a patient consults her doctor, and states that her age is 46, that she has noticed her changes becoming heavier and more frequent, most practitioners are content to adminster some astringent mixture and send the patient away with the assurance that she is suffering from an ailment incidental to the change of life, little heeding the disastrous consequences of their action. This attitude of mind is unscientific. The principle of neglecting to make the essential local examination has cost the lives of many valued patients; it is a great blot in modern gynæcology.

To deal *in extenso* with this important question would be beyond the scope of an ordinary lecturer. I may begin by stating that the whole subject of severe uterine hæmorrhages occurring near the menopause requires overhauling; many remarkable cases have been recorded in our literature of late, where the pathological findings have been almost as remarkable as the theoretical construction advanced in explanation of the hæmorrhages. This confusion lends an attractive interest to the subject.

I can best illustrate my contention by bringing under your notice to-day three cases that have recently come under my observation, and I am fortunate in having the pathological specimens for your inspection. The graphic description of the pathological findings made by Dr. Farrell, pathologist to St. Vincent's Hospital, will do much, I hope, to interest you.



Case II. showing Sessile Polypus and Adeno-Carcinoma.

Case I.—C. H., æt. 48, first consulted me for sheddings, which came on without any warning, and so heavy that the blood would stream down on the floor. From the loss of blood and the anxiety brought about by her dread of the hæmorrhage, made her condition very pitiable. She told me that for the past eight years her changes were heavy, but that for the past six months she knew not the day or the hour when a gush of blood would come. She saw her regular medical attendant, who prescribed ergot and iron mixtures for her. He also gave her ergo-apiol and styptol; in fact, he exhausted all the well-known remedies without benefit.

When I saw her she was quite blanched and run down. Bi-manual under ether gave uterus normal in position, slightly larger than normal; elastic in feel, rather like that of a pregnant uterus; but it did not contract on continued manipulation. On passage of sound blood squirted out from the os in a jet and was so alarming that I had to hastily plug the uterus and postpone investigation. One thing was clear to my mind, the necessity of a radical operation. But before attempting it, I deemed it advisable to build the patient up with tonics and rest. It was almost three weeks before I felt justified in performing a laparotomy and removing the uterus.

Cavernous Angioma of the Uterus.

The pathological condition consists of dilated spaces generally scattered throughout the uterine wall, in many places they are collected into groups, particularly in the centre of the wall and under the mucous coat. The disease chiefly occupies the posterior part of the organ, where, in two places, it almost reaches the peritonial surface. Much of it projects into the uterine cavity, pushing the connective tissue and mucous coat in front of it; in this place the spaces are numerous, though small, giving it a somewhat spongy appearance. The spaces vary in size, the majority being about 2 to 3 mm. in diameter. Two or three are of irregular shape and of remarkable size, about 2·5 cm. in longest measurement, and 2 cm. in greatest diameter and depth.

The cavities are lined by smooth endothelium of a whitish colour in the small spaces, though brownish in the large, where the lining membrane is thrown into folds of varying sizes. The consistency of the tumour is the same as that of the uterine wall, though softer and more elastic over the larger spaces. Around each of the cavities there is a more or less dense tissue running in bundles, holding some of the spaces open and constricting others. The fibrous tissue in places is arranged in whorls, some of which contain blood-vessels.

Angiomas of the uterus are extremely rare ; I cannot find any reference to more than two well-authenticated cases. Hence this specimen is of more than ordinary interest.

Case II.—N. S., æt. 40, had been suffering for some months from heavy menstrual discharges. Her physician told her it was quite natural to expect such irregularities, as she was coming to the change of life, and prescribed some astringent mixture. Her condition becoming worse, I saw the patient. A prune juice discharge was coming from the vagina, there was no offensive odour present. Examination under ether revealed a Sessile fibro-myomatous polypus growing from the fundus. Before attempting to remove the polypus by morcellation, a finger was introduced into the uterine cavity to accurately map out the tumour. It was fortunate I did this, as a small ulcerating patch was discovered on the posterior wall of the cervical canal, as shown in the drawing. A fragment was removed, the microscopic finding being adeno-carcinoma with active mitotic changes.

Case III.—M. B., æt. 47, was sent up to hospital in a blanched condition. She complained of losing heavily. Not only was her menstruation heavy, but that latterly sharp hæmorrhage came on in the interval between the ordinary menstrual periods.

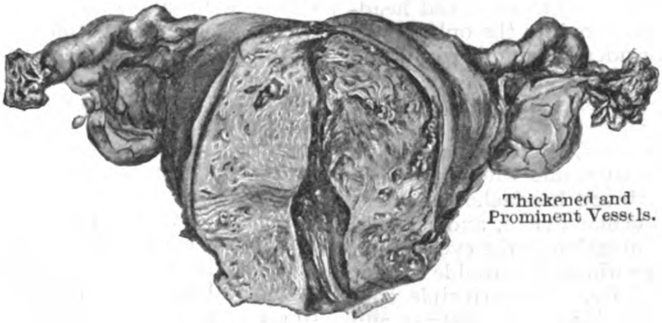
Her physician consoled her at first, that such heavy flows and irregular discharges were to be expected, that a bottle or two of a special mixture, assisted by rest in bed and hot vaginal douch would soon have her all right.

Both patient and doctor were soon disillusioned. Another sharp hæmorrhage determined the patient to come to Dublin.

Examination.—On bi-manual, uterus normal in position, somewhat enlarged, with almost a stony hardness. On curettage nothing came away. The diagnosis was made of arterio-sclerosis, and fourteen days' preparatory treatment of the patient was undertaken. The uterus was then removed by ordinary abdominal route.

ARTERIO-SCLEROSIS OF THE UTERUS.

The uterus, after hardening in formalin, measures 9 cm. by 8·5 by 6 cm. The serous surface is smooth and free from adhesions. On section, the uterine wall is thickened and firm, measuring 3 cm. across. The vessels on the cut surface are visibly thickened and prominent, and stand out very distinctly, particularly at the outer part of the uterine wall. The inner portion of the wall is firm, having a homogeneous appearance. The uterine cavity is 6 cm. long. The mucous membrane has a smooth, pale, undulating surface, and is slightly thickened. There are no ovarian changes.



Case III.—Arterio-Sclerosis.

Treatment.—In discussing the lines of treatment I am prevented by my preliminary restriction from detailing the routine treatment of simple uncomplicated cases of climacteric floodings. I must confine any observation I have to make to the types of cases just described—*e.g.*, malignant, arterio-sclerotic and angiomata. A fundamental principle guiding my practice in every case of climacteric flooding is to make a thorough local examination, nothing must be left to chance. A complete bi-manual, if necessary under anæsthesia, must be made ; the great importance of eliminating any possibility of the existence of malignant disease of the uterus by a preliminary curettage and the microscopical examination of the scrapings I insist upon. Much valuable information will be obtained by a digital examination of the interior of the uterus, as was demonstrated in Case 2 above.

Malignant.—Obviously for malignant and angiomatous types there is only one line of treatment for operable cases—panhysterectomy.

Arterio-Fibrosis.—In the aggravated forms of this type you may try all the recognised methods of arresting hæmorrhage—such as posture, curettage, tamponing the uterine cavity with sterilized gauze, or hot douching. You may give internally all the uterine tonics or astringents in the B.P., or the uterine tablets of fashionable pharmacists, but still the hæmorrhage persists. How then may the hæmorrhage be controlled ? Two methods are at present being advocated, *viz.*, hysterectomy and atmokausis. Hysterectomy is the method followed in those cases that came under my notice, and I have been well satisfied with the result. The alternative method is not so well known in this country ; it consists in applying superheated steam generated in a special kettle to the interior of the uterus. This method is known as atmokausis. It was originally introduced by Professor Snegiren, of Moscow, and established upon a firm scientific basis by the work of Dr. Ludwig Pincus, of Danzig ; it is now a well recognised therapeutic measure, being advocated by a number of well-known gynæcologists both on the Continent, America, and at home.

Some points in this comparatively new treatment may interest you. Whenever possible it is better for the operation of atmokausis not to follow immediately on that of curettage. The best results are to be obtained by the use of steam between 110°C. to 115°C. for a short a time as possible, *viz.*, from 5 to 40 seconds. If the steaming is repeated, this should not be done until three to four weeks have elapsed, the length of time during which the action of the steam is to be allowed to continue may be judged by the readiness with which the uterus responds to the stimulus of the heat by contracting ; cases where it is desired to use steam to procure complete obliteration of the uterine cavity it must be used at a temperature of 115°C. for one minute on two occasions, the second application to be made some 15 or 20 days after the first. Rest in bed should be enjoined in all cases until the slough has separated.

Pincus claims for this method a very strong position ; he goes so far as to state that no case of hysterectomy should be performed without at first giving atmokausis a trial. My experience has not been so satisfactory, there always seemed to me to be a great danger of causing occlusion of the internal os. The recent suggestions of Pincus to shield the cervical canal and internal os completely will, I hope, go a long way to prevent this regrettable accident.

The main features then of the three cases are :—The patients were all in or about the climacteric, they all suffered from heavy menstruation and irregular hæmorrhage, and the drug treatment was tried without benefit. Local examinations demonstrate three distinct pathological conditions.

My contention that a thorough local examination is justified, nay, demanded in all cases of hæmorrhage occurring at the menopause, is more than amply demonstrated.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Sir James Barr, M.D., I.L.D., F.R.C.P., F.R.S.E., Senior Physician Liverpool Royal Infirmary Chairman of the Medical Faculty of Liverpool University, President of the Lancashire and Cheshire Branch, British Medical Association. Subject : "The Treatment of Pneumonia."*

ORIGINAL PAPERS.

OCULAR HEADACHES. (a)

By R. PHILIP BROOKS, F.R.C.S.E.

Ophthalmic Surgeon to the Prince of Wales' Hospital, Tottenham.

Gentlemen,—The subject of ocular headaches, in spite of its importance, is one which is only dealt with scantily in text books. Although eye strain, as a cause of headache, is well recognised throughout the profession, one not infrequently meets with people who have suffered for many years from more or less continuous headaches and have been subjected to various treatments without the eyes having been suspected ; and yet an examination of the eyes, followed by proper optical correction, at once gives relief. On the other hand, among the cases of unrelieved headache that are rightly referred to the ophthalmic surgeon, there are a considerable number in which an exhaustive examination of the eyes fails to discover any physical or pathological defect which can be fairly assigned as even a factor in causation. It follows then, that it is by no means always easy to determine whether or not in a given case of continued headache the cause is wholly or partly an ocular defect, and I would urge that a careful examination of the eyes should be made in every case in which the trouble cannot be otherwise accounted for. The principle conditions of the eye which give rise to distress and headache are, firstly, certain errors of refraction which throw an excessive amount of work on the ciliary muscles ; secondly, a want of balance between the external muscles of the globe ; thirdly, what may be called retinal hyperæsthesia.

With regard to the first it must be remembered that the hypermetrope is using his ciliary muscle not only during near work, but also when the eye is focussed for distance and should be at rest. In astigmatism, whether hyperopic or myopic, the strain on the ciliary muscle is even greater, so that it frequently assumes a state of spasm, which only yields after the continuous use of a strong cycloplegic such as atropine. Frequently in this way what appears on first examination to be myopic astigmatism is, after the use of atropine, proved to be hypermetropic astigmatism, or the amount of the apparent myopia is diminished.

Simple myopia of moderate degree which is not increasing, I have not found to be a cause of headache, but inequality of refraction on the two sides, if binocular vision is still maintained, does cause both distress and headache.

Frequently the above conditions exist without there being any symptoms directly pointing to the eye as cause. The pain is most often frontal or brow, but may be in the vertex or occiput. It comes on in the daytime, increases towards night, and is relieved by sleep. It is generally most excessive in the lower degrees of ametropia, 1 or 2 D. of hypermetropia or 0.5 D. of astigmatism, causing more distress than when the error is 3 or 4 D. or more, the reason being that in the former case the ciliary muscle is in a state of constant activity, endeavouring to maintain perfect vision ; while in the latter the impossible has been given up, and the patient is content with less vision. It is in the lower degrees of ametropia that it is frequently difficult to convince the patient that there is anything wrong with his eyes. He has no direct eye symptoms. He protests that his sight is quite perfect, and, as a matter of fact, when tested with the distant types, can often read the normal standard without effort. Such a case then would not be detected unless a special examination were made.

Let us now turn to the external muscles of the eye. Want of balance between the external muscles is less common than error of refraction, but is more likely to cause headache, vertigo, and general distress. Let me explain for a moment what is meant by normal oculo-motor balance. If, with a pair of normal eyes, the gaze be directed upon a distant object, the visual axes are so perfectly adjusted that the images received are thrown upon corresponding portions of the two retinæ and binocular vision results. If now, a screen be placed in front of one eye so that the stimulus of binocular vision is removed, no deviation will occur, nor will any movement of adjustment take place when the screen is removed, provided there is normal balance between the muscles ; and this will be found to be the case in by far the majority of patients examined. When there is a want of balance between the muscles a deviation of the covered eye will occur. The most convenient way to demonstrate and measure the deviation is to place in the screen the cylindrical glass rod introduced by Maddox, and to direct the patient with both eyes open to look at a candle flame at five metres distant. The image of the candle flame seen by the screened eye is converted by the cylindrical rod into a light streak, which cannot be fused with the candle flame seen by the uncovered eye. The screened eye deviates, and if a scale is placed behind the candle flame the amount of deviation may be calculated from the distance between the candle flame and the light streak. Want of muscular balance or heterophoria, as it is called, is due (1) to a muscle or group of muscles being too strong or two weak for the opposing muscle. (2) To the insertion of a muscle being misplaced, and therefore acting at a greater or less mechanical advantage. (3) To defective innervation of a group of muscles.

(a) **An Epitome of a Lecture delivered February 5th, 1907, at the North-East London Post-Graduate College, Prince of Wales' Hospital, Tottenham.**

The most prominent symptoms produced are headache, especially brow pain, coming on towards the end of the day, pain in the eyes, giddiness, nausea, and occasional diplopia. Frequently symptoms which have remained dormant become distressing after a severe illness, or at the time of life when presbyopia begins to show itself. As with errors of refraction, the amount of distress produced is in no way proportionate to the degree of muscular inbalance. Often a considerable amount of excessive convergence (esophoria) or of a tendency to the opposite condition of divergence (exophoria) may exist without causing any distress. It is otherwise, however, when the tendency is for one eye to deviate upwards (hyperphoria). Here a single degree of deviation is sufficient to cause some distress and will require correction. Frequently such people have been to numerous opticians, and have been provided with various spherical lenses without relief; indeed, their symptoms have often been aggravated in this way. Many considerations must be taken into account before correcting heterophoria. Where no distress is caused, no correction is necessary. In some cases the tendency to deviation disappears when the refraction of the eye is corrected; or again, so close is the association between convergence and accommodation that an eye that has long been accustomed to the altered conditions brought about by an error of refraction, may, when that error is corrected, cause distress due to a false heterophoria.

In deciding on the prism, if any, that must be prescribed, besides the direction and degree of the deviation, the state of the patient's muscles must be investigated, and this is best done by finding the maximum prism which the various muscles are able to overcome without diplopia being produced.

Plainly the treatment of such conditions and the prescribing of lenses is a matter which requires a ripe experience based upon scientific knowledge of the conditions prevailing, both in health and disease, and should not be allowed to fall into the hands of those whose business it is to make spectacles. The attitude taken up by many general practitioners, of not touching eye work, is, I think, wrong. The apparatus sufficient for diagnostic purposes is both simple and inexpensive. In a suspected case I would advise the following routine to be carried out :—

(1) An inspection with the mirror of the ophthalmoscope to discover any opacities of the medea.

(2) Patient reads Snellen's test card. Failure of either eye to read the last line ($^{6}/_{6}$) at a distance of twenty feet indicates a defect for further investigation.

(3) If the patient can read about the same with a spherical lens say + 1 D., a diagnosis of hypermetropia can be made.

(4) A cylindrical lens say + 0.5 D. is placed before each eye separately and rotated. If vision is improved, a diagnosis of astigmatism is made.

N.B.—A concave spherical or cylindrical lens will often improve vision by calling the accommodation into use, and are therefore of little value for diagnosis. In such cases a mydriatic must be used unless the patient be presbyopic.

(5) Test the muscles (*a*) for insufficiency of the interni. The patient should converge by following the finger to the tip of the nose (*b*) by Maddox cylindrical rod above described.

INTUBATION OF THE LARYNX
IN
LARYNGEAL DIPHTHERIA. (*a*)

By CLAUDE BUCHANAN KER, M.D., F.R.C.P.

Medical Superintendent of the City of Edinburgh Hospital; Lecturer on Infectious Diseases, Dist. University of Edinburgh.

AFTER referring to the abortive attempt of Bouchut in 1858 to replace tracheotomy by intubation, the author remarked on the fact that while intubation is the operation of election in America, France and most other European countries, it has not many votaries in Great Britain. Its theoretical advantages over tracheotomy are: (1) breathing through the natural passages and diminished risk of pulmonary mischief; (2) a cutting operation is unnecessary; and (3) absence of a scar. No preparation is required, and relief is immediate. On the other hand, after tracheotomy the parts involved get complete rest, and if the tube becomes dislodged it can be replaced by an unskilled person. On account of the different conditions under which patients are operated on statistics are of little value in deciding between the rival operations. It might be thought that tracheotomy would allow more readily of the extrusion of membrane, but large pieces can be expelled through an intubation tabe, and on intubation, also, coughing is more vigorously performed. The danger of plugging the intubation tube is exaggerated, and if a string is attached to it it can be readily removed should it become blocked. Several times, however, the speaker had seen the tube push membrane beyond, and thus block the trachea; this however is rare, and not a fatal accident. The possible infection of the trachea by the dislodgement of small pieces of membrane is a theoretical objection only, and, in any case, has no weight since the introduction of antitoxin. Serum, unquestionably, has rendered possible the good results now obtainable by intubation, as the rapid disintegration of the membrane which follows its use, often makes it unnecessary to do more than tide the patient over two or three days, which can be done more safely by intubation than tracheotomy. Up to three years ago Dr. Ker's mortality rate never fell below 40 per cent. of those intubated—much the same as that of hospitals in which tracheotomy is practised—but great improvement in his results was shown since nasal feeding had been adopted. Prior to this he had depended almost entirely on rectal feeding. About the same time he had adopted vulcanite in place of metal tubes, and these were much better tolerated, and could be worn much longer by the patients. In hospital practice the operation should be postponed as long as possible; Dr. Ker's series of cases were mostly in the third stage of croup—*i.e.*, showing signs of exhaustion and heart failure, when they were intubated. It is well not to interfere so long as the respiratory difficulty remained paroxysmal, because many patients recover in this stage, severe though the paroxysm be. The great thing is to try to give the serum time to act, and to be at hand to operate at a moment's notice. In private practice, of course, early intubation was required. Since 1904 his mortality rate for ntubation was 27 per cent. More than a quarter of the total patients required secondary

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(*a*) **Abstract of paper read before the Edinburgh Medico-Chirurgical Society, May 1st, 1907** tracheotomy, and of this fraction 55 per cent. died. In only eight cases did tracheotomy succeed where intubation failed. The operation should, however, always be done if intubation does not give relief. Nine patients died in whom only intubation was performed; three of these succumbed from various causes after the tube had been finally removed; five died relieved of the respiratory difficulty with the tube *in situ*, and one died while being intubated, from cardiac failure.

The author thought that the tube should be removed some time between 48 and 72 hours—generally 2½ days. In most instances it is not necessary to replace it. In twelve cases intubation had to be performed twice, in three three times, in one four times, in one six times, in one seven times, and in one fourteen times. If a patient got through the first four hours without difficulty it is rare to have to replace the tube. The tube should be removed in the morning, as the breathing is likely to become worse at night. One satisfactory feature of intubation was that it might only be of momentary duration, tube and membrane being at once coughed up with immediate permanent relief. In his cases the tube was worn for from two days or less, up to twenty-nine days. It is doubtful whether tracheotomy is any use in cases in which the tube cannot be dispensed with, for the difficulty arises again as soon as the cannula is removed. The cause of the obstruction is atrophy of the laryngeal abductors, and adductor spasm.

To intubate dexterously requires considerable practice. The patient ought to be recumbent, to avoid risk of heart failure. It is best to leave the string attached to the tube in position, fixed to cheek with plaster strapping. Banjo string was preferable to silk, as less likely to be bitten through. Extubation is much more difficult than intubation, and the long American tubes cannot be removed by Bayeux's method. The string, therefore, should be left. Steam is useful at first; in bad cases of retained tube open air is preferable. The great difficulty in introducing intubation into private practice is the experience which it demands. Its advantage is that it may be performed early and so relieve the patient of the risk of being left without operation, and with no medical attendant immediately at hand. In severe cases, on the other hand, tracheotomy is probably safer in private. In country practice he would be inclined to intubate every case of laryngeal diphtheria as soon as it was diagnosed, provided the obstruction was not very marked, in which case tracheotomy would be safer.

THE SYMPTOMS, TREATMENT AND SEQUELÆ OF NON-MALIGNANT DUODENAL ULCER. (*a*)

By D'ARCY POWER, M.A., M.B. OXON., F.R.C.S. ENG.

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THE symptoms, treatment, and sequelæ of non-malignant ulcer of the duodenum have hardly received the attention they deserve owing to their frequency and severity. Until about the year 1892 duodenal ulcers were of purely academic interest. They were recognised *post mortem* and their occurrence was occasionally suspected during life, but no attempt was made to treat them surgically or to differentiate them from gastric ulcer. Increasing familiarity with the surgery of the stomach led naturally to a better acquaintance with abnormal conditions in the duodenum. Surgeons dealt first with duodenal ulcers which had perforated acutely: they were then led to interfere in cases where hæmorrhage was the chief symptom; more recently they have concerned themselves with the results of duodenal constriction due to cicatrisation of ulcers in this part of the alimentary canal.

My position as a hospital surgeon has given me numerous opportunities of seeing and treating various cases of duodenal ulcer and I have thought this a fitting opportunity of communicating what I have learnt about them and the opinions at which I have arrived.

Causes.—Nothing is known with certainty as to the causes of ulcer of the duodenum. It is rarely associated with ulcer of the stomach but the causes which produce gastric ulcer probably play a part in causing ulcer of the duodenum. The duodenum, too, is liable to the same inflammatory conditions as other parts of the alimentary canal. Tuberculous and typhoid ulceration are therefore not uncommon. There is no doubt that general septic and pyæmic conditions may be associated with duodenal ulcer and to these causes perhaps is to be assigned the duodenal ulceration found in a certain proportion of patients who have been burnt especially when there has been much suppuration. The experiments made by Dr. William Hunter (*a*) point in the same direction, for he showed that the subcutaneous injection of toluene-diamine into dogs was followed by marked duodenal ulceration, the drug being destructive to the red blood corpuscles, and being eliminated by the liver. There seems to be an ill-defined relation between duodenal ulceration and some cases of interstitial and tubal nephritis, whilst the stress of anthrax infection may fall upon this part of the alimentary canal. A duodenal ulcer either perforates or it does not perforate. If it does not perforate it may lead to hæmorrhage, or it may cicatrise, causing one form of pyloric obstruction.

(A) PERFORATING DUODENAL ULCER.

Perforation.—The subject of a perforating duodenal ulcer is usually a man in the prime of life who assures you that he has either never suffered from any dyspeptic symptoms up to the moment of his sudden illness or has had so little indigestion that he has taken no account of it. Without warning he is suddenly seized with a stomach-ache of such severity that he becomes collapsed at once and sends immediately for assistance. He may vomit, but from the onset he passes neither flatus nor fæces. Examination within an hour or two of the attack shows him lying on his back, afraid to move, his breathing shallow and rapid, his pulse small, regular and quick, but not nearly so much accelerated as his respirations. He looks pinched and haggard, but his temperature is normal. The patient cannot localise the pain, but complains that it is worse along the upper half and down the right side of the abdomen. The abdomen is not distended and is not motionless, though it moves less freely during respiration than it should do. At first it is held rigid and the muscles on the right side are somewhat more tonically contracted than those on the left. It is everywhere tender and tympanitic. The area of liver dulness may not be altered, and there is sometimes a point of maximum tenderness in the right hypochondrium. If no operation be performed, the pain becomes less acute and more generalised than it was at first. The patient rallies from the initial shock and may fall asleep; he loses his pinched appearance, and though the abdomen is still rigid it moves slightly during respiration. If unfortunately the patient is still left untreated, either because an incorrect diagnosis has been made, or because he does not apply for relief, the pain again becomes urgent, but is now felt in the right iliac fossa which becomes especially tender, full and motionless. The patient shows the ordinary signs of peritonitis, he again becomes collapsed, his pulse quickens, his temperature

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(*a*) "Pathological Society's Transactions," Vol. 41, p. 205.

rises, and he dies usually with a diagnosis of appendicitis.

The errors in diagnosis are quite excusable in those who have not already had to treat a case of perforated duodenal ulcer, and in those who are only called in to see a patient in the later stages. The initial shock caused by the sudden perforation is generally sufficient to indicate that some grave catastrophe has occurred and has overwhelmed the peritoneum. The symptoms are not quite like those of a perforated gastric ulcer, because the duodenal contents are more digested and less acid than those of the stomach, and there is consequently less irritation. The symptoms subside therefore for a time, and the fluid poured out by the duodenum slowly accumulates in the iliac fossæ and more in the right than in the left. The onset of peritonitis demands an examination of the abdomen and, as the patient now locates his symptoms to the lower part of his abdomen, it is easy to treat the case as one of appendicitis.

Diagnosis.—The diagnosis of a perforated duodenal ulcer should be easy but in practice it is often a matter of great difficulty as is shown by the cases I have just quoted. The patient is suffering acute abdominal pain and the attack began suddenly. The history of previous good health, the fact that the abdomen is moving during respiration, the absence of any great amount of rigidity in the abdominal muscles or of any point of maximum tenderness, are all misleading, and make it difficult for the surgeon to believe that the patient is suffering from such a dangerous condition as a perforated ulcer of the duodenum. He may think of a perforating or leaking gastric ulcer, but the symptoms are much less characteristic than he is accustomed to find in this condition, and it is not until he has seen one or two similar cases that the occurrence of a perforated duodenal ulcer is called to mind. The diagnosis, therefore, is too often left in abeyance in the hope that a few hours' delay will render the signs and symptoms more definite. Such advice is likely to prove fatal, for instead of making the diagnosis clearer time only renders it more obscure. The slight clues which could be picked up shortly after the onset when the peritoneum was only affected at the point of perforation are soon masked by the general peritonitis produced by the diffusion of the duodenal contents throughout the abdominal cavity. Delay thus allows the extravasated fluid to gain access to the innermost recesses of the peritoneal folds so that a subphrenic, pelvic or iliac abscess may still further complicate a condition which is well-nigh desperate from the beginning.

When I am called to a patient who has been seized suddenly with intense abdominal pain, without much history of previous indigestion, I ask that he shall not be given morphia, and that his pulse shall be counted carefully and accurately recorded by the same person every half hour. If on my arrival the pulse rate has increased although the patient has been kept at rest and free from disturbing influences, I have no hesitation in advising an immediate exploratory operation, even though the objective signs be very slight.

The escape of gas and liquid as soon as the abdomen is opened prove that a perforation has occurred and the first thought of a surgeon will then be that he is dealing with a ruptured gastric ulcer. The character of the fluid often gives the first indication as to the seat of the perforation. When it comes from the duodenum, it is limpid or bile-stained, free from smell, alkaline and thus wholly different from the extravasated contents of the stomach which often contain undigested portions of food. The fluid from the duodenum is the succus entericus and is, I suppose, the secretion of Brunner's glands. It is sometimes very abundant, and comes welling up from the perforated intestine in quite a characteristic manner. The perforation is usually small, close to the pylorus and often rather at the back of the duodenum, so that it is very awkwardly placed for suture. If is, however, quite possible to close it completely.

If the patient be left without operation, the diagnosis, as I have said, becomes still more obscure and my experience tells me that a perforated duodenal ulcer may be mistaken for pneumonia, for appendicitis, or for suppurative peritonitis from any other cause.

(B) NON-PERFORATING ULCER.

The second group of cases where there is a duodenal ulcer without perforation is even more interesting than the perforating variety which has just been considered. The diagnosis may be more difficult and the sequelæ demanding surgical treatment are no less urgent though they may be more remote. As may be gathered from what has been said of perforated ulcers, the signs of a duodenal ulcer may be absent or wholly inconspicuous and in such cases no diagnosis is possible. In some cases the patient complains of a continued pain in the abdomen which he can neither localise nor account for. He keeps his bed for a few days and then feeling better, goes about again saying that he has had a bad bilious attack. If he is nervous about himself or should the pain have been severe, he seeks medical advice, and is treated for gallstones, renal colic, or appendicitis. But the exact nature of his illness is probably not recognised unless he vomits a considerable quantity of blood, or has a sharp attack of melæna. Even then the case is thought to be one of gastric ulcer, unless an abdominal section is performed and the stomach is found to be healthy.

Hæmorrhage.—The hæmorrhage in some cases of duodenal ulcer is a characteristic symptom. It is sudden, painless, and very considerable in quantity. It seems to be due to erosion of the large arterial trunks which lie outside the duodenum—the superior pancreatico-duodenal artery being the most commonly affected, though the gastro-duodenal, the pyloric, the gastric and the pancreatica magna as well as the superior pancreatico-duodenal vein have been found ulcerated. The hæmorrhage may be so severe as to be fatal at once, more often the patient is blanched, or he may become faint without knowing the cause. This may happen on more than one occasion, and as the hæmorrhage is concealed, the cause is only recognised by the subsequent passage of large tarry motions. In other cases, the patient may have hæmatemesis instead of melæna, or both may be present.

Unless there is hæmorrhage, I do not know how a diagnosis can be established in the present state of our knowledge, but it is of no practical importance, for in the majority of cases the patient recovers from the attack unaided by art or if the bleeding be sufficient to need an exploration the surgeon performs a gastro-jejunostomy, whether the ulcer be situated in the stomach or in the duodenum. I have tried to recognise the condition by the character of the bleeding, by the time of the occurrence of pain after taking food, by the character of the material vomited and in many other ways, but always without success, for what is true and seems a valuable sign in one patient is worthless in another. I believe, therefore, that there is no pathognomonic sign of a non-perforating ulcer of the duodenum whilst the ulceration is in progress.

Constriction of the duodenum.—But if a non-perforating duodenal ulcer offers very few signs by which its presence may be detected, it may have sequelæ of the gravest character. The ulcer is usually single, and is situated in the first part of the duodenum, but like a gastric ulcer it is very chronic and may cause extensive inflammation in the submucous and muscular coats of the intestine. The inflammatory changes may extend to the serous coat and to the under surface of the liver. In process of time the ulcer heals and by the subsequent cicatrisation of the inflammatory products the duodenum is either narrowed, or it is constricted by the surrounding adhesions. The adhesions may not only affect the duodenum, but they may also involve the liver, the gall bladder, the pancreas, and such large blood vessels as the abdominal aorta, the hepatic artery and the portal vein. Such a patient presents himself as a man between 40 and 60, looking older than his years. Thin and haggard, he tells you that he is a martyr to indigestion, and that for months past he has suffered atrocious pain in his stomach which is relieved by vomiting. He has dieted himself in every possible manner, he has made all kinds of local applications to his stomach, he has visited all sorts of watering places, and he has gone in vain from one physician to another seeking a cure. Examination shows him to be a mere bag of bones, badly constipated with cold extremities and a listless dejected aspect. His abdomen is loose, the subcutaneous veins may be enlarged and there is visible peristalsis from left to right in the epigastric region. Palpation and percussion tell of a greatly dilated stomach and a tumour may sometimes be felt in the neighbourhood of the pylorus. For a moment you think of cancer of the pylorus or gall-bladder, and you question the patient a little more closely. He is sure that he has been suffering for years, for so long, in fact, that he hardly recollects the beginning of his trouble. A few well-directed enquiries may elicit that 25 or 30 years ago, when he was a young man, he once or twice brought up a large quantity of blood without serious pain or discomfort, or that he had an illness which no one seemed to know much about. He was treated for gallstones or for appendicitis or simply for "liver." The attack was abdominal, was painful, and kept him in bed, but the exact details have long since passed from his mind and for some years he was as healthy a man as ever.

This is a case of duodenal obstruction resulting from cicatrisation of an old ulcer, the irritation of which caused inflammatory thickening of the surrounding parts or of the duodenal walls. How many patients have been allowed to die of such a condition in the belief that they had malignant disease of the stomach no one can tell, but every pathological Museum contains several specimens of simple duodenal constriction.

The general symptoms of duodenal obstruction may be gathered from what has been already said. There is usually pain of the nature of dyspepsia felt an hour or two after taking food. The pain depends more upon the quality of food taken than upon the quantity. It is relieved by vomiting and the severity of the vomiting increases with the length of time the symptoms have lasted. It is usually copious and often painful. It is not a mere emptying of the stomach, for when the patient has vomited a large quantity, he will in an hour vomit as much again, although he has taken nothing in the interval. The attacks of vomiting are often worse at night than in the daytime. This seems to be particularly the case with business men, perhaps because they make a light breakfast, have but little lunch and make their chief meal in the evening. The attacks of vomiting, therefore, like the pain, bear a definite relation to the quantity, rather than to the quality of the food taken. The quantity of fluid vomited and the small amount of food digested and absorbed lead to very obstinate constipation. It is the relief of this symptom which is hailed with the greatest joy by a patient who has been cured by a gastro-jejunostomy, and the regularity of the bowels is one of the best proofs to the surgeon that his anastomosis is working successfully many months after the operation. The same loss of absorptive power leads to diminution in weight, to a harsh and dry skin, to a brittleness of the nails and to loss of the subcutaneous fat; in other words, the patient shows many of the signs of chronic starvation.

Diagnosis.—A systematic physical examination of the abdomen should be made in every case where there is reason to think that the patient is suffering from duodenal obstruction. The patient should lie flat on his back on a couch, with the knees bent and the shoulders slightly raised by a pillow. A good light is allowed to fall upon the abdomen and the surgeon should at first merely watch the abdominal movements without touching the patient. In thin people and in a case of marked duodenal obstruction the outline of the dilated stomach can often be seen with slow waves of peristalsis passing across the upper part of the abdominal wall from left to right. These waves in themselves are characteristic of some obstruction to the outflow of the gastric contents and the more healthy and active the person the more marked are the waves. The surgeon now places his hand flat upon the abdominal wall and his practised touch readily discovers the outlines of the enlarged stomach, even if there be no tumour or nodule perceptible in it. The position of the pylorus is often marked in these cases by a thickened nodule, which is easily mistaken for cancer, especially if, as in the case related above, the patient vomits a little blood from time to time. But the actual position of the pylorus varies greatly when the stomach is dilated and its exact position may not be detected at the first examination. The absence of a tumour does not preclude the diagnosis of duodenal constriction. Percussion is not of any great value in determining the size of the stomach, because a dilated stomach is often associated with a distended colon, and it is difficult to distinguish the note yielded by one from that of the other. Auscultation, too, is of no great service except to elicit the succussion splash. A dilated stomach can be easily distended by pumping in air, a proceeding which, though painless is unpleasant to the patient, or by the cruder method of administering separately the constituents of a Seidlitz powder. With these guides, there is really no excuse for overlooking a dilated stomach, or for being doubtful as to the existence of such a condition.

The teeth and gums should always be examined, as a matter of routine, to eliminate the possibility of the dyspeptic symptoms and constipation being due to chronic lead poisoning. It is better not to give a definite diagnosis until the bowels have been satisfactorily emptied by means of an enema, repeated if necessary, and it is wise to examine the abdomen more than once, and at different times after meals.

A test meal must always be given, and the presence or absence of free hydrochloric acid should be noted. The usual test meal consists of a thick slice of bread and butter with a breakfast cup of weak tea sweetened, but without milk. The meal is given at breakfast-time, and is withdrawn from the stomach an hour later by means of a stomach tube. The material withdrawn is filtered, and the residue is examined microscopically to see how far digestion has proceeded. The filtrate is tested with Günsberg's reagent for free hydrochloric acid. A few drops of the filtrate are mixed in a porcelain dish with an equal quantity of a solution consisting of phloroglucin 2 parts, vanillin 1 part, and absolute alcohol 30 parts. The mixture is evaporated to dryness at a gentle heat, and, if free hydrochloric acid is present, red crystals will form. As a broad rule, free hydrochloric acid is present in simple duodenal constriction: it is deficient or absent in cancer of the stomach.

Microscopically, too, the Oppler-Boas bacillus should be absent in cases of non-malignant constriction of the duodenum.

Treatment.—Palliative treatment in cases of duodenal constriction is chiefly directed to relieve the vomiting. This is done by rectal feeding and washing out the stomach, since the indications are clearly to keep the stomach empty and prevent putrefactive changes. The stomach is washed out with a warm solution of bicarbonate of soda (20 grains to the pint). A soft tube is passed into the stomach and its contents are evacuated, half a pint of the solution is then poured into the tube and is allowed to run out again, and this is repeated several times. In the early stages of duodenal constriction, the stomach need only be washed out every other day, and this is done most conveniently before breakfast; but in the later stages, when the vomiting is most distressing at night, the stomach should be washed out every evening just before the patient goes to bed, and about four hours after the last meal.

It is obvious that this treatment is only palliative, and it follows from what has been said already that patients who suffer from painful vomiting, with loss of flesh and constipation, should always be examined carefully to find out whether there is any dilatation of the stomach. When the stomach is dilated, and diet, combined with simple remedies, fails to bring about a cure, there should be no hesitation in recommending an exploratory incision with a view to the performance of a posterior gastro-jejunostomy by direct suture.

The operation should not be postponed until the patient has exhausted himself, because early operation is attended with comparatively little risk, and has a twofold advantage. If the patient is found to be suffering from cancer of the stomach, much more radical measures can be pursued in the early stages of the disease, than if delay has allowed the growth to infiltrate all the surrounding tissues. But even if the constriction proves to be due to malignant disease, and removal is impossible, gastro-enterostomy serves excellently as a temporary expedient. It has, too, the advantage over colotomy for the relief of an analogous condition in the rectum, that it leaves no open wound. The patient, therefore, is able to go about his ordinary work until the progress of the disease renders him incapable of further effort. If, on the other hand, the patient is suffering from duodenal constriction, which is not due to cancer, the surgeon can promise him a speedy relief from all the disagreeable symptoms, and a prolongation of his active life for many years in comfort.

CLINICAL RECORDS.

TREATMENT IN TWO CASES OF RECURRENT AND INOPERABLE CANCER.

By J. A. SHAW-MACKENZIE, M.D., Lond.

The following brief notes of one of my recent cases, are, I think, worthy of record.

1. Mrs. —, Recurrent Carcinoma of the Breast.—In February, 1904, a well-known surgeon removed the right breast. The patient made an excellent recovery, but in the following year there was recurrence of the disease, and in November, 1905, a second operation was performed. Recovery from this was extremely slow, and the patient was under surgical care until the middle of last year, when a well-known physician was consulted for increasing dyspnœa.

On June 6th, 1906, the patient came up from the country to see me. She was suffering from extreme breathlessness on exertion. Bronchial rales were present at both apices; the left breast was involved; there were several recurrent nodules on the right side of the chest, and the supraclavicular and axillary glands were enlarged on the left side. It was ascertained that there was a diabetic history on the father's side, and the patient herself had distaste for sugar. She had the strongest objection to any further operation, an objection which was also shared by her husband. Her physician kindly wrote to me that "there is much more trouble than a month ago when she was last here, and I think her breathing troubles are probably due to enlargement within the thorax. I agree with you that Mrs. —— is not a favourable case, but one feels that anything is worthy of trial." The internal administration of pancreatic and intestinal gland preparations (Allen and Hanbury's), together with purified ox gall were prescibed and excess of sugar recommended to be added to the diet. On June 26th she came to see me again. All pain which on the previous occasion was complained of had ceased, while the appetite and general condition had improved. She remained now in town for further treatment and hypodermic injections of soap solution (the method of Mr. J. H. Webb, of Melbourne), together with hypodermic injections of chian turpentine on alternate days were commenced. In three weeks' time the patient appeared to be distinctly better in every way, and her physician, after seeing her again, wrote to me: "The general condition is wonderfully better; in fact, all her subjective symptoms are in abeyance. The induration in the left breast seems to be rather less definite than when I last saw her, and they are certainly no larger. I hope things will go on as they have begun. It is certainly encouraging." She now returned to the country, and the treatment was kindly continued by her medical man. During August and September he wrote that she appeared to be holding her own. The treatment remained the same with the exception that in August iodipin was added to the chian turpentine injections, on the recommendation of Dr. John Shaw, who at that time was acting for me in my absence from town, and in September trypsin injections were alternated with the soap injections. In November, however, she was reported to have relapsed with a return of dyspnœa and cough, loss of of appetite and bad nights. The opsonic index of the blood to *M. neoformans*, which on several previous occasions proved to be normal, was now found by Dr. Aylmer May, on examination in series, to be irregular and characterised by very low and high phases. In spite of the unfavourable aspect of affairs, having learned from various examinations of the opsonic index, undertaken for me by Dr. May, in other cases that the dosage and strength of trypsin could be apparently increased, it was determined to push treatment, and the injections of trypsin and of chian turpentine were recommended to be given daily, while the pancreatic and intestinal gland preparations, which had been omitted for a time, were again resumed. On December 13th I visited the patient, who was able to be up and about, but very breathless on the least exertion. No physical signs in the chest were discoverable, and no increase in the external manifestations. There was no tendency to breaking down of the tissues, and the enlargement of the left breast appeared to be in a quiescent and atrophic condition, while the glandular enlargements were much less evident The same treatment was continued, and on December 30th she was reported to be again greatly improved. On February 17th, 1907, her medical man wrote to me: "The condition appears more or less stationary, she has, if anything, lost flesh, but the disease does not appear to have made way; the most marked symptom is dyspnœa on exertion." Towards the end of this month severe indigestion was complained of; the appetite fell away almost entirely, though when I saw her on the 28th there was no apparent increase of the disease or abdominal metastasis. It was agreed to continue the daily injections, which in themselves caused no pain or inconvenience, and to omit the pancreatic and intestinal gland preparations by the mouth. A bismuth mixture was suggested by her medical man, and almost immediately he was able to report improvement in the digestive and dyspnœal conditions. The opsonic index about this time was found by Dr. J. C. Matthews on two consecutive occasions to be above normal. The patient's husband—himself a son and grandson of members of the medical profession—now (May 1st) writes, with full permission to publish notes of this case: "For the past two months the appetite has become extremely good; she has slept well and her spirits are excellent. When weighed just over a month ago she had gone down to 7 stone 13 lbs. (a loss of nearly 2 stone); the weight remained stationary for a fortnight, but, last week—a further fortnight—a gain of nearly 3 lbs. was recorded, and, again now (May 10th) another 3 lbs. For months it was quite impossible for my wife to walk at all without her breathing becoming most distressing. For the last few weeks, however, this has all changed, she is now able to go up and down stairs quite freely, her breathing has become normal, and as recently as a fortnight ago—to show the improvement in her general health—she was able to take a drive of some sixteen miles, returning quite unfatigued. The lumps in the neck and on the right side have now practically all disappeared and the breast is becoming quite flexible. One remarkable feature is that during the time my wife has been under the treatment, she has been quite free from pain."

Note.—The diagnosis in this case cannot be questioned any more than the advanced and advancing state of disease eleven months ago. The obvious improvement and encouraging progress in this case must as I think, be attributed to treatment, coupled with—I cannot refrain from noting—the patience and determination of the patient herself.

The following case also will be read with interest :—

II. Mrs. —, Recurrent Carcinoma of Breast.—The right breast had been removed in September, 1904; further operation for recurrence in March, 1905; further removal of axillary glands in December, 1905, with tedious recovery and bad prognosis. The patient came to see me on March 6th, 1906; it was ascertained that she had avoided sugar for ten years; the weight of the patient was 9 stone 2¼lbs. She was pallid and feeble, but there was no obvious disease. With the object, if possible, of preventing recurrence, pancreatic and intestinal gland preparations (Allen and Hanbury's) were prescribed to be taken by the mouth and sugar recommended to be added to a carbohydrate and fatty diet. On July 17th the weight had increased to 9 stone 11 lbs. On this date some fullness was noted in the right supraclavicular region. On November 26th her weight was 10 stone 11 lbs., which she informed me was more than she recollected having weighed in her life; she looked well and stated that some glands had been removed in the autumn, followed by a quick and satisfactory recovery. Mr. P. W. L. Camps, of Teddington, who performed the operation, was good enough to write to me expressing the interest he had taken in the previous treatment, and the fact of the great improvement in her general condition which had taken place since Christmas, 1905, which he thought she owed to my treatment. He had removed four tiny lumps in the supraclavicular region, one of which proved, on microscopical examination, to be normal lymphoid tissue, the others carcinomatous, but quite limited at their borders by fibrous tissue, which fact appeared to show the localisation of the disease which was taking place. In a subsequent letter, December 18th, it is right to note that Mr. Camps wrote, "we have treated other cases here with trypsin and have been rather disappointed, but the case of Mrs. —— I have looked upon as the most interesting one, pathologically, which I have come across." May, 1907. In reply to me for any report Mr. Camps kindly writes that he has not seen the patient since but that he heard from her about a month ago briefly stating that she was pretty well.

OPERATING THEATRES.

NORTH WEST LONDON HOSPITAL.

Plastic Elongation of Tendons.—Mr. Jackson Clarke operated on a woman æt. 25, who had severe talipes equinus on both sides. She came to hospital seeking relief from a painful spot where tendon elongation had been done some two years previously on the right side. The condition of talipes equinus having recurred, the adherent scar over the newly-formed tendon had broken down partly owing to friction and partly to the working out of a stitch. The practical lesson to be learnt from the history in this case, Mr. Clarke said, was never to make the skin incision immediately over the tendon, and also to re-unite the sheath of the tendon over the sutured ends before closing the skin wound. These points he proceeded to illustrate in his operation, on the left foot where no operation had previously been done; the condition of equinus was a severe one, the foot being almost in a line with the leg. The patient being turned on the right side, an incision was made beginning near the middle line about five inches above the heel, and then passing downwards with an outward convexity to the outer border of the tendo achillis, close above the heel. This flap of skin and fat was dissected up and turned inwards to expose; the prominence of the tendo achillis in the middle line the external saphena vein was exposed in dissecting up this flap, and divided at the upper end. The sheath of the tendo achillis was now divided in the middle line to the whole extent of the exposed part, each half of the sheath being drawn apart in order to separate it from the side of the tendon, where it was attached, and it was pointed out that this synovial sheath did not extend to the front of the tendon from which the cellulo-fatty tissue was next separated by blunt dissection. The tendon was then divided down its middle for about three inches. At the upper end of this incision in the tendon a cut was made outwards and at its lower extremity another cut was made inwards, thus completing the Z-shaped section of the tendon. The position of the foot was now corrected, which brought the extremities of the tendon close to one another, where they were secured with two fine silk stitches. The delicate tendon sheath was now sutured with five fine silk points. The skin flap was then secured and the limb put up on a posterior rectangular splint which was so padded that there was no pressure over the site of operation. The other (right) foot was also in a state of rigid equinus and presented a scar which had broken down into granulation tissue in its middle point. This scar resulted evidently from an incision made two years previously in doing a tendon elongation. The scar was still closely adherent to the subjacent tendon which felt unusually hard. In this case Mr. Clarke made an incision similar to that already described on the left side and dissected up a flap of skin including the scar. The subjacent tendon was divided obliquely and a silk stitch which remained from the previous operation was removed; no sutures were used, but a gap was left between the ends of the tendon before the skin flap was replaced in position and the limb was put up with an anterior malleable metal splint. Mr. Clarke said that the condition presented on the right side showed how important it was to use a sound operative technique, even in a simple operation like the plastic elongation of a tendon. When the incision is made immediately over the tendon the resulting scar lies on a hard prominent structure, and chafing and excoriation are almost inevitable, and further when the synovial sheath which nature has placed on the posterior aspect of the tendo achillis, is not restored in the course of the operation the tendon becomes adherent to the skin and its freedom of action is impaired, whereas when the operation is done in the manner he had employed on the left side, the lengthened tendon works as freely and is as strong as the normal. He pointed out that this operation when skilfully performed was preferable to a simple tenotomy, the latter in many cases resulting in an excessive elongation which often produced talipes calcaneus, a deformity worse than the talipes equinus, for which the operation was indicated.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

Meeting Held Friday, May 10th, 1907.

The President, Mr. H. H. Clutton, in the Chair.

Mr. James Sherren read a paper entitled :

"Gastro-enterostomy for Chronic Gastric Ulcer. Healing of Ulcer Verified at Post-mortem Examination Twenty-Eight Months Later."

The patient, a man æt. 46, was admitted to the Poplar Hospital in October, 1904. He had had gastric symptoms for six years, and for nine months had been in bed with severe pain, and which prevented him from taking solid food. An operation was performed and a large ulcer was found on the lesser curvature. Posterior gastro-enterostomy, being impossible on account of adhesions, the anterior operation was done, with no loop. Great improvement ensued, but twenty-two months later melancholia developed and the patient cut his throat. At the autopsy the stomach was found to be only slightly adherent to the pancreas. The gastro-enterostomy opening admitted two fingers, and the pylorus was also patent. The ulcer, examined microscopically, had healed completely. Mr. Sherren commented on the good results obtained through gastro-enterostomy even when the ulcer was distant from the pylorus, so that excision was not the operation of choice even in such cases.

The President asked whether Mayo's method of fixing the jejunum so as to make it lie from left to right had been adopted. He had used it as a routine measure for the past eighteen months.

Mr. Sherren replied in the negative. He had tried Mayo's method in later cases but had given it up.

Dr. Herbert French and Dr. G. Louisson read a paper entitled :

"ON THE EXTENT TO WHICH WIDAL'S REACTION PERSISTS AFTER RECOVERY FROM TYPHOID FEVER."

The authors had traced 135 patients who had, whilst in Guy's Hospital with typhoid fever, given Widal's Reaction, the standard being clumping within half an hour in a dilution of 1 in 200. The test was repeated in these patients, at periods after the illness, varying from two months to ten years. They concluded : (1) In 7.5 per cent. of the cases a complete reaction was obtained, in 22.5 per cent. an incomplete one, and in 70 per cent. no reaction. (2) The interval that had elapsed after the illness made comparatively little difference. It would almost seem as if the cases that persisted at all, persisted perhaps indefinitely ; several cases lasted eight years. (3) A complete reaction was present in 11 per cent. of the men and in none of the women. (4) Suppurative complications made it only slightly more probable that the agglutinative power would persist. (5) Age bore no relation to the likelihood of persistence.

The President remarked that he had found the bacilli in bone complications three years after the fever.

Dr. W. P. Herringham discussed the question of second attacks in specific fevers. This bore no relation to the severity of the first attack, or to age. In measles women were more likely to suffer from a second attack than men, though the reverse held with typhoid.

Dr. French, in reply, said he had not examined the cases for bacilluria, &c., and it was possible that the persistence of bacilli might be correlated with the persistence of agglutinative power.

Dr. Leonard Guthrie and Dr. W. D'Este Emery read a paper on

"PRECOCIOUS OBESITY AND HIRSUTIES, WITH HYPERNEPHROMA."

The patient, a boy, æt. 4¾ years, was 36 inches high, and weighed over four stone. There was a large general growth of hair, but the genital organs were not developed. There was marked general obesity, especially pronounced in the cheeks and mammæ. After death from pulmonary tuberculosis a hypernephroma was found on the left side ; microscopically it consisted chiefly in necrobiotic cortical adrenal tissue ; many giant cells were present. It was probably a carcinoma, although there was no infiltration or metastasis.

Another case was also described in a girl, æt. 3½ years, who measured 30 inches high and weighed 37 pounds. In the previous three months she had grown an inch and gained six pounds. She measured 26 inches round the abdomen and 13 inches round the thigh. There was general obesity with pendulous mammæ. She had the appearance of a woman æt. 50. The cheeks were bloated and blotchy. There were lineæ gravidarum on the thighs. Hair grew on the pelvis at the age of three, but the sexual organs were not developed. At the autopsy no growth was found, but the adrenals were not microscoped. In both cases the pulse was very intermittent, and the intelligence good. The cases collected by Bulloch and Sequira were criticised, and stress was laid on the general obesity of the majority of them ; nine of the cases were in girls, and two in boys. In twelve cases the growth was on the left side, in two on the right.

Mr. Hughlett described a similar case in a boy, æt. 4. The overgrowth of hair had begun at the age of 2. He was 3ft. 7½in. high and weighed 3st. 12lbs. He was mentally bright. His muscular development was remarkable. The thighs measured 16in. around, and the chest 27in. His voice broke at the age of 4. The femoral epiphyses were united.

Mr. Raymond Johnson referred to a case he had seen of a boy, æt. 14, with enormous muscular development and hirsuties. The boy had had to shave daily since the age of 10. A large perithelioma of the advenal was present and slowly proved fatal.

Mr. John Malcolm spoke of a woman, æt. 50, who had had a large adrenal tumour removed by operation. An overgrowth of hair had been developing for years and she had had to shave daily.

Dr. Parkes Weber divided the cases into two groups. (1) Those with great muscular development ; (2) those with precocious obesity. He separated the latter cases, with a bloated stretched skin, from cases of "excessive obesity." There was a case on record in a boy, in whom such symptoms, including a beard, had disappeared after removal of a testicular tumour. Might an advenal tumour grow in connection with the testicle ?

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held Wednesday May 1st, 1907.

Dr. Geo. Hunter, Vice-President, in the Chair.

Dr. W. T. Ritchie read a paper on the

DIFFERENTATION OF THE VARIETIES OF EXTRA-SYSTOLE.

After a reference to the researches of Tawara and of Keith and Flack upon the muscular connections between the superior vena cava, the auricles and the ventricles, it was pointed out that the extra-systole was the evidence of the heart's response to a heterotopic stimulus. The general characters of the pulse in the extra-systolic irregularity were described, and it was shown that, by an analysis of graphic records demonstrating the sequence in which the auricles and the ventricles contract during an extra-systole and the time interval between their contractions on that occasion, the initial point of heterotopic stimulation might be deduced. The distinctive features of the varieties of extra-systole were then described. According to the initial point of heterotopic stimulation, three main varieties of extra-systole—the auricular, the auriculo-ventricular, and the ventricular—may be recognised. When an auriculo-ventricular extra-systole occurs, the auricular beat may be premature as well as the ventricular, and the former may then precede, coincide with, or follow the latter, according to the portion of the a–v bundle first stimulated. It was suggested that the auricular beat precedes the ventricular in the case of supranodal and nodal auriculo-ventricular extra-systoles ; when the mid-point, probably the main stem, of the bundle is the initial point of stimulation, the auricular and ventricular beats coincide ; in other cases of infra-nodal auriculo-ventricular extra-systole, in which the ventricular beat preceded the auricular, the heterotopic stimulus probably proceeded from the ventricular ramifications of the a–v bundle. In the latter instance, the auricular extra-systolic wave may be premature, or the auricular rhythm may be unaltered. Cases of continued cardiac irregularity resulting from auriculo-ventricular extra-systoles in series were recorded, and in conclusion the three forms of ventricular extra-systole—the retrograde extra-systole, the interpolated extra-systole, and that with a period equal to the succeeding physiological systole, as observed in cases of heart-block—were described.

The paper was fully illustrated with slides, showing cardiac and other tracings from numerous cases of extra-systole.

Dr. **Geo. Hunter** and Dr. **G. A. Gilson** discussed the paper.

Dr. **Claude B. Ker** read a paper on

INTUBATION OF THE LARYNX IN LARYNGEAL DIPHTHERIA.

A full abstract of which will be found on page 531.

In the discussion which followed

Mr. **Cathcart** spoke of the difficulty of learning to intubate, and asked whether practise on the cadavor was of enough value to be worth while giving to students He thought the hint about nasal feeding a very valuable one. Mr. Wallace spoke of the risk of the patient dying on the table during tracheotomy; he asked whether intubation was safer in that respect. Dr. Macmillan said that in Paris, Varrot, who once strongly opposed the practice, now performed intubation as the operation of election.

Dr. **Ker** said that undoubtedly the procedure was difficult at first, and unfortunately practise on the cadavor was no use. He had only had one death—from heart failure—at the moment of intubation.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held Friday, May 3rd, 1907.

Dr. T. R. **Whipham** in the Chair.

Amongst the cases shown were the following :—

Dr. C. O. **Hawthorne** showed a boy, æt. 14, with

DEXIOCARDIA AND VALVULAR DISEASE.

There was a systolic murmur heard at the apex on the right side and conducted round the right side of the chest. A skiagram could not be obtained, but there was no doubt complete transposition of the heart, but not of the other viscera. Dr. Hawthorne also showed a child with symmetrical congenital deformity of the ears, with sufficient hearing.

Mr. **Hugh Lett** showed a baby, æt. 7 months, with "Multiple Fractures of the Bones," noticed at birth; skiagrams showed old fractures and thickening due to callus. There was hydrocephalus and some evidence of rickets. The family history was good, but the mother had been in delicate health during pregnancy, and had two bad falls during the seventh month.

Dr. F. W. **Higgs** showed a case of "Monoplegia," presumably due to embolism of a cortical artery, in a girl æt. 8, who had chorea and rheumatism a year ago, and developed mitral regurgitation. Five weeks ago paralysis of the left upper limb occurred during sleep, there was no other paralysis. Partial recovery had occurred in the following order : flexors of fingers, of wrists, supraspinatus, flexors of elbow, extensors of fingers. He also showed a boy, æt. 3, who, while recovering from whooping-cough about two years ago, developed pain and swelling in certain joints. The lesions persisted in a subacute form, and at present there was periarthritis of the joints of the wrists, ankles, knees and cervical vertebræ. Spleen and glands were not enlarged. The disease was evidently toxæmic.

Mr. **Pernet** showed a case of "Erythema Iris."

Dr. **Porter Parkinson** showed a case of "Cerebral Tumour after Craniotomy." The optic neuritis, previously very intense, had disappeared, and the headache, vomiting and convulsions were completely relieved, while the paralysis had improved in the face and arm. The tumour was probably a subcortical glioma.

Dr. D. C. L. **Fitzwilliams** showed a boy, æt. 10, with "Multiple Exostoses" on the long bones, ribs, scapulæ and clavicles. The child was the youngest of a family of seven, the mother and all the children showed similar growths, but had suffered no inconvenience, and they had not increased after the first few years of life.

Dr. W. **Ewart** showed a boy, æt. 6, suffering from old standing "Spinal Caries," with much weakness of the legs and back; he had received much benefit from extension on a "sliding mattress" and by exercises on the "all-fours exerciser."

Dr. T. R. **Whipham** showed a case of "Morbus Cordis," in which there had been 7,800,000 red blood corpuscles. The patient, a girl, æt. 11, was subject to epistaxis. The heart was enlarged and there was a thrill at the apex and the aortic base, and presystolic and systolic murmurs at the apex, and a rough aortic systolic murmur. The second sound was absent except at the pulmonary base, where it could be faintly heard. There was no cyanosis or clubbing. There was probably aortic stenosis and congenital narrowing of the aorta.

Mr. **Lockhart Mummery** showed a boy, æt. 3 months, with "Erb's Paralysis of the Left Arm," due to a difficult labour. Apparently the posterior cords of the brachial plexus had been ruptured, causing paralysis and electrical changes of the flexor and extensor muscles except the flexor sublimis digitorum. There were some adhesions in the shoulder joint.

The cases were discussed by Drs. Hawthorne, Higgs, Chapman, Clutterbuck, Porter Parkinson, and by Messrs Mummery, Russell Howard, Lett, Jaffrey, etc.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Meeting held Friday, May 3rd, 1907.

The President, Dr. **Leonard Mark**, in the Chair.

A paper was read by Mr. **R. Lake**, on some results of

NASAL OBSTRUCTION.

Mr. **Lake** referred particularly to conditions connected with the special regions of the naso-pharynx, the pharynx, larynx and ear, and also with the general system, the chest, the general development and the intelligence. The reader also insisted on the differences existing between the results of structural obstruction of the nose, commencing in early life, and that arising in later or adult life.

The paper was discussed by the President, Mr. Garry Simpson, Dr. J. B. Ball and others.

Mr. **George Pernet** then read an exhaustive and valuable account of

HÆMORRHAGIC RASHES,

dealing with the pathology of these manifestations, the conditions under which they occur, the differentia in their diagnosis, and with the methods of treatment to be employed. The paper contained many important references to the literature of the subject.

A discussion followed in which the President, Dr. Phineas Abraham, Dr. Rice Oxley, Dr. Richard Lloyd, and others participated.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, May 12th, 1907.

Treatment of General Paralysis.

If the intensive mercurial treatment prolonged during some years has a chance to improve locomotor ataxy (Babinski gives an injection of one grain of calomel every eight days) it does not act with so much impunity in the treatment of general paralysis or softening of the brain where numerous complications have been observed.

Prof. Raymond declares mercury useless and dangerous in general paralysis, and the majority of neurologists share the same opinion. For these the disease, under the influence of the specific treatment, may become acute and rapidly fatal.

This opinion, however, has been contradicted by a rising neurologist, Dr. Roux, of St. Etienne, who considers that the calomel treatment has been wrongly accused. According to him, the complications of meningo-encephalitis are chiefly due to other influences: drinking to excess, infectious maladies or some other toxic influence.

All that an injection of calomel can do is provoke a febrile condition with pneumonia or gastric disturbance, but they are not peculiar to general paralysis as they can be observed in ataxy and syphilis of the brain.

M. Roux, who has treated hundreds of cases of general paralysis, and practised thousands of injections of calomel, has observed febrile complications chiefly in those patients where the apex of the lungs were slightly diseased. To avoid accidents of this nature he advises that the treatment should not be undertaken in the course of an acute paroxysm or during an acute intercurrent affection and in all cases to determine the susceptibility of the patient by very small doses. The urine should in all cases be examined for some abnormal condition.

If the result is negative, small doses (½ gr. of calomel) might be injected and if no febrile action or gastric disturbance are observed as a consequence of the injections the next injection, eight days afterwards, might be given a little stronger. If the treatment is well tolerated, the injections are repeated and the dose progressively increased to one grain, or one grain and a half of calomel weekly.

By these precautions all accidents are avoided and an improvement takes place in the state of the patient, on the condition, however, that the malady has not reached the period of dementia, for which nothing can be done.

At the very outset, the development of the malady is temporarily arrested; as to the hybrid forms, where the diagnosis hesitates between cerebral syphilis and general paralysis, where the patients present acute cephalgia, paralysis, delirium, and a weakening of all the faculties, a cure is the rule. Consequently no injections of calomel should be given in the acute form, during intercurrent toxic affections or where dementia has set in. In all others commence with small doses of calomel, and follow up the results obtained and cease altogether in case of complications.

Camphor and Ether employed in Large Doses.

Injections of camphor and oil are commonly employed in collapse as a good stimulant equal, if not superior, to caffein.

According to a confrère, the doses employed are much too weak and the results would be considerably better if the camphor were injected more freely.

For a long time he has been in the habit of injecting very large doses, 2, 3, or 5 drachms of a solution of 25 per cent. in the space of one or two hours, and he never met with any symptoms of poisoning, the effect, on the contrary, was such as to render unnecessary the administration of musk or caffein.

After the three days which followed this first injection of camphor, doses of camphorated oil are given less and less frequently, according as the condition of the patient improves. Finally the injections are replaced by the administration of camphor by the mouth.

The injections are made in the hypogastric region and are but slightly painful.

In all acute infectious maladies, as soon as the heart sounds become dull and the pulse irregular, the camphor should be injected. In cardiac and renal affections the action of digitalis and diuretics is increased by camphor given by the mouth, 4 grs. three or four times a day.

As to the injections of ether, they are seldom indicated as the camphor is sufficient But sometimes the state of the patient necessitates the employment of both. In such cases, large doses of ether should be injected (1 drachm) every hour or two, alternating with injections of camphor. The results are remarkable especially in alcoholic patients.

Abortive Treatment of Suppuration.

Every practitioner knows how to use hot water for a localised infection in some point of the organism.

Its employment has become general since Prof. Legars read a paper on the subject at the Surgical Congress of 1898. When a patient has an infected wound, or suffers from lymphangitis the result of a prick, for instance, he is recommended to place the limb in a large warm bath several times a day.

The results are very satisfactory, and superior to antiseptic dressings. Where bathing is impossible, hot moist compresses act equally well.

However, there exists another means of preventing suppuration still more active, and employed by Prof. Tillaux. After the parts are well rubbed with soap and the nail brush, a compress of several folds of gauze, moistened with ether is placed over the seat of inflammation, and covered with oil silk, to prevent too-rapid evaporation and fixed by a bandage. The patient is recommended to raise a corner of the dressing every hour to pour in a sufficient quantity of ether to moisten the compress. The treatment should be continued several days. The results are constant; the suppuration retrogrades, and a cure is certain to occur in less than a week.

GERMANY.

Berlin, May 12th, 1907.

At the Verein für Innere Medizin, Hr. Michaelis spoke on

Further Experimental Investigations with Cancer Inoculation.

He said that by a preliminary treatment of mice with normal liver tissue he had succeeded in setting up some degree of immunity, although he had failed in all other ways. Treatment with moderately indifferent material, such as cows' milk set up no trace of immunity whatever, not even when living cancer material from rats was made use of. His differences from Ehrlich's results he explained to be from difference of material.

Hr. Schöne had experimented in Ehrlich's Institute with hæmorrhagic spontaneous tumours and had achieved immunization in 50 to 80 per cent. of the cases which, after repetition of the immunization became almost absolute. Immunity was also brought about with tissue cells; this was probably different from the immunity from spontaneous tumours, as the rapidly growing tumour was opposed to any immunization, it was probably correct, therefore, to extirpate the tumour first.

Hr. Westenhoeffer agreed with Schöne's views. He regarded Michaelis' communication with a certain scepticism, as they bore their own contradiction, as a recurrence was a younger tumour that was attacked in its growth. So much seemed to be shown by Michaelis' experiments that nothing specific was contained in the tumour.

Hr. Lewin said that in rat tumours which grew rapidly and set up metastases abdominal recurrences were seen eight days after extirpation and, shortly afterwards metastases.

Hr. Sticker said that when a tumour was caused in a dog, a new tumour could not be set up. Several primary tumours might originate, but new tumours could not be set up by a new inoculation. That was the tumours might be "multilocular," but not "multitemporæ." A new tumour could only be set up when the first was removed. He assumed three zones—firstly, that of the tumour itself, the central zone; secondly, that lying in the periphery of the tumour, and governed by it, the tumour zone: and thirdly, the adjoining immune zone. If the tumour extended its region the immune zone became smaller and smaller, and finally disappeared. He related a case of retrograde development of carcinomata on the lips that could only be explained by destruction of the immune zone.

Hr. Lewin was firm in declaring that with rats with carcinomatous tumour in various places, inoculation from other animals had been successful. These were facts which he could not bring into unison with the conclusions of the last speaker.

The Surgery of the Heart.

In opening the discussion on Hr. Rehn's paper, Hr. Sauerbruch Greefswald remarked that the course run by wound of the heart was influenced by pneumo thorax. This arrested the hæmorrhage which at first was a favourable result, but the pressure at the same time seriously hindered the heart in its action, and fatally so. Then when the pneumothorax existed a long time it led to secondary infection. One advantage of the collapse set up by penumothorax was that operation could be carried out much more easily. What had been said of temporary compression of the heart without any definite injury he could confirm.

Hr. Glück, Berlin, mentioned a case of gunshot wound of the heart with hæmatopericardium that recovered, and further a case of total resection of the sternum, clearing out the anterior mediastrium of caseous masses and resection of the tuberculous anterior wall of the pericardium. The patient died of pulmonary phthisis a year and a half later. He recommended as the spot for making the opening the 4th or 5th intercostal space in the mammary line, or for pulmonary puncture 1 to 2 finger-breadths outside the line. For pericardiotomy the 5th rib should be resected outwards from the line. In this way there was some certainty of not wounding the pleura. He related two successful cases.

Hr. Thiermann, Jena, showed a labourer, who in lifting a heavy weight had forced a large sewing needle that was stuck in his coat into his chest, injuring both the right ventricle and right auricle; a suture was inserted, and the patient recovered.

Hr. Gœbell, Kiel, said that pneumothorax could be overcome without the aid of a special pneumatic chamber. Like Quénu, he had drawn off the air by Potain's suction apparatus. Injury could easily be inflicted on the cardiac muscle by suture. For suture he advised three silk ones made as aseptic as possible, the suture not to be too deeply placed.

Hr. Küttner Marburg, showed a patient on whom a year and a half before he had successfully performed cardiolysis for adherent pericardium.

Hr. Heller, Stettin, said that it was often not possible to make a diagnosis as to the injury. But even when the diagnosis was doubtful, the thorax should be opened so as to make quite certain, and to operate if necessary. It was the only means of saving life. Sometimes only a very small incision was required. Large flaps were objectionable.

Hr. Kümmell, Hamburg, said that even after cessation of the heart beat, the beat could be restored by immediate massage of the heart after opening the thorax.

Hr. Franke, Brunswick, said that, as the movement of the heart was often arrested by pressure of blood poured out into the pericardium, the surgeon first called to the case could often help by puncturing the pericardium, and aspirating the hæmorrhagic contents.

Hr. Reidal, Jena, mentioned a case of massage of the heart. A medical man had to be operated on for ulcer of the stomach. When the speaker had opened the abdomen, respiration and cardiac movement suddenly ceased; the patient lay dead on the operating table. All the various methods of restoring life failed. After at least half an hour had been spent in this way he began to massage the heart from the open abdomen. After about ten minutes it began to beat again, and the patient was carried from the table to his bed alive. He never came to, however, but died some hours later of collapse.

In reply, Rehn said that Barth agreed with him as to the value of large bony flaps. He was acquainted with the value of massage of the heart and had seen cases saved by it.

AUSTRIA.

Vienna, May 12th 1907.

LUPUS PERNIO.

SALOMON showed a young woman to the Gesellschaft suffering from lupus erythematosus of a chronic character on the hands. She had also extensive cicatrices from scrofulous glands in the neck with a scurvy-lupus exfoliation, but the marked reddening of the hands was the most interesting point in this case. Hutchinson applied the term "chilblain lupus" or lupus pernio to this form which was sometimes recognised as a combination of lupus erythematosus and lupus vulgaris, if such a combination be possible. It has long remained a disputed question whether these two diseases produce the clinical appearances described under the term lupus pernio or whether the latter is a distinct disease, having a totally distinct cause.

Lang said the combination of typical lupus erythematosus with lupus vulgaris was a very rare coincidence in the same individual at the same time. In all his experience, he could recall to memory only one case where the two diseases were present. The patient suffered from lupus erythematosus for years and finally took on the lupus vulgaris in a typical form along with the former which was subsequently proved histologically.

MULTIPLE CARTILAGINOUS EXOSTOSIS.

Necker exhibited a patient with a large osseous tumour which had commenced to form two years ago about the seventh cervical and first dorsal vertebræ. Tumour was about the size of a man's fist, and pressed on the cervico-brachial plexus, producing atrophy of the muscles of the right hand without any loss of sensibility with ptosis and pupillary dilation of the right side. The radiographic examination showed atrophy of the bones in the right arm. On the posterior surface of the tibia there was another localised exostosis of a sarcomatous nature leading also to degeneration. A particular feature in this case was the hereditary tendency, as a daughter, æt. 22, was afflicted with the same kind of swellings here and there of a cartilaginous character.

PHOSPHORIC NECROSIS.

Eiselberg presented a case of phosphoric poisoning, where the whole of the upper jaw was necrosed and broken. By the application of bandages to the neck the congestion had loosened the large sequestra which he now purposed to remove by operation.

On the etiology of this destruction of tissue and bone, Latyko affirmed that it was not the local application of the phosphorus that produced the necrosis, but the presence of a surplus in the body. In support of this assertion he related the case of osteo-malacia which came under his charge to which he gave full doses of phosphorus for years with the result that caries of the teeth led to periostitis and destruction of the upper jaw, which ultimately produced septic poisoning and death. This he thought threw a different light on the action of phosphorus as he had always understood that it was the direct action such as the fumes that caused the necrosis, but he now was persuaded that it was the indirect action of the metalloid that produced the destruction of tissue and bones. It was in reality a chronic state of phosphorus poisoning.

SCOLIOSIS.

Frisch next brought forward a case where scoliosis commenced a year ago without any real cause in the young man's history, who was now eighteen years of age and a locksmith by trade. The usual causes are traumatism, growths, caries, and congenital weakness. The first, second, and third were negatived by the Röntgen photographs, which only leaves the congenital in this case. It appears from closer observation that the first lumbar vertebra is quite absorbed, leaving only a rudimentary trace. That the scoliosis only appeared a year ago is not incompatible with a congenital origin, as many other examples of spinal defects have not declared themselves till as many years had passed. To show the difference in an accident he presented a man who, when carrying a heavy load, fell and was afflicted with paralysis, but after nine weeks recovered. The Röntgen rays showed luxation of one of the lumbar vertebræ nearly its own width towards the left.

Engelmann was of opinion that the case was the result of a fall and not congenital.

THE spotted fever epidemic is on the increase in Belfast. At the last meeting of the health authority it was reported that the total cases up to the present were 398. During the week twenty-five deaths occurred, bringing the total deaths up to 279. Six new cases were reported.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

The late Dr. Hamilton Ramsay.—A figure of some note in contemporary Scottish history has been removed through the death of Dr. Robert Hamilton Ramsay, which took place at Torquay on May 4th. He was born in Edinburgh in 1824, the son of Mr. Peter Ramsay, Banker, and the Hon. Susan Mary Hamilton, daughter of the seventh Earl of Belhaven and Stenton. Dr. Ramsay was, while scarcely more than a schoolboy, attracted to the study of medicine by charitably attending cases of cholera during an epidemic in a mining district, and he entered at the universities of Edinburgh and Glasgow to obtain a degree. He spent several years as house surgeon in the Royal Infirmaries of the two towns, in the latter of which he served under Lord Lister. As the oldest of the many house surgeons whom Lord Lister had trained, Dr. Ramsay handed to his master an album containing an address from his " grateful and affectionate pupils " on the occasion of his elevation to the peerage in 1897. Dr. Hamilton Ramsay was for nearly half a century a prominent figure in the ecclesiastical world of Scotland, or at least, in that section of it which adheres to the Church, " as by law established." In his youth he was constantly at Holyrood in attendance on his uncle, the Lord High Commissioner of the period, and from 1853 to 1892 he discharged the duties of purse bearer to a series of Lord High Commissioners. On his retirement past and present members of the assembly gave him a loving cup, an address, and a purse of gold. Dr. Hamilton Ramsay was an ardent horticulturist, and his garden at Torquay was one of the finest sub-tropical gardens in existence.

Aberdeen Royal Infirmary.—Lord Mount Stephen, who, in 1902, endowed the Infirmary to the extent of £1,000 a year, has generously handed a further benefaction of £10,000 to the institution.

BELFAST.

Public Health.—During last week there were 30 cases of cerebro-spinal meningitis notified, bringing the total up to 398. There were 25 deaths, making 279 in all. There are at present 45 cases under treatment at Purdysburn fever hospital. At a recent meeting of the Public Health Committee of the Corporation a lengthy report on house-cleansing was considered. It appears that at present many houses only have the ashpits cleared once in every month, or even two months. It is now proposed to cleanse them fortnightly, to work the refuse destructor to its full power, and to provide two more destructors in other parts of the city. The approximate cost of daily cleansing of ashpits would be £29,000 per annum, of weekly cleansing £24,000, and of fortnightly cleansing £19,000. It is recognised that the state of the back passages, where refuse accumulates in mud, and the drainage from it soaks into the ground, is a constant source of soil contamination, and it is recommended that all back passages be flagged or concreted without delay, in such a way as to allow of thorough flushing out with a hydrant.

Dairy Cases.—The crusade against impure and adulterated milk, started by the authorities a few weeks ago, is happily being continued. Last week one dairyman was fined for leaving cans of milk uncovered in the cowshed while the shed was being cleaned. Another was fined for selling buttermilk with 68 parts of added water, in addition to the 25 per cent. allowed for churning. In a third case a milk vendor was fined for selling milk with 10 per cent. added water. The apathy of the authorities in these matters has long been a scandal in the city, and it is most satisfactory to see them stirred up at last, no doubt by the searching inquiries of the Health Commission. The Commission did not sit last week.

LETTERS TO THE EDITOR.

THE ALCOHOL MANIFESTO.

To the Editor of The Medical Press and Circular.

Sir,—Will you kindly contradict absolutely an editorial statement contained in The Medical Press and Circular, of May 8th, p. 498, under the heading, " Our Alcohol Counter-Manifesto." You there state that " the original manifesto . . . was adopted by our contemporary and signed by the various signatories under more or less misapprehension." We did not " adopt " the " manifesto." We published at their request a letter signed by a group of medical men, and we in no sense " adopted " or endorsed or supported or supplemented their views.

We are, Sir, yours truly,
The Editors.

Lancet Office, London, May 8th, 1907.

[We are glad to publish the above explanation, without which it was difficult to understand the precise position of our esteemed contemporary with regard to the original manifesto. It is to be regretted that the British public, as a whole, has insisted on regarding it as a *Lancet* manifesto, and as being in that way endorsed by the highest medical journalistic authority in the world.—Ed.M.P. and C.

THE ALCOHOL MANIFESTO.

To the Editor of The Medical Press and Circular.

Sir,—The Manifesto of the sixteen worthies in support of alcohol as a food and as medicine has somewhat staggered the temperance orators. From whence has sprung this advocacy for strong drink ? Who is responsible for this collocation of past masters of our craft ? They come from the North, from the East, and from the West. These revered teachers of twenty years ago are now canonized as saints in their exalted positions of partial retirement from active work. These advocates of the moderate use of alcohol when teaching their students at the universities, colleges, asylums, and hospitals in their daily visits to the wards had to illustrate the pernicious effects of alcohol upon their patients, and in the *post-mortem* room to show the destructive effects upon vital tissues.

As we read between the lines of the Manifesto we ask again : Who is responsible for having brought this jumble of scientific folk-lore to the Bar of public opinion to be trumpeted forth in every ale house as the verdict of self-appointed jurymen in league with " the trade " ? I am particularly surprised to see the names of certain Alienist physicians of very high reputation in our profession, who know well enough that at least 50 per cent. of the patients in their asylums are there simply because of previous indulgence in strong drink either by themselves or their ancestors. To all such and their relatives moderation is but the spark which will kindle a gigantic conflagration in many a protected home unless strong drink is for ever kept " out of bounds."

But if we turn from the cryptic utterances of these apostles of moderation to the practical experience of the physicians and surgeons on the active staff of all our general hospitals, what do we find ? Take for example the evidence of Bartholomew's Hospital during the past twenty years in the consumption of wines and spirits. In the year 1886 with 6,613 in-patients, we had 1,008 gallons of port wine consumed, 345 gallons of brandy, and 10 gallons of whisky. In the year 1905 with 6,721 in-patients, there were only 290 gallons of port wine consumed, 284 gallons of brandy and 5 gallons of whisky.

The evidence of Guy's Hospital is still more marked in the declining use of wines and spirits. In the year 1905, with 8,626 in-patients, only 99 gallons of port wine were consumed, 180 gallons of brandy and six gallons of whisky. Of this amount the resident staff no doubt help to consume a fair amount of alcoholic drinks in each hospital. As a contrast to this, other tables have been prepared to show the very rapid increase in the consumption of milk as a beverage in our general hospitals. I cannot but think that if these eminent members of our profession had anticipated the use, or shall I say the abuse, which would be made of their powerful signatures, they would never have appended their names to such a glaring attempt to bolster up a declining trade.

Side by side with this manifesto of sixteen doctors we may set the testimony of 2,000 practising doctors who are agreed "that the most perfect health is compatible with total abstinence from all intoxicating drinks."

I am, Sir, yours truly,
F. Churchill, M.D., F.R.C.S.
Cranley Gardens, London, S.W.

THE ALCOHOL COUNTER-MANIFESTO.

To the Editor of The Medical Press and Circular.

Sir,—In common, I am sure, with most of your readers, I rejoice that you have taken up an attitude of dignified protest against the *Lancet* manifesto. How much harm that ill-advised document has done can only be guessed at by those who have worked for years against the superstitution that alcohol is a necessary part of a strong man's diet. We who are "in the know" have heard about the genesis of that manifesto. It was the work of a journalist friend of the "trade," and by most of the signatures I have no doubt it was merely intended for use as an advertisement of alcoholic liquors. A temperance friend of mine informs me that the manifesto has reached him with an advertisement of certain stout which is pushed for sale under the claim that it is good for the health! Thus do the leaders of our profession lend their names—unwittingly, I hope, to forward the interests of a trade which is the wealthiest, most powerful, and most opposed to the interests of the community—a trade that lives on the weakness of human nature, and that should only be allowed to subsist in a properly-organised country under the strictest Government control and supervision. I hope your counter-manifesto (which might have gone further, in my opinion) will be able to undo some of the harm that its predecessor has done, but it will not be able to undo all, I know, and am assured.

How pitiable to see medicine—that noblest of callings — prostituted in the interests of wealthy brewers in heartless companies who aim solely at selling drink to the people.

I am, Sir, yours truly,
Salus Populi.
London, S.W.

MILK AND TUBERCULOSIS.

To the Editor of The Medical Press and Circular.

Sir,—A family doctor has not ventured to give us his views as to how the cow gets tuberculosis. If he were to study the question carefully for himself, starting free from prejudice, it might get him out of the furrow he is now ploughing with so little advantage. I will try to answer for him by a reference to the case of the human subject. Why has "consumption diminished 50 per cent. during the last quarter of a century?" It is not as the result of bacteriological investigation, but because of the improved conditions under which people live—more money, greater comfort in life, food more plentiful and of better quality, better housing, more cleanliness, &c. These are the lines on which progress is to be made and the last two especially are applicable to the case of the cow. This is my answer to his postscript.

A family doctor is on very unsafe ground when he uses the *contra mundum* argument, which can never be employed in *proof* of anything. It reminds me of the little girl and her mother. Says the child: "Is it true, mother, what everybody says?" "Yes, my dear." "Then, mother, you're a witch."

Now, I am not afraid of this argument, for the position he assigns to me is just what I was in, over a quarter of a century ago, when I was battling against the so-called Antiseptic, or Listerian, method in surgery, in which the *mundus medicus* so firmly believed at that time. I am not ashamed of the almost isolated position in which I then stood. Very much the contrary. The warning given him by the history of this subject has evidently been thrown away upon him.

I could have wished that he had stuck to the question raised by my first letter; but as he has introduced a side issue, I feel compelled to follow him in his digression, lest he should think I had no reply, and therefore it is that I proceed to point out that he is on no safer ground, when, to fortify his position on the question of enteric fever, he appeals to the result of a tolerably recent action in one of the Law Courts—the glorious uncertainties of which have become proverbial. If he have no stronger argument than this, then he is, indeed, in "very bad case." It will be a sad day for the art of medicine when medical questions at issue come to be decided in a Court of Law. In the case to which he refers, if my memory do not betray me, some of the most eminent bacteriologists supported the defence, and the verdict was based wholly on "circumstantial" evidence. The case was *not* "proved with scientific exactitude." The result of the Maidstone inquiry was the same, and I venture to affirm that no more unjust verdict was ever given than in that case.

So long as attention is centred on the water-borne theory, as it is now, so long will our ignorance of the true cause continue. I ask him to study carefully, as I have done, the history of the war in South Africa in respect of this disease, and other fevers with which it was at first confounded. It is all very well to indulge in high-flown phrases and to talk of "ten thousand instances which could be adduced in which the contagion has been clearly followed to its source." Not one of these can stand rigid investigation or furnish proof. I suppose he includes among these the King's Lynn epidemic, of which an *expert* could find no other explanation than the fact that the stream from which the water was derived, "ran past a churchyard."

As I have already indicated, I am not alone, as a family doctor seems to hold, in refusing to accept the modern teaching of bacteriology. I maintain that the bacteriologists are putting "the cart before the horse." Of this I have given conclusive evidence in my paper on bacteriology. The utter failure of the bacteriologists to produce a single typhoid bacillus from incriminated water, as in the Maidstone and King's Lynn epidemics, ought to "give them pause." As Dr. Boucher has well said: "We can make clear the exact value of the hypothesis of contagion by the microbe by means of this suggestive formula. Every time we find the epidemic we do not find the generative centre, and every time we find the generative centre we do not find the epidemic."

I am, Sir, yours truly,
George Granville Bantock.
London, May 10th, 1907.

LONDON HOSPITALS AND GENERAL PRACTITIONERS.

To the Editor of The Medical Press and Circular.

Sir,—In to-day's *Daily Telegraph*, under the heading "London Hospitals," reports are given of appeals by festival dinners for those of our London hospitals—the Middlesex, the Westminster, and St. John's Hospital for Skin Diseases. At the Middlesex dinner Lord Cheylesmore made some remarks on the general question how "hospitals should be supported and managed"; and at the Westminster Dinner Sir J. Wolfe Barry said "they were face to face with the question as to whether hospitals should go on depending upon voluntary efforts, or whether they must in the future be rate-supported, &c." Lord Cheylesmore "scouted the suggestion that the hospitals should be supported and managed by the State." I think that some of us would not agree with Sir J. Wolfe Barry that "the patients would lose the highest skill in the medical and surgical world," if our hospital system were to change from the old-fashioned kind of charity on which they have long depended for a State supported system; for it cannot be said that our London hospitals are the very best schools of medicine and surgery. There is little to encourage good teaching by the physicians and surgeons at our hospitals, who not unnaturally look more to income derivable from private and consulting practise, that come from reputation, than from teaching. It would be well if the great body of general practitioners were to express their opinion on this question of our hospitals.

I am, Sir, yours truly,
R. L.

May 10th, 1907.

TINKERING WITH THE LAW.

To the Editor of The Medical Press and Circular.

Sir,—Assuming that Lord Hylton's Bill becomes law—a very doubtful assumption—it will do nothing to interfere with the main power of quackery, or to diminish the gigantic evils to which fraudulent practice is giving rise. Not five per cent. of quacks are using the Companies Act as a cloak. They do not need it; many other more safe and convenient devices are available. The favourite method now is to use the name of a bogus doctor, to pretend to sell nostrums or apparatus of his invention, and by cunningly-worded advertisements to lead the public to believe that in consulting the quack they are dealing with a legally qualified medical man. To illustrate this I enclose two advertisements from the same recent issue of the *Times*—the leading journal, which, up to late years, was the friend of the profession and the denouncer of quackery—and two from country papers—samples from hundreds of a similar kind appearing daily in the London and Provincial Press. A separate law to prevent unqualified solicitors from practising under the cover of the Companies Act is not needed. It is impossible for a fraudulent lawyer to employ with impunity in advertisements or circulars words remotely implying that he is qualified. The Statute is clear, magistrates never fail to administer it with severity, and the continued existence of unqualified solicitors in any guise is impossible. A similar Act could be constructed to meet the case of the doctors, whilst very slight amendment of existing laws would ensure the prosecution of the majority of vendors of nostrums, panaceas, and bogus medical apparatus for obtaining money under false pretences. In the meantime quackery flourishes apace. It affords large incomes to many clever adventurers. The latest stamp duty returns show that no less a sum than £2,764,557 was spent in quack medicines in one year. At least £1,500,000 is annually expended in quack advertisements; and this has sufficed to subourne the entire newspaper press, from high to low, with rare exceptions, in tacit support of this the most cruel of all systems of cynical knavery. The silence of the great bulk of the newspaper press being thus assured, there remains only one means by which the exposure of quackery can be effectively brought about, namely, a Royal Commission. The story which could be there unfolded would compel speedy legislation of a drastic character. If Lord Hylton and those acting with him desire this consummation, it would be well if, instead of tinkering with the present law they would devote their energies towards achievement of the necessary preliminary step I advocate.

I am, Sir, yours truly,
Henry Sewill.

Cavendish Square, May 10th, 1907.

According to the *Diario Universal*, the organ of the Conde de Romanones, the epidemic which is raging at Cartagena is not typhus, but bubonic plague. Three hundred cases are said to be in hospital, and 2,000 tubes of serum have been requested by the Governor.

A case of cerebro-spinal meningitis has occurred at Derby, the victim being a little child, who has succumbed to the disease. It had no connection with a similar case that occurred at Derby about six weeks ago.

OBITUARY.

SAMUEL LODGE, M.R.C.S. Eng., L.R.C.P. Ed.

A Notable Career.

We regret to announce the death of Dr. Samuel Lodge, which took place on May 9th, at Bradford, after a prolonged illness, at the age of 83 years. In the later years of his life, Dr. Lodge had been stricken down with serious illness upon more than one occasion, but he displayed considerable recuperative power, and after a short absence he was back in harness. Born at Witney, near O ford, on March 16th, 1824, Dr. Lodge was the eldest of the large family of a yeoman in passable circumstances. An apt scholar, he attracted the attention of the headmaster of Witney Bluecoat School, from whom he received private tuition. Even in these early days he had made up his mind to be a doctor, and prosecuted his studies to this end. He became the articled pupil of the late Dr. Field, a medical man of considerable standing in the Dudley Hill district. During his apprenticeship he was accustomed to walk to Leeds to hear the medical lectures, which at that time were delivered in the Infirmary, and to discharge the duties of dresser in that institution. It is an interesting fact that he acted as dresser at the Leeds Infirmary for Dr. Thomas Pridgin Teale (father of the present surgeon of the same name), a distinguished member of the faculty, who introduced what is known as amputation by the square flat. Not until 1859 did Dr. Lodge qualify as an M.R.C.S. of England and L.R.C.P. of Edinburgh. Dr. Lodge started practising on his own account at Bradford, and his first public appointment was that of medical officer of the third district of the Bradford Poor Law Union, a position which he held for thirty-five years, and resigned so recently as 1903. The offices of police surgeon to the City and the Bradford West Riding police forces were obtained later, and were retained to the last by Dr. Lodge.

Very early in his medical career Dr. Lodge had the serious misfortune to meet with an accident which resulted in the destruction of one of his eyes. Later in life the accident befell which caused his lameness. In visiting his patients he was wont to ride on horseback a good deal, and it was a fall from his horse that caused him to be laid up for many months with a broken thigh. More recent was the attack made upon Dr. Lodge by a prisoner at the Town Hall. Passing through a corridor where the prisoners were allowed to parade the police surgeon suddenly felt a burning pain in the neck, and turning round discovered that he had been stabbed. His assailant proved to be a lunatic who had managed to conceal a pen-knife about him. Fortunately the wound was not of a dangerous character.

Dr. Lodge's long career formed a link between the old surgery and the new. He particularly distinguished himself as one of the body of medical men who first took up the study of wool-sorter's disease, and established its identity with splenic disease in cattle. As early as 1854, he published a booklet on woolsorters' disease. All his life he was a wonderful worker, and it is estimated that of autopsies alone he must have made upwards of a thousand in Bradford.

Dr. Lodge was something of a virtuoso. A busy life did not prevent his indulging in the hobby of collecting art treasures and his house was adorned with many excellent pictures and interesting pieces of antique furniture.

T. B. LUSCOMBE, M.R.C.S, L.R.C.P., L.S.A.

The death took place at Teddington on April 29, of Dr. T. B. Luscombe, a gentleman well known to many Twickenham residents. The deceased, who was 54 years of age, succumbed to a severe attack of influenza after only a fortnight's illness.

Dr. Luscombe was a member of the Royal College of Surgeons, a Licentiate of the Royal College of Physicians, and a Licentiate of the Society of Apothecaries. Coming to Teddington about 25 years ago he founded a practice as a surgeon, and pursued his profession here with considerable success. He was a life-long abstainer, and on many occasions publicly advocated the cause of total abstinence. He was of a quiet and unassuming disposition, and was highly respected throughout the neighbourhood. Never very robust, he unfortunately met with a serious accident some two years ago, when he was thrown from his dog-cart, and sustained severe concussion of the brain. Although he recovered, and was able to resume his professional duties, the shock told seriously upon a none too robust constitution, and he was never quite the same in health. He was on the medical staff of the Cottage Hospital for many years.

His chief hobby, whenever he could find relaxation from his arduous professional labours, was the breeding of pedigree Jersey cows on the twelve acres of land attached to his residence, Cromer House, Hampton Road. He could also be counted upon to support any worthy cause for the advancement of the social and spiritual condition of the working classes, and his loss will be keenly felt.

JOHN T. O'HARE, M.B., Ch.B., B.A.O., D.P.H

WE regret to announce that Dr. John J. O'Hare died at his residence, Hill Street, Newry, May 3rd. The deceased was 29 years of age, and had only taken his degrees five years ago. Before leaving Dublin to start practice in his native town of Newry, Dr. O'Hare filled the position of Assistant Master in Holles Street Hospital for three years, and previous to that appointment he was resident surgeon to the Mater Hospital. During his entire medical career his genial manner and kindly disposition endeared him to all with whom he came into contact. Dr. O'Hare had been ailing for only a fortnight.

R. JALLAND, M.R.C.S., L.R.C.P.

THE death occurred on May 9th, of Dr. Robert Jalland, a retired medical practitioner, of Horncastle, at the age of 77. Deceased, who was a native of Rolleston, Notts, came to Horncastle early in life as assistant to the late Dr. J. B. Boulton, afterwards practising on his own account. The late Dr. Jalland was for many years a Governor of the Horncastle Grammar School, and some years ago published a comprehensive history of that ancient institution. One of the sons is Mr. G. H. Jalland, a well-known contributor to *Punch*; the other was for some time connected with Mr. Benson's Company as manager.

PROFESSOR POIRIER, PARIS.

☛ ONE of the most celebrated French surgeons, Prof. Poirier, died on May 1st, in Paris. He returned recently from Trouville, where he and his family had been stopping. His condition being very unsatisfactory, he consulted Professors Chauffard and Cunéo. His death which was quite unexpected, will cause a great sensation in medical and society circles.

Professor Poirier was a Norman by birth. He succeeded Professor Farabœuf in the chair of anatomy at the Faculty of Medicine about six years ago. His lectures from the first attracted large numbers of students. He was celebrated not only for his skill in diagnosing and operating, but for his cheery optimism and humour, which proved of great service to many patients. On M. Waldeck-Rousseau, who was one of his most intimate friends, he performed the operation which was much commented on recently. Professor Poirier recently formed a cancer research league. He was barely fifty years of age.

GEORGE BECK, a German waiter, was ordered six months' hard labour for threatening the life of David Hunter, a medical superintendent of Goodmayes Asylum, Essex. Prisoner had an idea that his wife was being ill-treated in the asylum. He now apologized for his conduct towards the doctor.

SPECIAL ARTICLES.

THE PREHISTORIC INHABITANTS OF ENGLAND.

AT the Royal College of Surgeons on Friday last, Professor William Wright, F.R.C.S., concluded a series of three lectures on the "Prehistoric and Early Historic Inhabitants of England." The following is an extract of the lectures which were largely attended :—

After a brief reference to the methods of investigation and the division of Time. Prof. Wright mentioned the presence of anthropoid apes on the Continent in the Meiocene Age. The evidence for Pliocene man was much stronger without being quite conclusive. In England his presence is attested by the high plateau flints of Kent, by flints found at Dawlish, and in the Cromer forest bed.

On the Continent there were three early and different types of Pleistocene man as exemplified by the Spy, Grimaldi, and Brunn Skeletons. In England the discovery of the Galley Hill skeleton in undisturbed stratified palæolithic gravel with a Pleistocene fauna and the unearthing of a fragment of a calvaria near Bury St. Edmunds in high palæolithic gravel between the valleys of the Lark and the Linnet, testify to his presence and appearance. His habits were his dwelling in caves and rock shelters, his practise of painting the body, and adorning himself with shells, crystals, and teeth. He had knowledge of fire and light, and interred, in some cases at least, the dead. He was astonishingly versatile as an artist, being equally proficient in sculpture, engraving and painting. The average height of palæolithic man was five feet five inches.

Professor Wright defined the neolithic age as that characterised by the culture of the earliest Swiss lake dwellings—the polishing of weapons, the practice of agriculture, the presence of domestic animals, and the knowledge of weaving. The period between that which saw the departure of the Reindeer from Southern Europe and this neolithic age he designated the Mesolithic Age. On the Continent this was characterised by harpoons made from deer-horn, coloured pebbles —possibly the first attempt at writing—and the kitchen-middens of Denmark and Portugal. In Britain evidence for the corresponding age is found in such caves as those of Obor and Aronsay, in the kitchen-middens of Hastings and Sevenoaks, and in the rude flints from Grimes Graves and Cissbury.

Neolithic man is in all probability to be identified to-day with the short dark, dolichocephalic inhabitants of Cornwall, Devon, Wales and Ireland. His language was probably Gaelic.

Towards the end of the neolithic period or the beginning of the bronze, a new type appeared, along the Eastern shores of our country. This type was in strongest possible contrast to the earlier type and there could be little if any doubt that it came from the region of the Baltic. Skulls with the closest resemblance to the famous Borreby skull from Denmark have been obtained from the round burrows of East Yorkshire. The lecturer showed how archæology strongly supported the anthropological evidence for this hypothesis. The lecturer briefly referred to the ethnology of Europe at the dawn of history and produced evidence for the downward movement of a tall fair-haired people upon the short, dark-haired people of the Mediterranean. He referred to the very mixed character of Europe ethnologically as gathered from the Homeric poems and the earliest historical records.

The evidence of Cæsar as to the inhabitants of England was considered, particularly his statement that the eastern portion of England was inhabited by tribes of Belgæ who had passed over. taking the names of the corresponding Continental tribes with them, into England from Gallia Belgica. They spoke the Brythonic language. A short account was given of the life, and physical appearance of the inhabitants of England during the early Iron Age, as obtained from the examination of such sites as the Danes Graves, Yorkshire, the urn fields, at Aylesford, the lake dwelling at Glastonbury and the cist graves of Harlyn Bay. In conclusion the lecturer gave an account of the coming of the Romans, and expressed the view that their ethnological effect was more pronounced and permanent than is usually considered to be the case.

REVIEWS OF BOOKS.

THE MENSTRUAL FUNCTION IN SKIN DISEASES. (*a*)

IN the study and treatment of skin diseases it has long been recognised that for success the patient as well as the disease must be studied and treated. We believe that every teacher and every text-book of value insists on the necessity of general as well as local treatment in dealing with skin diseases. If it be true, as Jacobi asserts, that 46 per cent. of women suffer more or less during menstruation, it is not surprising that one can show that women who are the subject of skin diseases experience more or less increase in their symptoms at this period. Our author has brought together a list of some twenty-two skin diseases in which he has found aggravation of the symptoms during menstruation and with him we believe the list might be much enlarged. The exact explanation of the connection between the skin lesion which is aggravated and the menstrual epoch is a much more difficult matter than the general establishment of the connection between them, and we fear the book before us has not added much to our knowledge on this point. The influence of menstruation in aggravating acne, and, indeed, all skin lesions due to infection by micro-organisms has long been recognised, and recently our knowledge of this connection has been extended by the demonstration of the fact that at this period the opsonic index of the blood for many micro-organisms is considerably lowered. Dr. Bulkley, however, does not give us any information on this point. The book, we believe, will be useful in so far as it impresses on the practitioner the necessity of general as well as local therapeutics in the treatment of skin diseases. Appended to the book is a very full bibliography on the subject which will be of service to those who wish to pursue the subject further.

FORCHHEIMER ON INTERNAL DISEASES. (*b*)

THIS book, which is intended for the advanced student and practitioner embodies the results of Dr. Forchheimer's thirty years' experience in hospital and private practice, and as such is a welcome addition to any medical library. Every practitioner will recognise the value of a book which enables him to revise his therapeutic methods by comparison of them with the ripe and reasoned experience of a successful teacher and practitioner. In many points no doubt our readers, like ourselves, will differ from the opinions expressed by Dr. Forchheimer, but, on the whole, we believe the teaching contained in the book will be admitted to be sound and in many cases admirable. The book contains a useful appendix on the composition of food materials as estimated by Atwater for the United States Department of Agriculture.

A TREATISE ON SURGERY. (*c*)

IN presenting a new work on surgery, the author has endeavoured to bring together the most recent and improved methods of surgical practice, and, with the aid of cross-references, to arrange these in a form readily available to the student and practitioner. The first volume deals with general surgery. An excellent and most useful chapter is given on "Laboratory Aids in Surgical Diagnosis and Prognosis." The chapter on Bandaging is one of the best with which we are acquainted in any surgical work and is illustrated with photographs which, in the way they fulfil their purpose, are excellent.

The second volume deals with regional surgery. We have perused both volumes of the work with much pleasure. It is necessarily more or less a compilation, but it is pleasant to read, well illustrated, thoroughly up-to-date, and abounds with the names of authorities on every subject dealt with. There is a full index and a separate index of names.

The book is one we can recommend to the student and practitioner. Few, if any, could read it without pleasure and profit. We have, however, one suggestion to make—this work errs, as do most books of American origin, on the score of weight (the two volumes weigh nearly 14 pounds). The class of paper on which the book is printed no doubt improves the character of the illustrations somewhat, but the weight of the book to the student at any rate will cause considerable inconvenience, and we fail to see the reason for this artificial creation of weight at the expense of comfort to the reader.

THE EXAMINATION OF THE CHEST. (*a*)

MANY manuals have been written on "the how and the why" of examining the thorax and its contents, but Dr. Gee's concise and precise little work still maintains its popularity as is evidenced by the appearance of a fifth edition. It is not only the work of an experienced physician, but is also the outcome of a long and useful professional career among students. The author is a lover of aphorisms, and is a marker in the dogmatic expression of clinical facts and has, moreover, a keen insight into the needs and necessities of the student desirous of equipping himself for the arduous duties of practice. This work has long been a favourite with Bart's men, but its merits have gained for it a field among all English students. In the present edition its familiar form is maintained and, strange to say, it has not been increased in bulk. While it has many advantages, it is not without its limitations. It is perhaps a pity that the author has considered it wisest to omit all reference to the use of X-rays in the diagnosis of diseases of the chest. The usefulness of the book would have been increased by a more liberal use of illustrations. We think, moreover, that a convenient system of "short-hand" charting of pulmonary and cardiac signs might have been suggested to the student, for some such is almost essential in actual practice. But, as far as the work goes, it is a model of systematic arrangement, clear definition, and accurate writing.

THE MEDICO-LEGAL SOCIETY. (*b*)

AMONG the recently formed societies specially appealing to the medical mind, but also concerned with matters outside the strictly professional pale, the Medico-Legal Society occupies a foremost place. Although only a six-year-old, it has already accomplished much, and in this, its third volume of Transactions, affords abundant evidence of vigorous development. It contains valuable articles on finger-print evidence, consultations among medical witnesses previous to trials, inconclusive post-mortem examinations, alcoholism, and irresponsibility, insanity and murder, and the modes of ascertaining the fact and cause of death. There is much in this volume which demands the careful study of all serious students of forensic medicine. Although the Medico-Legal Society has a roll of only 104 members, it is evidently destined to fulfil a most useful and necessary function, and such a volume as this will extend the sphere of its service far beyond the limits of its strict membership.

(*a*) "The Influence of the Menstrual Function on Certain Diseases of the Skin." By L. Duncan Bulkley, M.D., Physician to the New York Skin and Cancer Hospital. 8vo, pp. vii. and 108. London: Rebman, Limited. 1906.

(*b*) "The Prophylaxis and Treatment of Internal Diseases." By F. Forchheimer, M.D., Professor of Theory and Practice of Medicine and Clinical Medicine, Medical College of Ohio. 8vo, pp. xvii. and 652. Sidney Appleton and Co. 1906.

(*c*) "A Treatise on Surgery." By George Ryerson Fowler, M.D., Professor of Surgery in the New York Polyclinic, &c. 2 Vols., pp. 888 text, with illustrations. Philadelphia: W. B. Saunders Company. 1906.

(*a*) "Auscultation and Percussion: Together with the Other Methods of Physical Examination of the Chest." By Samuel Gee, M.D., Consulting Physician to St. Bartholomew's Hospital. Fifth Edition. Pp. 325. London: Smith Elder and Co. 1906. Price 6s.

(*b*) "Transactions of the Medico-Legal Society for the Year 1905-1906." Edited by R. Henslowe Wellington. Lecturer on Medical Jurisprudence, Westminster Hospital School of Medicine; and Stanley B. Atkinson, M.A., M.B., J.P. Vol. III., pp. 122. London: Bailliere, Tindall and Cox. 1906. Price 7s. 6d.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT PATHOLOGICAL LITERATURE.

Recent Contributions on Opsonics.—Though the subject is not at present receiving the wide-spread attention which was given to it a year ago, yet our knowledge of opsonics and their various relations is growing by constant contributions. Among the more recent papers of importance are two abstracts here:—

I.—Value of the Opsonic Index in the Diagnosis of Tuberculosis.—Stewart and Ritchie (*Edinburgh Medical Journal*, May, 1907) discuss this subject after the examination of the blood in 122 cases. Their cases fell into two groups—82 probably tuberculous, and 40 probably non-tuberculous. Of the 82 tuberculous cases exactly one-half had an index within normal limits; of the 40 non-tuberculous 29 had an index within normal limits, and the remainder an index outside those limits. A diagnosis based merely on one examination would therefore have led to serious errors. Seventy-five patients were treated however, by injections of small quantities of tuberculin, and their bloods examined on the succeeding days. Sixty-two of these were tuberculous, and in 56 a definite negative phase followed the injection; in none of 13 non-tuberculous patients did any negative phase occur. The authors conclude:—(1) a single estimation of the opsonic index is an unsatisfactory method of diagnosis, as both tuberculous and non-tuberculous cases fall within and without normal limits. (2) If a negative phase appear after inoculation, the presence of tuberculosis may be diagnosed. (3) The absence of a negative phase indicates the absence of a tuberculous infection. The authors add that they have reason to believe that a patient recovered from tuberculous disease, like any patient without the disease, fails to show a negative phase.

II.—Marmorck's Serum and the Opsonic Index.—Bosanquet and French (*British Medical Journal*, April 13th, 1907) publish the report of an investigation into the effect of Marmorck's anti-tuberculous serum on the opsonic index of the patient treated. Particulars, with opsonic charts, are given of five cases of advanced tubercle of the lung. The result was very similar in all cases. Rectal injections given daily were accompanied by a high opsonic level, which, however, did not persist after the injections were discontinued. On the other hand, subcutaneous injections in the one case where they were given produced a rapid fall of the opsonic index, which subsequently rose when the rectal method was substituted. That the raising of the index was not due to the serum being itself rich in opsonics is shown by the fact that when tested the serum was found to have an index of only .127. The general result is in support of the good opinions expressed by many clinical observers of the curative effect of Marmorck's serum. R.

Immunity toward Cancer.—Clowes (*Cleveland Medical Journal*, February, 1907) summarises the evidence which has led him to believe that mice may develop an immunity toward carcinoma. (1) Spontaneous recovery from three tumours occurs. (2) After such spontaneous recovery mice are not reinoculable. (3) A small percentage of tumours is obtained on reinoculation of mice which have failed to take on the first inoculation of tumour material. (4) Inoculation with one strain of tumour gives a certain protection against future inoculation with another strain. (5) The serum of mice which have spontaneously recovered appears to exert a slight effect upon growing tumours when injected directly and also to interfere to a certain extent with the development of tumour cells when admixed with the latter previous to inoculation. All the evidence accumulated by Clowes tallies with the parasitic theory, though it is not incompatible with Ebreich's suggestion that cancer cells tend to proliferate by virtue of their possessing side chains with greater affinity for food than those of the normal cells of the body. R.

Absorption from the Peritoneal Cavity.—Buxton and Torrey publish a series of papers (*Journal of Medical Research*, 1906, 1907) bearing on the absorption of bacteria and toxins from the peritoneal cavity. Their experiments have a direct relation to the pathology of peritonitis. They find:—(1) Bacteria injected into the peritoneal cavity of animals even in minute doses reach the circulation in a few minutes; (2) this rapid absorption takes place by the lymphatics of the diaphragm; (3) in cases of peritonitis in man, in order to avoid the rushing of bacteria to the diaphragm, the half-sitting posture is indicated, and flushing of the peritoneal cavity is contra-indicated. The authors make the proviso that their investigations have no bearing on streptococcal infections, which probably cause death by rapid systemic action. On the other hand, colon and similar infections tend to become localised, and treatment should be directed toward assisting this tendency. Irrigation of the peritoneal cavity may clear out some of the invading organisms, but it must at the same time wash out the protective bodies, and it may spread the invading organisms over a larger area of peritoneum. The authors quote from Harte and Ashurst (*Annals of Surgery*, 1904, 43) a table showing the different rates of mortality after operation for typhoid perforation, different methods of dealing with the peritoneum having been adopted. With drainage, without wiping or irrigation, there was a mortality rate of 41 per cent., with wiping and drainage 61 per cent., with irrigation and drainage 74 per cent., and with wiping, irrigation, and drainage 90 per cent. These figures must, of course, be discounted to some extent, since it is probable that the more rigorous measures were adopted in the more severe cases, but they at least suggest that the mildest treatment is the best. R.

The Diagnosis of Cholera.—Armand Ruffer and his colleagues publish (*British Medical Journal*, March 30th, 1907) some important results of their investigations on the bacteriological diagnosis of cholera. Up to the present the agglutination test has been regarded as perhaps the most trustworthy in the bacteriological diagnosis of any organism, and reliance has sometimes been placed on it without due precautions being taken. Ruffer shows that in cholera patients and in others there may be an infection of a vibrio resembling in many particulars the cholera vibrio, and consequently that there may be developed in a cholera patient agglutinins specific to these pseudo-cholera vibrios. In pursuit of this view Ruffer discovered in drinking-water obtained from ships, six strains of vibrio agglutinated in high dilutions by serum from a cholera patient. That they differed from the true vibrio was shown both by their failure to produce disease in the ships where they were found, and by their possession of multiple cilia. His conclusions are:—(1) A certain number of vibrios, although agglutinating to some extent with cholera serum, are sharply differentiated morphologically from the cholero vibrio, by the fact that they are multiciliated; (2) whereas some vibrios found in ship water are agglutinated by very dilute secretions of cholera serum, others are agglutinated by far stronger solutions only. The latter form a transition stage, so to speak, between the non-agglutinating and the highly agglutinating vibrios; (3) although an active cholera serum agglutinates all the vibrios to some extent, yet only two of these vibrios when injected into animals produce serums having a powerful agglutinating effect on cholera vibrios; it is concluded, therefore, (4) that it is not advisable to trust to the agglutination test only in the bacteriological diagnosis of cholera. The test is useful, but not specific. R.

Diagnosis of Sleeping Sickness.—MARTIN (*Annales de l' Institut Pasteur*, March, 1907) publishes a careful description of five cases of sleeping sickness, treated at the Pasteur Hospital. The clinical diagnosis rarely presents any difficulty, but there are certain points which may give assistance in doubtful cases—(1) *Enlargement of the Glands.* In all Martin's cases the glands of the groin and the axilla were enlarged; other observers emphasise enlargement of the glands of the neck as a characteristic feature. (2) *Presence of the tympanosome in the blood.* In all cases the trypanosome is in the blood from the start of the disease. It can usually be found by simple examination of a drop of blood beyond slide and cover glass. In other cases it may be necessary to centrifuge the blood with citrated water, and search the layer of white corpuscles which lies at the top of the deposit. In rare cases it is necessary to inoculate animals with the blood. For this purpose, guinea-pigs, rats, mice, or monkeys may be employed. (3) *Auto-agglutination of the blood.* The blood of subjects infected with trypanosomiasis presents a curious feature when allowed to stand between a slide and cover glass: the corpuscles rapidly come together into heaps of various sizes, visible to the naked eye, the intervening serum becoming clear. (4) *Puncture of the lymph glands gives a* fluid containing many trypanosomes. (5) Presence of trypanosomes in the special fluid is a constant feature. The fluid should be centrifugalised before examination. R.

Cardiac Anomaly.—Ingalls reports a rare cardiac malformation (*Johns Hopkins Hospital Bulletin*, April, 1907). The specimen was obtained from a patient who died in hospital, but who had not suffered from cardiac trouble during life. The heart at the autopsy was slightly larger than normal, but nothing noteworthy was detected till the pulmonary veins were examined. These were five in number, two on the left and three on the right side. Of these, two, namely, the upper two right veins, opened abnormally into the superior vena cava, while the remainder opened normally into the left auricle. The walls of the left auricle were normal everywhere except at the extreme upper part, where the septum was deficient, and thereby a communication was established between the cavity of the left auricle and the superior vena cava. The abnormality appears to be almost if not quite unique, as no similar cases could be found reported in the literature. M.

Acute Pancreatitis.—Egdahl has analysed the records of 105 cases of acute pancreatitis (*Johns Hopkins Hospital Bulletin*, April, 1907), with the special object of determining the more important etiological factors which produce that disease, and, in addition, reports two cases of his own. The conclusions at which he arrives are as follows:—(1) Gallstones are probably the most common single cause of pancreatitis, having been present in 42 per cent. of the present series. (2) Gastro-intestinal disorders are the next most common cause of acute pancreatitis; retrojection of bile probably being caused by intestinal disorders closing the papilla of Vater. In the present series there was alimentary disturbance in 38 per cent., and a history of alcoholism in 17 per cent. (3) Other causes of pancreatitis appear to be typhoid fever, tuberculosis, trauma, syphilis, emboli, appendicitis, malaria and gastric ulcer. (4) The most common organism present is the B. coli communis; while next in frequency come the streptococci and the staphylococci. (5) Typhoid fever is the most common of the acute febrile diseases present, according to the previous histories of these cases of acute pancreatitis. M.

Necrosis of Maxillary Bones after Measles.—Dr. Majima calls attention to necrosis of the superior maxillary bones as a sequela of measles (*Sei-I-Kwai Medical Journal*, February 28th, 1907). He points out the fact that the condition is barely noticed in the text-books, although the allied condition, gangrenous stomatitis, has been for so long recognized. He himself has met with two cases within the course of a month. The first was that of a boy, æt. 6½, who, following measles, suffered from complete necrosis of the front part of the alveolar process of the upper jaw. The second case was that of a boy, æt. 2. Ten days after the onset of measles the incisor teeth of the upper jaw fell out, and the alveolar process was found in a necrotic state, and later had to be removed. The cause of the necrosis is still unknown, but the writer believes that its direct connection with measles is easily demonstrated, and in proof of his point has collected some of the scanty references in the literature. M.

Tuberculous Osteitis Simulating Sarcoma.—Gaudier and Bernard (*La Rev. Internat. de la Tuberculose*, April, 1907, p. 287) report a case of the above condition occurring in the lower jaw of a child, æt. 5. The patient was brought to hospital with a swelling of the entire left half of the mandible, and no history of previous dental trouble could be obtained. The swelling had developed slowly, and did not fluctuate, but was quite hard and painless, presenting, in fact, the typical appearance of a sarcoma of this region. The tumour continued to grow slowly for some time, and then at last the skin, which at the beginning was quite normal, became involved, and several fistulous openings formed. Through these necrotic tubercular material and bony fragments were discharged, and a good result, except for the existence of some deformity, was ultimately obtained. The authors insist on the rarity of this form of osteitis of the mandible. M.

The Blood in Asthma.—Several investigations of the blood and sputum in cases of neurotic asthma have been made and have established the existence of eosinophil. Saleckei (*Munch. Med. Woch.*, 1907, No. 8) has now made an extensive investigation of the blood in fourteen cases, both during and between attacks, and reports his results. During the intervals there exists a distinct eosinophil, while the percentage number of neutrophile cells is lessened, and the number of mononuclear cells is increased. Shortly after an attack, on the other hand, the total number of leucocytes is increased, and the neutrophiles now preponderate, while the eosinophiles are decreased possibly owing to the outpouring of eosinophiles in the sputum. The mononuclear cells, grouping under this term both lymphocytes and hyaline cells, do not undergo much change in number after attacks. M.

North-East London Post-Graduate College Conversazione.

A SUCCESSFUL conversazione of the North-East London Post-Graduate College (Prince of Wales's General Hospital) was held on May 7th. The guests, including ladies, were received by Mr. and Mrs. John Langton, and much interest was displayed by them and the members of the nursing staff, who were also invited, in the various medical and surgical exhibits, and the special X-ray demonstrations given at intervals throughout the evening by Dr. Pirie, the hospital radiographer. A conjuring entertainment by Mr. Algernon Fox was also much appreciated. The opportunity was taken by a large number of those present to inspect the new wards and theatre of the hospital, which had been formally opened in the afternoon by T.R.H. the Prince and Princess of Wales, accompanied by the Princess Louise (Duchess of Argyll), the President of the Hospital.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons, England.

AT a meeting of the Council. held on Thursday last, Mr. Henry Morris, F.R.C.S., president, in the chair. Dr. Alex. Hill, Master of Downing College, Cambridge, and Professor Arthur Thomson, of the University Museum, Oxford, were admitted Fellows of the College. The Jacksonian Prize for the year 1906 was presented to Mr. Donald Armour, Assistant-Surgeon to the West London Hospital. This being the first occasion that the prize has been won by a Canadian. The President reported that Dr. Thomas James Walker, of Peterborough, to mark the completion of the fiftieth year of his membership of the College, had presented to the college a volume of original notes of John Hunter's lectures. It was resolved that the best thanks of the Council be given to Dr. Walker for his valuable gift.

Alterations in the Midwifery Regulations.—A report was received from the committee of the conjoint examining board recommending the following alterations with regard to the course of instruction in midwifery for candidates for the diplomas of the two Royal Colleges:—1. That every student shall himself conduct twenty labours. 2. That before conducting such twenty labours he be required (*a*) to have held the office of Medical Clinical Clerk and of Surgical Dresser at a recognised hospital during six months each; and (*b*) to have attended a course of practical instruction in Midwifery. 3. That the certificate of having conducted the required number of cases be signed by a member of the staff of a Lying-in-Hospital or of the Maternity Charity of a General Hospital, or by the Dean of the Medical School attached to the General Hospital. 4. That every student be required to discharge the duties of Clinical Clerk in the Gynæcological Wards or Out-Patient department of a recognised hospital. 5. That every student be required to complete the curriculum of professional study before presenting himself for examination in Midwifery and Gynæcology. The recommendations were adopted.

A further report from the same committee on the examinations of the Egyptian Medical School at Cairo was received from Dr. T. D. Acland, who was appointed by the two Royal Colleges to visit and inspect the examinations. A cordial vote of thanks was given to Dr. Acland for his "interesting and valuable report."

NOTICE was officially given in this journal of the prizes to be awarded by the Council of the College. These are the Quinquennial Cartwright Prize; the next award will be for the five years ending December 31st, 1910. The prize consists of a bronze medal and an honorarium of £70. The subject for the essays to be submitted in competition for this prize is "The Prevention of Dental Caries." The subject for the Jacksonian Prize for the year 1908 is "The Prethology and Treatment of those Conditions and Diseases of the Colon which are relievable by Operative Measures." Candidates must be Fellows or Members of the College, and Essays must be delivered at the College not later than December 31st, 1908. Further particulars may be obtained on application to the Secretary of the College.

The Royal Visit to Tottenham Hospital.

THE new wards and the operating theatre of the Tottenham Hospital were formally opened by the Prince and Princess of Wales on May 7th. Their Royal Highnesses were received by H.R.H. the Princess Louise (Duchess of Argyll), the President of the Hospital; Sir Francis Cory-Wright, Bart., chairman; Lady Cory-Wright; the Right Hon. the Earl and Countess of Jersey; Sir James and Lady Reid; Mr. John Langton, F.R.C.S.,; the Director (Mr. F. W. Drewett), and the Matron (Miss E. Margaret Fox). The royal party then proceeded directly to a marquee erected in the grounds of the hospital where a concourse of about two thousand people had assembled. After a brief dedicatory service by the Ven. Archdeacon of London, representing the Bishop of London, the Chairman read an address of welcome in which he alluded to the visit paid to the hospital for a similar purpose by Their Majesties, when Prince and Princess of Wales, just twenty years ago. The Prince of Wales in replying, expressed his pleasure at being present, and amid loud cheers announced that in future the hospital should be called "The Prince of Wales' General Hospital, Tottenham," and that he was proud to think that it should bear his name. His Royal Highness then declared the new buildings to be open. A list of special contributions to the hospital was then read by the director, after which the Princess of Wales received a large number of purses. The amount thus realised was £4,000. A certain number of presentations were then made, after which the royal party inspected the hospital, and before leaving their Royal Highnesses graciously signed the visitor's book. The hospital and grounds were then thrown open for the inspection of the invited guests, among whom were Sir Henry Burdett, the Chief Rabbi, Dr. Alder, the Warden of the Drapers' Company, Mr. Ernest Gardiner. M.P., Mr. Herbert Nield, M.P., the Mayors of Hackney and Stoke Newington, Mr. Joseph Howard, Mr. Henry Burt, and Mr. Henry Morley. The extensions of the hospital thus opened could not have been undertaken were it not for the munificence of King Edward VIII.'s Hospital Fund, and the Worshipful Company of Drapers.

Royal College of Physicians of Ireland.

DR. JOSEPH REDMOND, President of The Royal College of Physicians, entertained a large party at dinner in the College Hall on May 8th. Dr. Redmond presided. On his right were his Excellency the Lord Lieutenant the Very Rev. Father Delany, S.J.; the Master of the Rolls, the Provost of Trinity College, Sir Francis Cruise. Mr. Justice Dodd, the President R.A.M., Sir A. Vicars, K.C.V.O.; the Registrar-General, and Serjeant O'Connor. On his left were Mr. Swanzy, President Royal College of Surgeons; Lord Anson, A.D.C.; Dr. Atthill, Mr. Justice Boyd, Dr. Little, the Hon. the Recorder of Dublin, the Dean of the Chapel Royal, Sir P. Coll, K.C.B.; Lieut.-Colonel Scott Elliott, Sir Charles Cameron, C.B., and Sir John Moore. The Lord Lieutenant, who was warmly applauded, replied. He said there were some notable names connected with the career of the College, such as Graves, Stokes, and Corrigan; and when they spoke of distinguished men they could not but think of one happily, still amongst them, though not able to be present there that night—their Senior Fellow, Sir John Banks (applause). It was enough to pass his house in Merrion Square to have one's mind raised to feelings of thankfulness because of the fact that such a noble personage was still amongst them, an example of what could be done by true attention to duty and true goodness and kindness of heart (applause). The College was the third body in the United Kingdom to institute diplomas in public health, Trinity College, being the first. The College of Physicians was the first medical body to admit women to its licences (applause). At present there was a kind of awakening in the public mind as to the importance of having these matters dealt with more fully and efficiently than heretofore (hear, hear). That College could do much not only to awaken but to guide any great movement. Among the influences which they might look for from that institution was that of increasing a tendency of which, perhaps, they saw too little in Ireland, namely—the habit of not allowing differences in political and other matters to interfere with social progress. He endorsed what the President had said about the earnestness and zeal of his distinguished predecessor, Lord Dudley, who had shown the permanency of his interest in Irish matters by the manner in which he had presided over the Congested Districts Commission (applause). The President proposed the toast of "The Guests." They were all guests, and he had the melancholy privilege of drinking their healths alone (applause). The Lord Lieutenant proposed the toast of "The President," which was enthusiastically honoured.

Meath Hospital and County Dublin Infirmary.

LAST week the new Home for Nurses, which has recently been added to the Meath Hospital and County Dublin Infirmary, was opened by His Excellency the Lord Lieutenant. There was a large company present. Sir John Moore presided. Mr. Francis Penrose, Secretary, read an address to His Excellency, in which a brief history of the hospital was given. Regarding the nursing arrangements in the hospital the address stated that in 1904, the committees having decided to take the nursing of the hospital into their own control, the duty immediately devolved upon them of securing probationers, and providing a residence for them. To meet the emergency of the housing accommodation a temporary arrangement was arrived at, by which several small wards in the hospital were set apart for the purpose; but the Joint Committee were confronted with the necessity of establishing permanent accommodation for the nurses, either by building a Home on the grounds of the Hospital or by renting houses in the vicinity. After mature consideration the Committee at length resolved to erect a Home on the grounds of the Institution, and trust to the charitable public to supply them with the necessary financial assistance. The Joint Committee were largely influenced in coming to this decision by the fact that the sleeping accommodation for the servants of the Hospital had become quite inadequate. The building contains accommodation for thirty nurses and fourteen servants, and is provided with everything necessary for their comfort. The sum of £5,306 15s. has been paid on account, leaving a balance due of about £600. A sum of over £250, and many useful articles have been contributed, including a piano, kindly presented by Mr. Charles Lawler, a member of this Committee, towards the furnishing of the Home. His Excellency then declared the Home open.

Post-Graduate Courses in Dublin.

THE President and Council of the Royal College of Surgeons have arranged to hold two courses of post-graduate study during the months of June and September respectively. The object of these courses is to render available the whole of the clinical material in the city for the post-graduate student, so that he may see as much as possible during the brief time at his disposal. Ten general hospitals are available, as well as the various hospitals devoted to special subjects. In the event of the post-graduate students exceeding a certain number at either of the courses, arrangements will be made to divide up the classes into practical working groups. The first course will begin on Monday, June 10th, 1907, and will terminate on July 2nd. The second course will begin on Monday, September 23rd, 1907, and will terminate on October 15th. Further particulars appear in our advertisement columns.

The Ingleby Lectures.

DR. THOMAS WILSON delivered the first of these lectures at Birmingham University on May 9th. Dr. Wilson said it was customary for the Ingleby lecturer to select some subject with which he had special or particular acquaintance, and he was following the usual custom that day. The lectures, he pointed out, were established in connection with Queen's College in 1876, and were intended to promote the advancement of obstetric surgery and medicine, being a branch of medical science in which Dr. Ingleby acquired considerable reputation. Dr. Ingleby practised from the year 1816 until his death in January, 1845, and he completed his fiftieth year shortly before his death. He was a victim to study and devotion to the duties of an immense practice. He was the first to practise obstetric surgery in Birmingham, and was one of the original members of the still flourishing Medical Benevolent Society, and as an evidence of the esteem in which he was held by his professional brethren he was elected president of the society in the year 1836. As an author in obstetric subjects he was without a professional rival, and his writings were evidently the outcome of close personal observation and sound judgment. Dr. Wilson then proceeded with his lecture. The next lecture will be delivered on Thursday, in the Medical Theatre of the University, at four o'clock in the afternoon.

The Judgment of Pharaoh.

SHOULD any of our readers feel interested in the work of a medical man in the direction of dramatic art, let them "hie to La Scala Theatre," in Fitzroy Square, where they will see represented one of the most gorgeous and artistic productions of stage-craft of recent years. And this, be it said, by a medical confrère, Mr. E. Distin Maddick, F.R.C.S., formerly a surgeon in the Royal Navy, surgeon to the Royal Italian Hospital, and subsequently in consulting practice in the West End of London. This position and these appointments were recently put on one side in order that the subject of their embodiment might devote his undoubted talents to the development of dramatic art. The result is seen in the erection of the most sumptuous and at the same time the most hygienic theatre in London, and the production of a play thereat, which, like the building, is something quite different from anything hitherto presented on the stage. The scenes are laid in the ancient Hebraic-Egyptian days, and during the progress of the play real camels traverse the desert, and apparently real lions (although they are huge dogs cleverly disguised as lions, as the Lord Chamberlain refused to license lions, and, we think, wisely) bound hither and thither in quest of prey, and the Oriental and barbaric splendour of the Court of Egypt is reproduced, as presumptive evidence of the work of a cultured and travelled scholar. The acting, like the house and the play, is of a refined order, and it affords us much pleasure to congratulate our confrère on an unquestionable success in his new departure.

The Irish International Exhibition.

THE Irish International Exhibition which was opened with full State by His Excellency the Earl of Aberdeen, Lord Lieutenant of Ireland, on the 4th inst., promises to be one of the most successful exhibitions of recent years. The grounds, which are situated in the neighbourhood of the well-known grounds of the Royal Dublin Society, are extensive and contain numerous fine buildings. As is only natural, the exhibition is not yet in full swing, but it is sufficiently advanced to enable its visitors to see that when everything has been completed it will be a most successful undertaking. Even at the present stage, it has been visited by large numbers. Amongst the most notable sections it may be mentioned the Fine Art section, which is universally stated to contain the finest selection of modern pictures which have ever been exhibited in Ireland, the Machinery Hall and the Canadian Pavilion. Many of the exhibits are of great interest to medical men, and we are sure that during the coming months they will find that a visit to it will well repay the cost, even if they have to travel a long way to see it.

A Medical Golf Club for Dublin.

AT a meeting held on May 6th, at 6, Merrion Square, to which a member of the staff of each of the Dublin Clinical Hospitals had been invited, the following resolutions were passed:—It has been decided to form a Society to be called the Dublin Hospitals Golfing Society, the membership is to be limited to the staff and assistant staff of the Recognised Clinical Hospitals, and in this category the Dental Hospital is included. Officers of the R.A.M.C. serving in Dublin will also be eligible for membership. The annual subscription has been fixed at 5s. Gentleman who are eligible and who desire to join are requested to send their names to the Honorary secretary, Mr. J. B. Story, 6 Merrion Square, and, if possible, to attend a meeting to be held on Wednesday, May 15, at 5 o'clock in No. 35, Dawson Street to elect officers and transact other business.

A Preposterous Counter-Claim.

At the Greenwich County Court recently, before Judge Willis, K.C., Dr. Middlebrook, of Eltham, recently sued David T. McCulloch for £3 12s. 6d., fee for medical attendance, and defendant counter-claimed for £50 damages for careless treatment and faulty diagnosis of his wife's illness, alleging that his wife met her death from this cause.—Mr. Mathew. (instructed by the solicitors of the London and Counties Medical Protection Society, appeared for the plaintiff). The doctor's claim being admitted, judgment was given for £3 12s. 6d., and His Honour then proceeded to the counter-claim.—The defendant, David McCulloch, said that he called in Dr. Middlebrook to attend his wife in November, 1904. Plaintiff told him that his wife was suffering from overwork and had gall stones and a growth. Plaintiff never mentioned that witness's wife was suffering from Bright's disease. Witness called in Dr. Rice, who at once pronounced the deceased to be suffering from Bright's disease. On January 7th he called on Dr. Middlebrook and asked him for his bill. He did not then complain, nor had he subsequently complained with regard to his treatment.—Dr. John Rice said he first saw the deceased on January 9th. She was in bed, and subsequently he was able to inform the husband that his wife was suffering from chronic Bright's disease.—Cross-examined: He had no knowledge of the treatment employed, and had never passed any opinion on it.—Dr. Middlebrook said that he diagnosed the deceased's complaint as Bright's disease on his first visit, and, in support of that statement produced his notes on the case. He never treated the case for anything but Bright's disease. His Honour, in giving a judgment in favour of Dr. Middlebrook, said the defendant's claim should never have been brought. Nothing that Dr. Rice had said had in any way supported the accusation brought against Dr. Middlebrook. The latter's treatment had been skilful and proper, and there was not the slightest evidence to show that any one of the defendant's statements was justified.

Royal Institute of Public Health.

The Harben Lectures this year will be delivered by Professor Dr. Paul Ehrlich, on June 5th, 7th, and 11th, at 5 p.m., subject, "Experimental Researches on Specific Therapeutics." Among special lectures arranged for will be one by Professor R. T. Hewlett, M.D., F.R.C.P., on Thursday, May 30th, subject, "The Problem of the Pure Milk Supply." On Thursday, June 6th, Professor G. Sims Woodhead, M.D., F.R.S., will lecture on "Blood Immunity." Dr. E. W. Goodhall, M.D., B.S., will lecture on "The Treatment of Infectious Diseases Regarded from the point of View of Hospital Administration," on Thursday, June 13th; and Dr. Louis W. Sambon, will close the Summer Course with a lecture on June 20th, on "The Development of Africa: A problem of Comparative Pathology." All these lectures will be delivered in the Lecture Theatre of the Institute, 37, Russell Square, at 5 p.m., and the attendance of all interested is cordially invited.

Medical Congress at Budapest.

We understand that the fifteenth International Medical Congress, held in Lisbon, have chosen Budapest the capital and residence of Hungary, for the site of their next assembly, and the preliminaries are already in process. His Imperial Majesty the King of Hungary has graciously extended it his patronage, and the State and town have each contributed 100,000 crowns to defray the expenses. There are to be 21 sections, each branch of science having a separate section assigned to it. August 29th, 1909, has been fixed as the date of opening, and the session will be continued till September 4th.

Schools of Medicine and North Dublin Guardians.

On May 8th at a meeting of the Guardians of the North Dublin Union, a question of great importance to the Medical Schools of Dublin came on for consideration. Mr. John Carolan, J.P., T.C., presided.

Mr. Long said he wished to have rescinded a resolution, which was passed on April 17th, and for that purpose he would move the following resolution: That, inasmuch as the resolution of the Board of April 17th, dealing with the sending of bodies to the School of Medicine would be a grave injury, not alone to the schools, but to the City of Dublin, that the portion of the resolution directing notices to be posted in the wards be rescinded; that certificates as usual be issued by the medical officers in attendance on the deceased, as required by Act of Parliament; and that the Master be directed to have all the legal formalities strictly carried out. Mr. Long said he was not concerned so much about the hospitals or about the officers there, as he was about the young men who were studying for the profession of medicine and surgery. Young men were already sufficiently handicapped in this country, and their opportunities were few, and he would not like to see them deprived of those which they had.

Mr. Denis Lynch moved as an amendment:—That the whole question be referred to a committee, which will consider it thoroughly, and after consultation suggest to the Board the best means of dealing with a question of such delicacy and importance; that officers and doctors be asked to attend, and all action be stayed pending the report. This amendment was then put, and adopted unanimously.

Aliens in the Port of London.

Dr. Herbert Williams, the medical officer of health for the Port of London, who has been responsible for the carrying out of medical inspection in the port under the Aliens Act since it came into operation, states that the work was conducted last year between the hours of 6 a.m. and 8 p.m. A certain proportion of alien steerage passengers were found to be "undesirable" on medical grounds and were refused admission. In nearly every instance they appealed to the Immigration Board, and, on appeal, a certain number of them were allowed to land. Last year 72,824 aliens arrived in the Port of London, of whom 29,003 were cabin passengers, 11,661 exempted second-class passengers, 17,221 transmigrants, and 14,939 of other descriptions. In the whole of the United Kingdom the aliens arriving numbered 465,000. The number of expansion orders made under the Act was 294. During the year 1,975 non-immigrant alien ships arrived in the port with 29,290 passengers and 550 immigrant ships with 43,534 passengers. Transmigrants were all examined with a view to the detection of any case of infectious disorder amongst them, while the immigrants were subjected to a more careful and thorough examination. In other ports there arrived 6,996 non-alien immigrant ships with 88,330 passengers and 3,561 immigrant ships with 294,340 passengers.

The Middlesex Hospital.

A festival dinner in aid of the funds of this institution was given on Friday evening at the Princes' Restaurant, when the Duke of Connaught occupied the chair. He was supported by Prince Francis of Teck (vice-president), the Duke of Northumberland (president), Lord Sandhurst, Lord Michelham, Lord Cheylesmore (chairman of the board), Lord Derby Lord Lathom, Sir Elliott Lees, Lord Duncannon, Mr. Andrew Clark, F.R.C.S., the Hon. Walter Rothschild, M.P. (treasurer), Colonel the Hon. C. G., Gathorne-Hardy, Mr. W. E. Gillett, Sir W. Vaughan Morgan, Sir T. H. Brooke-Hitching, Mr. W. H. Burroughes, Dr. J. Kingston Fowler, Mr. G. J. Marjoribanks, Sir R. D. Powell, Dr. William Duncan, Lord Rosmead, Mr. H. E. Ormerod, K.C., Sir. E. Hay Currie, Mr. S. Vaughan Morgan, Sir G. Anderson Critchett, Major General Sir Reginald Thynne, Dr. F. Ford Anderson Dr. W. E. Wynter, Mr. John Murray, Mr. C. H. Burnand, Sir William H. Humphrey, Colonel Charles Needham, Mr. Frank Debenham, Mr. W. C. Houghton, and Mr. F. Clare Melhado (secretary superintendent).

After dinner the Chairman gave the toast of "The King, the Patron of the Hospital," which was enthusiastically received.

His Royal Highness next submitted the toast of he evening, "Continued Prosperity to the Middlesex Hospital," with an eloquent appeal for funds. A list of subscriptions to the amount of £4,500 was announced during the evening.

Chemists' Exhibition.

At the Royal Horticultural Hall last week a very successful exhibition of articles of interest to pharmaceutical chemists was held by the *British and Colonial Druggist*. The exhibition naturally differed in many respects from that held for medical practitioners under the same auspices last summer, but there was still much of interest to medical men. One novelty that deserves mention was a substance known as "Ratin,"—a bacteriological preparation which is said to infect rats and mice with a disease from which they quickly die, but which is innocuous to man and all domestic animals. The preparation has been largely used in Germany and Denmark, and is now being experimented with in India. The various stalls were well loaded with things new and old, and the usual accessories in the way of music and refreshments were liberally attended to. The enterprise of the organisers was particularly shown in the fact that they paid the cab-fare of every chemist in the London radius who came to the Exhibition. Very large numbers of pharmacists from all parts attended.

International Red Cross Conference.

The following official delegates to the International Red Cross Conference, to be held in London in June, have been appointed:—

By the Admiralty.—Inspector-General Herbert M Ellis, K.H.P., Director-General of the Medical Department of the Navy; and Deputy-Inspector-General Arthur W. May, of the Medical Department of the Navy.

By the War Office.—Surgeon-General Sir A. Keogh, K.C.B., M.D., Director-General, Army Medical Service; Lieut.-Col. M. W. Russell, R.A.M.C., Deputy-Assistant Director-General, A.M.S.; Lieut.-Col. W. G. Macpherson, C.M.G., M.B., R.A.M.C., Deputy-Assistant Director-General, A.M.S.; and Lieut.-Col. J. E. Edmonds, R.E., of the Department of the Chief of the General Staff.

PASS LISTS.

Royal College of Surgeons of England.

At a meeting of the Council, on Thursday, May 9th, the following candidates, having passed the required examinations and conformed to the bye-laws, were admitted Members of the College:—G. H. Adam, F. O. Arnold, B.A., H. T. Ashby, B.A., P. H. Bahr, B.A., Camb.,H. J. Beddow, B.A., Camb., R. C. P. Berryman, John Birch, R. E. Brayne, Josiah Browne, C. W. G. Bryan, M. B. S. Button, H. V. B. Byatt, B.A., Camb., W. J. Chapman, P. J. Chissell, Spencer Churchill, B.A., Camb., E. B. Clayton, B.A., Camb., H. C. Colyer, P. S. Connellan, P. A. Creux, T. H. Davies, A. H. T. Davis, H. E. T. Dawes, B.A., Camb., Geo. Denholm, A. T. Densham, B.A., Camb., Horace Dimock, B.A., M. M. Earle, H. R. Elliott, C. A. Ellis, W. A. Fairclough, J. H. Farbstein, Marmaduke Fawkes, Norman Fowler, B.A., W. E. L. Fowler, C. H. S. Frankau, W. D. Frew, P. C. Garrett, Harold Gibson, W. S. Gibson, B.A., A. S. Graham, George Graham, R.A., W. R. Greening, F. W. W. Griffin, B.A., R. E. V. Hale, B.A., H. McC. Hanschell, R. N. Hartley, L. C. Hayes, A. W. Hayward, B.A., C. E. K. Herapath, G. A. F. Hayworth, B.A., W. de M. Hill, Hendrik Houwink, R. de S. Illesinghe, C. G. Jarvis, R. S. Jenkins, B.A., W. G. Jones, A. J. Kendrew, Solomon Krestin, Malcolm Leckie, H. E. Leeson, W. S. Leicester, B.A., Camb., R. L. Ley, B.A., Camb., Conrad Loddiges, Wm. Lovell, F. B. Lowe, J. B. Macalpine, C. F. F. McDowall, E. L. Marchant, W. B. Martin, J. H. Mayston, B. B. Metcalfe, H. L. Morgan, E. L. R. Norton, H. S. Ollerhead, Arthur O'Neill, G. L. Parsons, B. T. Parsons-Smith, Walter Patey, Stanley Paulin, C. A. Pemberton, E. C. Pope, O. C. W. Prausnitz, Geoffrey Price, J. L. Rankine, J. A. Renshaw, Kenneth Robinson, C. F. Rumsey, A L. Sachs, M.A.., Cambs., L. St. V. Welch, John Selfe, E. A. Shirvell, A. L. Singer, B.A., Camb., W. F. Skinner, F. G. Snoad, E. C. Sparrow, B.A., Camb., L. D. Stamp, Frank Standish, George Stone, A. A. Straton, J. R. Sutherland, R. E. Todd, S. S. Vazifdar, J. L. Walker, N. H. Walker, R. R. Walker, B.A.. Camb., H. G. Webb, Henry Weir, H. B. Wickham, J. W. J. Willcox, C. L. Williamson, L. A. Wilson.

Royal College of Surgeons in Ireland.

At a meeting of the President, Vice-President, and Council, held on Tuesday, May 7th, the following Examiners were elected for the ensuing year:—

FOR CONJOINT LICENCE, DIPLOMA IN PUBLIC HEALTH, AND PRELIMINARY.

Anatomy.—Alexander Fraser, F.R.C.S.; Bertram C. A. Windle, B.S., Univ. Dub.

Surgery.—Charles A. K. Ball, F.R.C.S.; Alexander Blaney, F.R.C.S.; F. Conway Dwyer, F.R.C.S.; G. Jameson Johnston, F.R.C.S.

Physiology and Histology.—Denis J. Coffey, B.S., R.U.I.; E. L'Estrange Ledwich, L.R.C.S.

Pathology and Bacteriology.—Arthur Hamilton White, L.R.C.S.

Midwifery and Gynæcology.—Frederick W. Kidd, L.R.C.S.

Biology.—John J. Burgess, F.R.C.S.

Ophthalmology.—Arthur H. Benson, F.R.C.S.; Patrick H. Maxwell, F.R.C.S.

Sanitary Law and Vital Statistics.—Edward Francis Stephenson, F.R.C.S., D.P.H.

Engineering and Architecture.—Caleb J. Powell, F.R.C.S., D.P.H.

Languages.—L. J. Woodroffe, M.A., Dub. Univ.

Mathematics, Physics, Dictation, and English Essay.—J. W. Tristram, M.A., Dub. Univ.

Dutch.—John C. Pretorius, B.A., Dub. Univ.

FOR FELLOWSHIP, LICENCE IN SURGERY (FOR REGISTERED PRACTITIONERS), LICENCE IN MIDWIFERY (FOR REGISTERED PRACTITIONERS), AND LICENCE IN DENTAL SURGERY.

Anatomy.—Patrick Joseph Fagan, F.R.C.S.; Alexander Fraser, F.R.C.S.

Surgery.—Alexander Blaney, F.R.C.S.; F. Conway-Dwyer, F.R.C.S.; G. Jameson Johnston, F.R.C.S.; Richard Lane-Joynt, F.R.C.S.

Physiology and Histology.—Denis J. Coffey, B.S., R.U.I.; E. L'Estrange Ledwich, L.R.C.S.

Pathology and Bacteriology.—Arthur E. Moore, B.S., Royal Univ.; Arthur Hamilton White, L.R.C.S.

Midwifery and Gynæcology.—Frederick W. Kidd, L.R.C.S.

Chemistry and Physics.—Edwin Lapper, F.R.C.P.; Robert J. Montgomery, F.R.C.S.

Dental Surgery and Pathology.—George M. P. Murray, F.R.C.S.; William G. Story, L.D.S.

Mechanical Dentistry.—Daniel L. Rogers, L.D.S.; Thomas F. Studley, L.D.S.

The Scotch Diploma in Public Health.

At the May meetings of the Examiners in Public Health of the Royal Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow, held in Glasgow, the following candidates passed the respective examinations: First examination—James Dundas, M.B., Edin.; Herbert James Norman, M.B., Edin.; Albert Davies Edwards, M.B., Lond. Second examination and admitted Diplomates in Public Health—James Dundas, M.B., Edin.; Ferniehurst Halidon Borthwick, M.B., Edin.; Albert Davies Edwards, M.B., Lond.; and William Edward Home, Fleet Surgeon, R.N., M.D, Edin., M.R.C.P.E.

At the inquest on the thirteen-year-old son of a painter named Cornhill, living at Clayton Street, Caledonian Road, it was stated that he became suddenly ill on April 30th and died on May 5th. A *post-mortem* showed that death was due to acute cerebrospinal meningitis, and the jury returned a verdict to that effect.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

THE LAST OF THE LIGHT BRIGADE.

Surgeon-Major Lancelot Armstrong, who died at Weston-super-Mare, on Saturday last, is associated with the ride of the Six Hundred at Balaclava. He commenced the ride, but dismounted when men were falling, and attended to the wounded under the murderous fire of the Russian batteries. He was the only medical survivor, and almost the last of the celebrated six hundred.

DR. F. A.—We cannot inform you of any work on the subject of the effect of methylene blue in cancer in this country, but an interesting article on the question appeared in the Journal of the American Medical Association last November. The drug has been used for years by Dr. Jacobs, the writer of the article, and though he does not claim that it cures, in his opinion it gives relief and prolongs life. One case, cancer of the liver, has been treated for eight years, and the patient is not only alive but able to deal with the ordinary affairs of life.

ORIGIN OF "COLONEL BOGEY."

MEDICAL golfers will be interested to learn that the origin of the renowned Colonel Bogey is closely connected with one of their number. The "World of Golf" says he originated at Coventry in December, 1890, and that some six months later some of the club went to Great Yarmouth, where the idea was explained to Dr. Thomas Browne, R.N., the hon. secretary, who went out to play against Major Charles A. Wellman on this system.

At that time the "Bogey Man" song was in great vogue, a song with the refrain, "He'll catch you if he can!" and it flashed across the mind of Major Wellman when he was getting caught by bogey. "Why," said he, "this player of yours is a regular Bogey man."

A little while afterwards Dr. Browne was playing at the course of the United Service Club, at Alverstoke, in Hampshire, and introduced them to the "Bogey man," and after working out a score for him for that course they went out to play with him.

"Stay!" said the secretary at the moment of starting. "Every member of this club has a proper service rank. Our new member ought to be a commanding officer. He must be a Colonel!"

POST CARD.—The correspondent who questions the accuracy of our note, p. 471, May 1st, as to the attendance of Dr. Glendening on the Queen of Spain may, we think, rest assured that the gentleman in question has not returned to England. Many reports and contradictions have been bandied to and fro upon the whole affair, oftentimes with a want of delicacy that does not altogether redound to the credit of modern journalism.

DR. FINSEN AND HIS DISCOVERY.

MR. JACOB RIIS, the American author, says: "I learned from Dr. Finsen's own lips the story of his great temptation—how, when he found what he sought, the power to combat the disease with the ravening name ('lupus,' a wolf)—he lay awake one whole night, debating with himself whether to turn it to account in private practice—Finsen was a poor man—or to give it and his life to the world. He chose poverty, and the world is the richer for his sacrifice." Of course, when he decided to make public his discovery, Dr. Finsen only acted in accordance with the noble traditions of his prefession, but the temptation was nevertheless strong.—*Daily News.*

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 15th.

ROYAL MICROSCOPICAL SOCIETY (20, Hanover Square, W.).—8 p.m.: Exhibition of Pond Life. Papers:—Prof. A. W. Porter and Mr. P. F. Everitt: Diffraction Rings due to a Circular Aperture.—Mr. E. M. Nelson: An Improved Vertical Illuminator.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m.: Dr. H. W. G. Macleod: Trypanosomiasis or Sleeping Sickness.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. M. Collier: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. B. Harman: Injuries to the Superficies of the Eye.

NORTH-EAST LONDON POST-GRADUATES' COLLEGE (Prince of Wales' Hospital, Tottenham, N.).—Cliniques: 2.30 p.m.: Skin (Dr. Meachen), Eye Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, MAY 16th.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND (11 Chandos Street, Cavendish Street, Cavendish Square, W.).—3 p.m.: Papers:—Dr. W. F. Robertson and Dr. G. D. McRae: Futher Bacteriological and Experimental Investigations into the Pathology of General Paralysis.—Dr. H. Devine: A Case of Katatonia in a Congenital Deaf-Mute.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.; Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. M. Yearsley: Syphilis in the Ear.

NORTH-EAST LONDON POST-GRADUATES' COLLEGE (Prince of Wales' Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m.: Special Demonstration of Surgical Cases (Mr. W. Edmunds).

HOSPITAL FOR SICK CHILDREN (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. G. E. Waugh: Hip Disease in Children.

FRIDAY, MAY 17th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5 p.m.; Wightman Lecture:—Dr. F. Taylor: Pneumonia in Children.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W. C.).—4 p.m.: Mr. W. Stuart-Low: Clinique. (Ear).

NORTH-EAST LONDON POST-GRADUATES' COLLEGE (Prince of Wales' Hospital, Tottenham, N.).—9.30 a.m.: Clinique:— Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient Dr. Auld), Eye (Mr. Brooks). 3 p.m. Medical In-patient (Dr. Leslie).

Vacancies.

Cheltenham General Hospital.—House Physician. Salary £65. per annum, with board and lodging. Applications to W. H Head, Secretary. (See advt.).

Cheltenham General Hospital.—Surgeon-in-Charge of the Branch Dispensary. Salary £90 per annum, with board and lodging at the General Hospital. Applications to W. H. Head, Secretary. (See advt.).

Incorporated Orthopædic Hospital of Ireland. Surgeon. Applications to J. W. Berthisle, Capt., Secretary.

Kensington Board of Guardians.—Second Assistant Resident Medical Officer.—The Guardians of Kensington require the services of a Second Assistant Resident Medical Officer for the Workhouse and Infirmary at a salary of £100 per annum, with apartments, board, and washing. Applications to the Clerk to the Guardians, Marloes Road, Kensington.

Middlesex Hospital, W.—Medical Official and Registrar to the Cancer Department. Salary £100 per annum, with board and lodging. Applications to F. Clare Melhado, Secretary-Superintendent.

Royal Albert Edward Infirmary, Wigan.—Junior House Surgeon. Salary £100, with apartments, washing, and rations. Applications to Will. Taberner, General Superintendent and Secretary.

West Suffolk General Hospital, Bury St. Edmunds.—House Surgeon. Salary £100 per annum, with board and lodging. Applications to the Secretary.

Brentford Union.—Second Assistant Medical Superintendent, etc. Salary £125 per annum, with lunch and tea daily and dinner. Applications to William Stephens, Clerk to the Guardians, Union Offices, Isleworth, W.

Bailbrook House, Bath.—Assistant Medical Officer. Salary £140 per annum, with board, lodging, laundry, and attendance. Applications to Herbert Coates, 39 Broad Street, Bristol.

North Staffordshire Infirmary and Eye Hospital, Hartshill, Stoke-on-Trent.—House Physician. Salary £100 per annum, with furnished apartments, board, and washing. Applications to the Secretary and House Governor.

Oldham Union.—Resident Medical Officer. Salary £120 per annum, together with furnished residence, coal, gas, rations, washing, and attendance. Applications to Horace A. Quarmby, Clerk to the Guardians, Union Clerk's Office, Oldham.

Appointments.

FRENCH, J. GAY, M.B., B.S.Lond., M.R.C.S.Eng., L.R.C.P.Lond., Surgeon to the Ear and Throat Department, with Charge of Out-Patients, at the Great Northern Central Hospital.

GILBERT, WILLIAM, M.B., Ch.B.Glasg., Assistant House Surgeon at the Huddersfield Infirmary.

HERTZ, A. F., M.B., B.S.Oxon., Assistant Physician to Guy's Hospital.

JORDAN, ALFRED C., M.D., B.C.Cantab., Medical Radiographer to Guy's Hospital.

MURRAY, H. LEITH, M.D.Aberd., Joint Pathologist to the David Lewis Northern Hospital, Liverpool.

REITH, W. R., M.D., M.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the Erdington District of the county of Warwick.

SHAW, LAURISTON E., M.D.Lond., F.R.C.P.Lond., Physician to Guy's Hospital.

SYMES, J. O., M.D.Lond., D.P.H., L.R.C.P.Lond., Consulting Physician to the Cossham Memorial Hospital, Kingswood, Bristol.

TAYLOR, FREDERICK, M.D.Lond., F.R.C.P.Lond., Consulting Physician to Guy's Hospital.

Births.

COOPER.—On May 9th, at 19, Sutton Court Road, Chiswick, the wife of Bertram Cooper, M.R.C.S.,Eng., L.R.C.P.Lond., of a son.

PRICE.—On May 7th, at Castle Cary, the wife of David Price, M.B., of a son.

GRAHAM.—On May 1st, at Gwydir House, Cambridge, the wife of J C. W. Graham, M.A.(Cantab.), M.R.C.S.(Eng.), L.R.C.P.(Lond.), of a daughter.

Deaths.

HIGGINBOTHAM.—On May 8th, at Mentone, France, William Higginbotham, M.D., formerly of St. Petersburg, in his 94th year.

JALLAND.—On May 9th, at Rollestone House, Horncastle, Robert Jalland, M.R.C.S.Eng., L.R.C.P.Lond., aged 76 years.

WHITE.—On May 3rd, at 24, Nevern Square, London, Charles Vaughan White, M.R.C.S., L.R.C.P.Lond., son of the late F. S. White, Esq., of Southsea.

MACKENZIE.—On May 11th, at 72, Warwick Avenue, London, W. Emily Eliza, widow of John Ingleby Mackenzie, M.D. Cantab, aged 67.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, MAY 22, 1907. No. 21

NOTES AND COMMENTS.

Specialists' Fees.

AN unpleasant but important public duty was performed by Mr. C. H. Fagge last week in bringing a High Court action for fifty guineas against Mr. A. C. Roberts, a district auditor. Mr. Fagge had performed an operation on the defendant's child, thereby saving her life. His usual fee was one of a hundred guineas, but in consideration of the defendant's position, and on the family attendant's representation, he reduced it by one-half; yet when the time came to pay, Mr. Roberts offered twenty-five guineas, which he considered sufficient. In court it was stated that the defendant enjoyed a salary of over eight hundred a year, and as the operation appears to have been performed in the suburbs and to have been thoroughly successful, the charge cannot be considered disproportionate. No doubt it was one of some magnitude to the defendant, but if he wished to have a London hospital surgeon from the West End, it was necessary that he should be prepared for a considerable fee. There are always a number of excellent young surgeons available who are thoroughly capable of performing skilled operations, and unless surgeons of reputation, holding senior hospital posts maintain the level of their fees, it is very difficult for the juniors to get the less-well-paid work for which they naturally look in the early years of practice till their names are established. Physicians and surgeons of assured status do themselves little good in taking nominal fees from middle-class patients, and they certainly inflict a grave injury on their junior brethren.

"Iron Ox" Decision.

A HIGHLY-IMPORTANT decision was given by Mr. Justice Parker in the Chancery Division on May 10th. The case was one brought by the "Iron-Ox" Remedy Company against the Co-operative Wholesale Society Limited, of Manchester, for an injunction to restrain the defendants from passing off a medicine which the plaintiffs thought might be mistaken for their preparation, known by the name of "Iron-Ox." The defendants called the medicine they manufactured "Compound Iron Oxide Tablets," but there was no evidence that anyone had been deceived thereby. We have not the slightest sympathy with either of the parties to the suit, because we consider the patent medicine business in its aim and essence to be opposed to the public interest; but we are staggered at Mr. Justice Parker's decision to grant the injunction asked for, at least so far as the use of the word "Iron Oxide" is concerned. Iron oxide is an ordinary chemical name, denoting a salt of the metal which is used in medicine, and to forbid the use of such because a trading company have invested capital in the use of the word "Iron-Ox," is a dangerous and far-reaching procedure. It is no case of Tweedle-dum and Tweedle-dee, but of the right of persons to obtain for themselves the use of common chemical names, and if carried out logically, a trader has only to register the name "Cod-Ol," or "Zinc Ox," for a physician to be precluded from prescribing cod liver oil or oxide of zinc. We hope the matter will not be allowed to rest.

College of Surgeons and its Members.

IN answer to a question put by Sir William Collins in the House of Commons last week, Sir Henry Campbell-Bannerman detailed the stage which the contest between the members and Council of the Royal College of Surgeons of England has reached. It will be remembered by those interested that Sir William Collins a little while ago introduced a deputation of members of the College to the Prime Minister with a view to enlisting the support of the Government in the movement for reform of the College which has been so long on foot, and has made so little way. The Prime Minister promised to have the matter attended to, and now is able to announce that Lord Crewe, as Lord President of the Council, has referred the petition of the members to the Council of the College, received their reply, and subsequently seen a deputation of the members. The latter have furnished a reply to the reasons against reform put forward by the Council, and this has been forwarded to the latter with an intimation from Lord Crewe that he will be glad to receive a deputation from the Council if they wish to send one. It may be taken, therefore, that the trouble is in a fair way to being settled, and certainly the thanks of the members are due to the Prime Minister and Lord Crewe for their trouble in the matter. It is more than an anomaly for the control of the College to remain in the hands of a small minority who take advantage of the wording of a Charter granted many years ago, to exclude the whole mass of members from any share in the government of their institution.

"Ox-Runners and Pimply Gut."

One half of the world, it is truly said, does not know how the other half lives; it may be hoped that the half of the world in which one lives will never eat the things which form the comestibles of another half. The other day in Hackney a firm bearing a German name was summoned at the instance of the Hackney sanitary inspector for selling 150 sets of ox-runners (the intestines of the ox), which were said to be unfit for human consumption. The reason which, in the eyes of the health authorities, disqualified these articles was that they were afflicted with "pimply gut," apparently a condition of infection of the lymph-follicles of the intestine. "Ox-runners" were said to be in vogue as a covering for black-pudding, and a witness was called to prove that the skins were considered as an edible portion of that delicacy. In the defence it was argued that runners were used also for making tennis-racquets as well as black-puddings, and that there was no evidence that the particular parcel was designed for the food of man. The magistrate held that though the goods were liable for seizure he would give the defendants the benefit of the doubt, and he dismissed the summons. Black-pudding sounds little enough inviting, but if it is liable to be compounded with ox-runners afflicted with pimply gut, we fancy the strongest argument has been made out for the East-Enders to follow the simpler life, at any rate as regards their edible luxuries.

Semper Paratus.

The hygienic lessons of the Japanese war have been dilated upon times out of number, but it is not a little significant of the character of that nation that the precautions which excited so much occidental admiration, and which were crowned with such striking success, are not merely war precautions. The Japanese realise that what prevents disease in time of hostilities is equally capable of preventing disease in time of peace, and it was remarked by the troops at Gibraltar that the Japanese sailors who disembarked there the other day for an outing, all carried their own water-bottles containing sterilised water. No aspersion was intended for the sanitary resources of the Rock, but the Japanese officers realise that when a good thing in disease-prevention is found it is as well to stick to it under all circumstances. The Japanese hygienic religion is not an affair for Sunday only.

LEADING ARTICLES.

EDALJI COMMITTEE'S REPORT.

Now that the Edalji case has been finally decided, it may with pardonable pride be pointed out that The Medical Press and Circular was the first and for several years the only paper that pointed out the injustice of the conviction of that unhappy man. It will be in our readers' memory that in November, 1903, we got up a petition which was largely signed by leading medical men, asking the Home Secretary to revise the conviction, and that, though pressed several times, nothing beyond a formal acknowledgment could be obtained from him. The subject was kept alive in our columns till the expiration of the reduced sentence, and then, feeling that all we could do had been done, we allowed the matter to lapse. The subsequent steps taken by Sir A. Conan Doyle and the *Daily Telegraph* to obtain a free pardon from the present Home Secretary have now been successful, and we congratulate Mr. Gladstone on having acted with justice and discrimination. We must, of course, accept the opinion of the committee that Edalji, by his own folly, brought himself under suspicion, and that the police, acting on that suspicion, sought to bring the crime home to him. The theory is a new one, and without access to the information in the hands of Sir Arthur Wilson and his colleagues, we are not in a position to criticise it. The course taken by Mr. Gladstone—that of granting a free pardon but withholding any compensation—is, under the circumstances, the nearest approach to justice that can be attained after all the complications of what he has described as "this extraordinary case." But, without wishing to lay claim to undue perspicacity, we think we are entitled to point out to the Home Office and to the public that the administration of justice cannot be conducted in a civilised country merely by a staff of forensic experts, however much experienced and however able. We are willing to acknowledge that a sound lawyer is a better judge of what constitutes evidence—in the Edalji trial at the Quarter Sessions there was no such person on the Bench—than a physician, if the lawyer will grant that *pro tanto* the sound physician is a better judge of what constitutes crime, of motive, and of mental responsibility. A physician knows that criminals differ in type as much as lunatics do, and that to arrive at a decision as to the probability of a certain kind of crime having been committed by a certain person it is necessary to make a diagnosis of that person's mental predisposition and predilections. For an intelligent diagnosis of such a kind the same training is needed as that which enables a physician to decide whether a mental patient is suffering from (say) dementia prœcox, recurrent mania, or general paralysis. A lawyer is hidebound by evidence and facts, both of which are without doubt of the highest possible value; the medical man goes back further and judges of motive, that is of how the facts elicited by the lawyer are ætiologically related to the mental and physical constitution of the suspected person. So that we claim emphatically that the system of justice in this country is incomplete without a strong admixture of a medical element with the legal, and it is a ridiculous anachronism that provides the Home Office with no staff of physicians to aid the Minister responsible for the administration of justice with the means of linking up fact and probability. We are far from claiming that criminology is a complete science; but it is a budding science, and one in which medical men alone can become expert. Medical evidence in court is none too respectfully received in many cases, and medicine rightly claims a position, not of representation before a court, but of equality with the judiciary. We have only to point to the Edalji case as one in point. At the time of the trial it was apparent to us on medical grounds that Edalji was wrongly convicted, and we protested. It has taken the lawyers nearly four years of revising, discussion, and study to arrive at the same conclusion. A little medical knowledge about the class of criminal who indulges in crimes of lust and violence, and of their type of mental constitution, would certainly have saved Edalji, in spite of his foolish letter-writing, from three years' penal servitude, and the whole country from another severe dislocation of faith in the integrity of justice in Great Britain. We clearly saw from the first the strongest *prima facie* case against Edalji's guilt, and it was reserved for a medical man, Sir A. Conan Doyle, finally to move the Home Office. There can be little doubt that there are many prisoners at the present moment suffering similar injustices, which a little of the sweet reasonableness of medicine would have averted. Surely in the Edalji case medicine has been justified of her children.

THE DISAPPEARANCE OF SMALL-POX.

THE vindication of a scientific theory can be brought about only by the test of practical experience. In many instances it is impossible, owing to the lack of knowledge of essential facts, to formulate anything more authoritative than a sound working theory. The science of medicine has at the present time to deal empirically with a vast number of problems presented to her consideration in the phenomena of disease. Fortunately it is often possible to deal with morbid conditions in a perfectly satisfactory way by the application of general principles deduced from accumulated experience of the past. The disappearance of plague and cholera from the United Kingdom and the gradual lessening of other specific infectious diseases were accomplished for the most part prior to the discovery of the *rôle* played by pathogenic bacteria in their pathology, and to the identification of the specific micro-organisms concerned. Even at the present day it is a commonplace of medical interest to remark that the organism of so well-marked a malady as small-pox has not yet been identified. The battle of the sanitarian against that loathsome malady, however, has been fought and won wherever the counsel of the orthodox and authoritative medical world has been followed with zeal and thoroughness. The result in London has been a whole year—that of 1906—without a single death from small-pox, while in the three preceding years the deaths from that cause had fallen to the small proportion involved in the figures, 13, 25, and 10. Had the main mass of the population of the metropolis not been protected by vaccination, and a large proportion of her unprotected citizens weeded out by death or rendered immune by attacks of the disease in the epidemics of recent years, the result of the invasion in 1903, 1904, and 1905, would probably have been multiplied a thousandfold. The negative order of the picture, however, is rarely taken into account by the anti-vaccinationist who shuts his eyes resolutely to the argument based on what might have been the state of affairs had not Jenner noted the protection afforded to dairy-workers by cow-pox, with which he first vaccinated a boy in 1798. At that time inoculation was largely practised, inasmuch as that method of direct communication of the disease offered the best chance of securing a mild attack. The mortality from small-pox was very great, while a great amount of blindness resulted, and pitting of the face, oftentimes of great and disfiguring severity, was the rule rather than the exception. Compulsory vaccination has changed all that, at least that is the profound belief and conviction of the scientific medical world. This view is fiercely opposed by the anti-vaccinationists, who contend that the decrease in small-pox is due to improved sanitation with its special preventive measures of notification, isolation and disinfection. Clearly the argument on neither side is capable of exact proof or disproof. Perhaps one of the strongest arguments in favour of the efficiency of vaccination is the way in which the disease picks out the unvaccinated for attack, and the excessive mortality of small-pox among unprotected persons. Yet the greatest proof of all is surely the fact that a little over a hundred years after Jenner's first vaccination, London, instead of being riddled and decimated with small-pox had not a single case of death from the disease during a whole year, in spite of the enormous relative increase of population. Jenner himself could hardly have hoped for a more triumphant vindication of his theory. To have prophesied such a result in his day would have been, to the mind of the wise as well as of the foolish, to have given food for ridicule. Men have come and men have gone, small-pox has disappeared, but the anti-vaccinationist goes on for ever. Of late years he has received some encouragement at the hands of Government, in spite of the solemn and weighty warning of the medical profession, and although the conscientious objector clause was provided to give the honest, if ignorant, antagonist to vaccination a graceful way of retreat, even that has not satisfied the professional agitator. It can but be regarded as unfortunate that many magistrates did not realise sooner that arguing and pleading with anti-vaccinators was merely to waste time, and that such methods only keep alive a controversy which should have died from inanition in 1898. As it is, Mr. Burns is preparing to pass a bill to make the way of the anti-vaccinationist still easier by enabling him to make a simple statutory declaration of objection, and it can but be expected that the idle and careless will take wholesale advantage of it, alongside of the prejudiced and ignorant. The logical correlative of primary vaccination is re-vaccination at school-age, but that ideal in the present state of public opinion is likely to remain an ideal for many a year.

CURRENT TOPICS.

The Health of Dublin.

THE contempt shown by the Corporation of Dublin for the lives of the citizens was emphasised again last week, when the Corporation declined to take steps to have the provisions of the Municipal Milk Depots Bill, at present before Parliament, extended to Ireland. The effect of the Bill would have been that the health authorities would have obtained wider powers for the supervision of the milk supply of the city. We do not know that much would have been gained, as it is not lack of power but lack of energy that hampers the Dublin Health authorities. The powers of which they are already possessed are far from being exercised as fully as they might be. The carelessness of the Corporation, however, in regard to the Bill is typical of the indifference which prevails in Dublin on all matters affecting the health of the citizens. Among the causes of the high death-rate in that city infant mortality is one of the most important, in spite of the fact that there are few if any married women employed in industrial work. By their recent decision the Corporation declines to take any measures to safeguard the health of the infant population, to whom milk is so important an article of diet. The only satisfactory point in the whole business is that the scandal is so open that some of the daily papers have at length lifted their voices in protest.

National Sanatorium Association.

AN eminently successful banquet was given in the Grand Hall of the Hotel Cecil on May 14th, by the National Association for the establishment and maintenance of Sanatoria for workers suffering from Tuberculosis, of which the Princess Christian is President. The chair at the dinner was taken by the Prince of Wales, who was supported by Prince Christian, in the vice-chair, and a large number of ambassadors, noblemen, and gentlemen. After the usual loyal toasts, the Prince proposed the toast of the evening, namely, that wishing success to the Association. In an excellent speech he showed that he had a very clear idea as to the aim of the Association and a good knowledge of its needs. The object is to help the working-classes to help themselves in the matter of providing sanatoria and maintaining them, and what is not less important, to give to the convalescent patients by means of a farm such employment as not only will be useful to their fellows, but will fit them to return to their own work when health is established. The Association numbers among its supporters a large number of friendly societies and trade unions, all of which are prepared to contribute liberally to the upkeep of the sanatoria as they are built. The first has already been opened at Benenden in Kent, but the number of beds available for workers is utterly disproportionate to the need for them. The movement is deserving of the warmest support because it is being managed on sound businesslike lines, and money is not being sunk in palatial buildings and extravagant fittings. Moreover, by the ability of the Association to take charge of a consumptive bread-winner on the recommendation of his society, the sick-pay he is entitled to can go wholly to his dependents. At present the provision of sanatoria for the working-class is in a pitiable condition, for throughout the country, in which some 70,000 persons a year die of tuberculosis, only something like 1,000 beds, all told, are capable of being used. It is gratifying to be able to record the success of the Prince's appeal, for no less than £13,261 was subscribed at the dinner, including 100 guineas from the Chairman himself.

Coroners and Death Certificates.

THE granting of death certificates is one of the most important and responsible duties that devolve upon the coroner. Indeed the document in question may be regarded as the outward and visible token of the semi-judicial function which he is called upon to exercise. The recognition of the vital importance of the death certificate lies at the root of the strong conviction held by the majority of medical men that coroners should always be chosen from members of their own profession. Last week a Medical Officer of Health reported in a scathing manner upon the loose way in which certificates of death had been in some cases granted by the district Coroner. He maintained that from a public health point of view the practice was dangerous. In several cases the cause of death had been reported as "probably convulsions," whereas there is no such disease as "convulsions," which are only a symptom of disease. In a case of death from spotted fever, in which the only apparent symptom was convulsions, and in which death ensued within twelve hours of the seizure, it was quite possible that if the parents had not obtained medical aid—as they frequently did not in cases of supposed convulsions—the death would have been certified as "probably from convulsions." In this contingency spotted fever might have spread to a serious extent. In the ensuing Council discussion a member said that quite recently the coroner had criticised the conduct of a Wrexham medical practitioner in refusing to give a death certificate, although the doctor had not seen the deceased before death ensued. Now it is certain that a medical man, even if he has not seen a patient during life, is in a far better position to give a certificate of death than a lay coroner, and if it is risky for a medical man to give such a certificate, as it undoubtedly is, *a fortiori* it is highly undesirable that a coroner should be in a position to do so.

The Cost of Small-Pox.

AT the last meeting of the Metropolitan Asylums Board, a long and interesting discussion took place on the provision of beds for small-pox patients in London. One of the speakers who raised the question of cost showed that to keep London in a state of preparedness for a possible outbreak of small-pox, the Board are spending on the hospitals and ambulance services £89,000 a year, and that for this enormous outlay they could only point to twenty-seven cases treated last year. The other speakers did not seriously dispute the figures, so that they may be taken as substantially correct. The matter after discussion was referred to the General Purposes Committee for investigation, but there can, one fears, be little hope that the Committee will be able to do much to reduce their expenditure. It does seem that the British is the most unpractical of nations, for it declines to insist on the [proper safeguards against small-pox, namely, vaccination and re-vaccination, and yet while it spends large sums annually on primary vaccination, at the same time it pays these stupendous sums for small-pox isolation. Every intelligent man knows that there is the choice of two methods for combatting the disease, either efficient vaccination with re-vaccination, or the provision of large isolation hospitals. In London at the present moment things have reached a climax, for money is being freely disbursed both for vaccination and small-pox treatment, and the amount reaches a respectable total. Perhaps some day the paradox of it will strike the observant ratepayer, but as it is he smiles and groans alternatively.

Hospital Abuse and the Lay Press.

One cannot wonder that the question of hospital abuse is attracting attention in the lay Press, and if some of the weekly papers of the baser sort have seized the opportunity to indulge in general abuse of the medical profession and hospital managers, the latter have, to some extent, themselves to blame. It is, of course, unfortunate that the man in the street cannot be rightly instructed in the question, since it is with him that the solution of this, as of most other practical problems, finally rests. The formation of public opinion can hardly be aided by such views as Mr. James Douglas publishes in a recent number of *M.A.P.* Mr. James Douglas is well known as a gentleman of melodramatic imagination, but this article of his is particularly fertile in exaggeration. "The hospital nurse is a white slave. . . . She is brutally overworked and underfed. . . . A few nurses are lucky enough to marry a doctor, but the majority of them find rest in an early grave." An accusation of polygamy is by no means the only charge he brings against medical men. "The central hypocrisy of the hospital is the glittering staff of honorary consultants." "In the East End of London the cheap doctors are a public nuisance and a public danger." "Hundreds of lives are lost through the gross incapacity of young doctors who are learning their trade at the expense of their patients." These are samples of the wit and wisdom with which Mr. James Douglas entertains the public. To him, as to some greater men, consistency is a matter of small importance. Thus we read that "the poor unanimously detest it" (the hospital), while at the same time "the hospital habit ~~is~~ common among the poor." We hope this sort of nonsense is not really typical of the attitude of any section of the public toward the hospital question, but apparently there is a public willing to pay for it.

PERSONAL.

Professor S. Ehrmann gave an address at the first meeting of the newly-formed Austrian Society for the Repression of Venereal Diseases.

Professor Wolfram C. Fuchs, of Chicago, has just died of malignant disease which is believed to have been caused by exposure to Röntgen rays.

Dr. Teizo Iwai, Physician to H.I.H. Prince Fushimi, has been appointed an Honorary Member of the Fourth Class of the Royal Victorian Order.

Dr. Doumer, of Lille, will read a paper on "The Fundamental Principles of Electrotherapy" at the British Electro-Therapeutic Society on Friday next.

Dr. William Hunter has been nominated Curator of the Museum of the Royal College of Physicians of London.

Dr. E. Cyril Doyne has been appointed honorary assistant surgeon and Dr. A. Douglas Hamilton assistant physician to Chester Infirmary.

Sir Thomas Frazer, F.R.S., Professor of Materia Medica in the University of Edinburgh, is to receive the honorary degree of D.Sc. at Cambridge University.

Sir William Collins is to preside at the annual general meeting of the Asylum Workers' Association at the Medical Society's Rooms, Chandos Street, W., on May 29th, at 4 p.m.

Colonel J. Lane Notter will take the chair at the provincial meeting of the Royal Sanitary Institute at Plymouth on May 31st. The subject for discussion is Infantile Mortality.

Dr. J. Walker Downie has been elected President, and Dr. R. Barclay Ness and Dr. Joshua Ferguson, Vice-Presidents, of the Glasgow Medico-Chirurgical Society for the next session.

Dr. James Evelyn Pilcher will deliver the address at the American Medical Editors Association at Atlantic City on June 1st. His subject will be "The Future of Medical Journalism."

Mr. R. H. Swanzy, President of the Royal College of Surgeons of Ireland, presided at the annual meeting of the King's Coronation National Fund for Nurses in Ireland on Monday, May 13th.

Dr. Alexander McPhedran, of Toronto, will preside at the fortieth annual meeting of the Canadian Medical Association at Montreal on September 11th and following days.

Dr. Donald MacAlister, M.D., LL.D., D.C.L., will take the chair at the dinner to be given by the Glasgow University Club, London, at the Trocadero Restaurant on May 31st, at 7.30 p.m.

Sir David Gill, LL.D., K.C.B., D.Sc., F.R.S., late Astronomer-Royal at the Cape of Good Hope, will preside at the British Association for the Advancement of Science annual meeting at Leicester on July 31st.

The late Lieut.-General George E. Baynes, of Hayward's Heath, has left by will £1,000 to Guy's Hospital and the Royal Hospital for Incurables, Putney, and the residue of his estate, after paying all bequests, to King Edward VII.'s Hospital Fund for London.

Dr. Knowsley Sibley will submit a resolution advocating a central hospital authority for London at a special general meeting of the Metropolitan Counties Branch of the British Medical Association, to be held on Thursday, June 6th, at St. James's Vestry Hall, Piccadilly, at 4.30 p.m.

Baron Takeo Ozawa and Dr. Nagao-Ariga have been chosen by the Japanese Red Cross Society, and Surgeon-Major Kasai, Colonel Gori Shibi, and Surgeon Kenji Kawanishi by the Japanese Government, as representatives at the forthcoming Conference of the Red Cross Societies.

Professor Paul Ehrlich, Director of the Royal Institute of Experimental Therapeutics at Frankfort, will deliver the Harben Lectures at the Royal Institute of Public Health on June 5th, 7th, and 11th. The subject he has chosen is "Certain Experimental Researches on Specific Therapeutics."

A Clinical Lecture

ON

THE TREATMENT OF PNEUMONIA. (a.)

By Sir JAMES BARR, M.D., L. and L.L.D., F.R.C.P., F.R.S.E.,

Senior Physician, Liverpool Royal Infirmary; Chairman of the Medical Faculty of Liverpool University; President of the Lancashire and Cheshire Branch, British Medical Association.

PART I.

Gentlemen,— We have just had three cases of pneumonia in my wards, male patients, æt. respectively 7, 17, and 40. There is nothing out of the common in these cases, but the subject is to me a very interesting one, and therefore I wish to make these cases an excuse for giving you a lecture on the treatment of this disease.

The boy, æt. 7, had a fairly sharp attack, involving the whole of the left lung. He was admitted on the third day of the disease, and the crisis happened on the ninth day. His temperature which was controlled by an ice-bag on the abdomen, ranged from 102° to 104° Fah., his pulse 140 to 160, and his respirations 40 to 60. His breathing had the character which you often notice in this disease in children, viz., it was catchy and at the end of the inspiration there was a distinct pause. This, as I have often pointed out, renders great assistance to the right side of the heart, which is very much needed by these small weak hearts. He had herpetic spots on the lips and tongue. He is now convalescent.

The youth æt. 17, was admitted April 25th, 1907, suffering from well-marked cardiac failure accompanied by urgent dyspnœa. He had rheumatic fever, several times during the last fourteen years, accompanied on more than one occasion by endocarditis and pericarditis. He has now a double aortic murmur, dilated and hypertrophied heart, mitral pre-systolic and systolic murmurs, and a dilated left auricle, adherent pericardium, and well-marked *pulsus paradoxus*. On May 2nd his temperature which had previously been subnormal, ran up to 100.8°, pulse 150, and respirations 36. When I saw him the following day his temperature was 103.2° Fah., pulse 160, and respirations 40. There were the usual signs of pneumonia of the left lower lobe. Dr. Baker had found pneumococci, streptococci, and staphylococci in his sputum. We did not examine his blood for lime salts, but there was no doubt in my mind that they were deficient as his expectoration was very hæmorrhagic, and he had slight epistaxis. He was therefore put on a mixture of calcium chloride and the tincture of the perchloride of iron. There was a large mustard poultice applied as a counter irritant to the left back, and he had an injection of 10 cc. of a polyvalent anti-streptococcal serum. The patient looked very ill, but I told my house Physician that in my experience valvular heart disease in young people did not much increase the gravity of the prognosis in a case of pneumonia. In these cases the heart muscle is healthy, and responds well to treatment, but it is quite a different matter when you have to deal with a fatty or fibroid heart. On the following day his temperature became normal, and in the evening rose to 100°, and on the 5th became subnormal, and has since continued so. This is a good example of what can be done if you get hold of a case early and treat it energetically. It also shows you that the pneumococci are not the only organisms which can give rise to pneumonia.

The man æt. 40 suffered from pneumonia of the right lower and middle lobes, with slight pleuritic effusion, in the right side. He is a very spare delicate man, had an attack of pneumonia nine years ago. This attack began on April 27th, and the crisis occurred on the night of May 3rd. His highest temperature in hospital was 103.2, pulse 120 and respirations 44. His teeth were septic, he had a slight herpetic eruption on the lower lip, and his expectoration was mucopurulent. The lime salts in his blood were only in the proportion of 1 in 8,700 parts of blood. He was therefore at once placed on a mixture of chloride of calcium and iron.

I do not claim any special credit for the success of these three cases, the treatment of which was of the general routine character which you see in my wards, and you often see much more severe cases all of which have not such a happy termination. I therefore wish to-day to take a much wider view of the treatment of this disease, which in my opinion is one of the most important diseases which you will have to encounter when you enter into private practice.

The widespread prevalence of pneumonia and its fearful mortality must always make the study of the treatment of this disease an interesting one for medical men. The utter futility of all treatment in many cases should I think make us approach the subject from the standpoint of prevention, a line of action which has hitherto scarcely commended itself to the medical profession. There is a frequent cry in the present day that the general practitioner is being crushed between the upper and nether millstones of special practice on the one hand, and the hospitals and cheap dispensaries on the other. If the general practitioner is to be restored to his former position as the friend and counsellor of his patients, he must teach them that the preservation of health is even more important than the cure of disease, and that his income should increase with the healthiness of the community and the fall in the death-rate. In this way the interests of Society and the practitioners of medicine will be linked together, and the necessity for even the existence of the surgeon and the specialist must be a gradually diminishing quantity.

From this standpoint let us review the disease in question, the incidence of which according to Jürgensen, equals on an average 3 per cent. of all diseases, while the death rate stands at 6·6 per cent of the total mortality. These statistics would show that the percentage mortality of

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(a) Delivered at the Liverpool Royal Infirmary, May 7th, 1907.

pneumonia is more than twice as great as the average of all other diseases combined. In Liverpool, in 1905 the percentage death-rate of pneumonia to deaths from all causes was 9.7 whereas in 1896 it was only 7.6, and the deaths per 100,000 inhabitants in these two respective years were 187 and 172. The incidence and case mortality is rather increasing. The death-rate is usually put down at 15 to 25 per cent. If we reckon that one in six affected dies, then over 1 per cent. of the whole population of Liverpool is affected yearly. Why should anyone get this disease? It is an infective process for the most part due to the pneumococcus of Fränkel, though many other micro-organisms play an important *rôle* in its causation, such as the influenza bacillus, staphylococci, streptococci, and practically all the pathogenic bacteria. During the last sixteen years the prevalence of influenza has led to an increase of pneumonia. Here the inflammatory mischief is of a low congestive type and often rapidly fatal; but the bacillus of Pfeiffer does not seem to lead to the marked consolidation of the lung which takes place in cases associated with the pneumococcus of Fränkel. However, in these cases there is not infrequently a mixed infection. The pneumococcus usually exists as a harmless organism in the mouth and upper air passages. What, then, are the predisposing causes which give rise to its cultivated malignancy in the air cells giving rise to a disease which occurs in all climes? Its incidence is as great in some tropical countries as in northern latitudes. In this country it reaches its maximum about December and January, and is about twice as frequent in the winter and spring months as it is in the summer and autumn. It is less prevalent in the country than in the cities, and less among those who lead an outdoor life than among those whose occupations confine them to close apartments. It rarely arises at sea, and none of the polar expeditions seem to have suffered from it. Exposure to cold seems to lead to catarrhal affections rather than to true pneumonia; sudden variations of temperature may so depress the resisting powers as to become a markedly predisposing cause of the disease. It has been correctly asserted that exposure during sleep increases the predisposition to the disease, and this is no doubt due to the lessened resistance of the nervous system. This applies more especially to the aged and young, whose resisting powers are easily enfeebled. Consumptives and others who can keep the furnace burning within, readily withstand the cold air in their bedrooms, though cold draughts may readily induce catarrhal conditions. Frequent draughts of alcohol are, in my opinion, a much more important predisposing cause than any draught of cold air, and this may perhaps to some extent account for its somewhat greater prevalence among men than among women. While the incidence is less among women the mortality is greater perhaps owing to their having a smaller vital capacity. It frequently attacks those of strong constitution, but rarely when they are in good health, while the weak and debilitated are very prone to the disease. The way to prevent pneumonia is to increase the resisting power of the individual, hence you should encourage temperance or even total abstinence, and the avoidance of all debilitating agencies; have an abundant supply of fresh air night and day, maintain the body temperature by a proper supply of food and suitable external clothing, and warmth to assist the regulative mechanism of the body in maintaining and distributing the heat which it has generated. A fever patient may be packed in ice so long as the temperature is high, but if the treatment be continued after the temperature has fallen to normal you quickly get congestion and œdema of the lungs. When we see a big, plethoric, pot-bellied man, perhaps with a heart infiltrated with fat, and who gets out of breath on the slightest exertion, how often do we contemplate what poor chance such a one would have with an attack of pneumonia? It is the duty of the medical adviser of such an individual, to point out to him that he is living in a fool's paradise, and he must either never get pneumonia or be prepared for the struggle when it comes.

The mouth (including the teeth) and nares should be kept scrupulously clean; a foul-mouthed individual is liable to many troubles. As many of the micro-organisms which induce pneumonia are introduced by other paths than the respiratory passages all sources of pulmonary infection should be obviated. The prevention of pneumonia must alway rest with the medical adviser; the work of the medical officer of health can only be indirect by improving the general sanitary conditions of life, and in dealing with epidemics of the disease.

Your clientele will, however, get pneumonia, in spite of you, and we will now consider how we should deal with such a case when it does occur. Early recognition is of great importance. You must not keep hovering between conflicting opinions as to whether the patient has got pneumonia, or typhoid fever, or some other disease; waiting to see what will turn up. You must be prepared to treat the individual rather than the disease. You must find out the condition of every organ of his body. and if you do this the affection will not long escape your investigation.

A typical case with a flushed face, rapid breathing, high temperature, and a stabbing pain in the side is early recognised, but the majority of cases are not typical in their outset. In the young and aged errors most frequently occur, but with careful examination every case should be diagnosed within the first twelve or twenty-four hours. If you have any doubt in your mind as to what the case may turn out to be do not let your doubt interfere with your appreciation of the disturbances of the physiological processes of the various organs of the body. The febrile process and quickened respirations should arrest your attention.

This is a disease which varies very much in intensity and its prominent symptoms are more or less pronounced according as the individual is robust and plethoric, or weak and debilitated. But however the attack may arise the temperature affords a reasonable point of attack and I am strongly in favour of the increased dissipation of heat. It is therefore well to let the patient have a warm bath with plenty of soap, but if this be impracticable either from the condition of the patient or the environment he should be well washed, and the action of the skin encouraged by a diaphoretic mixture. If the temperature rapidly reaches a high level such as 104° Fah., the sooner a large ice-bag is applied to the abdomen the better Promptitude of action in the early stage often arrests the spread of the disease and may even arrest its further progress.

The question of blood-letting is one which perennially crops up, and I have no doubt in some few plethoric cases it does good. If it be deemed necessary in any particular case the sooner it is performed the better.

It should never be adopted after the first 48 hours, and never at any time if the pulse be small and feeble and compressible. Pneumonia in the female is often relieved by a commencing menstruation, and an epistaxis is occasionally beneficial. If at the beginning of the disease there be a full, bounding pulse and laboured respiration in a plethoric individual you may abstract 10 or 12 ounces from the arm. Venesection should not be performed on the very young, the old, or debilitated. After bleeding the patient should abstain from fluids for some hours. The cases, however, in which venesection is beneficial are few and far between.

VENTILATION.

The room should be the best in the house, and if possible should contain at least 1,000 cubic feet for each occupant, and the whole air of the room should be changed three times every hour. Often we find the patient, a nurse, and one or more friends in a small room of about 1,000 cubic feet, from which all fresh air is religiously excluded. How can a patient be expected to withstand such slow suffocation for a week? The physician may perhaps order 20 cubic feet of oxygen, which is equivalent to about 100 cubic feet of air, and may thus console himself that he is aerating the patient's blood. The air contains as much oxygen as the patient's blood can take up, and we have not merely to apply oxygen, but also to get rid of the carbonic acid which is best effected by an abundant supply of fresh air. Of what value are 20 to 60 feet of oxygen compared with 72,000 cubic feet of air, which supply the patient should have every 24 hours. I am pleased to think that the craze for cylinders of oxygen is dying out. There is no difficulty whatever in freely ventilating a room. Feverish patients do not catch cold, so that bugbear may be set on one side. Of course I would not recommend a draught of cold air to be played on the patient, lest it should set up a catarrhal condition or rheumatic pains. Night and day a stream of pure air should be admitted without creating draughts, I usually throw a window widely open. Dr. W. P. Northrup, a New York physician, has lately been treating pneumonia patients on the open roof of the hospital, for six hours a day in all weather, when harsh high winds, rain, and snow did not prevent.

The atmosphere of the room should be maintained about 60° to 65° Fah., by a large fire. The ordinary atmosphere at this temperature is not saturated with moisture and is therefore capable of holding the patient's exhalations, and there is not much danger of him drowning in his own excretions. I have never found the atmosphere in this climate so dry as to require any additional moisture. The man who invented the bronchitis kettle should have been hanged; death from strangulation would only have been a fair return for the number of deaths from drowning caused by his appliance

So long as a strong light or radiant heat from the fire is not playing on the patient, the more bright and cheerful the room the better. I do not believe in converting the bedroom into a dark chamber, which makes it difficult for the patient to distinguish day from night, and is apt to give him the impression that he is cast into outer-darkness. If the patient has a comfortable night he will not require much sleep during the day.

Whatever means be adopted for dealing with the temperature of the patient it should be kept within moderate bounds, as high temperature leads to granular degeneration of the heart muscle, sleeplessness, delirium, and nervous exhaustion. It is often sufficient to keep the patient very lightly clothed, and then allow free escape for the evaporation of the sweat which thus carries off a large amount of latent heat. All eiderdowns, cotton wool, waterproofs, and every impervious covering should be avoided. A large moist poultice, if the patient be lightly clothed and evaporation allowed to take place freely, removes a great amount of latent heat. The object should be to cool the patient, not to keep the poultice warm. However, I have almost abandoned poultices as they disturb the patient too much, and for the reduction of temperature I prefer the use of ice-bags to the abdomen. I usually apply a pure mustard poultice for half an hour as a revulsive agent at the begining of the disease.

(*Part II., conclusion, will appear in our next issue*).

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Sir James Barr, M.D., LL.D., F.R.C.P., F.R.S.E., Senior Physician Liverpool Royal Infirmary Chairman of the Medical Faculty of Liverpool University, President of the Lancashire and Cheshire Branch, British Medical Association. Subject: "The Treatment of Pneumonia," concluded.*

ORIGINAL PAPERS.

OBSERVATIONS ON THE OPERATIVE TREATMENT OF INFLAMMATORY DISEASES OF THE UTERINE APPENDAGES, BASED ON A CONSECUTIVE SERIES OF 120 CASES.

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In discussing the subject of the surgical treatment of inflammatory conditions of the ovaries and Fallopian tubes, it is, happily, not necessary to begin with a vindication of the justifiability of this treatment. This has been settled by medical public opinion, on the basis of the work of pioneers in this branch of surgery. I feel, however, that it is fitting that in making some observations which are the outcome of my personal experience, I should linger a moment on the threshold to pay a whole-hearted tribute to one of the most eminent of those pioneers, who gave me my first instructions in gynæcology as a student, and whose stimulating enthusiasm led to my taking up the special branch of medicine in which he was a master. I refer to my honoured teacher and friend, Dr. C. J. Cullingworth.

Some fifteen years ago Dr. Cullingworth read before a sister society an important communication on "The Value of Abdominal Section in Certain Cases of Pelvic Peritonitis, based on a personal experience of 50 Cases," with an appendix giving the results of a second series of 50 cases. It was a masterly contribution, involving an enormous amount of work, and gave rise to a heated discussion in which Dr. Cullingworth, like most pioneers, came in for a great deal of adverse, I might almost say, hostile, criticism. But the criticisms were not all adverse; three speakers entirely concurred in Dr. Cullingworth's views and it is interesting to note that these three—Mr. Mayo Robson, Dr. Heywood Smith, and Prof. J. W. Taylor—have since then been presidents of the Society. I think that there is no doubt that Dr. Cullingworth's teaching has been accepted by the great majority of the profession as well as by nearly all gynæcologists of the present day; and that the surgical principles which are adopted, for example, with regard to a diseased appendix are considered equally binding in dealing with diseased Fallopian tubes. Further, with the great reduction in operative mortality it has been conceded that women have a right to ask relief from conditions that rob them of health and usefulness as well as from those that directly threaten their life.

Many conditions of chronic non-suppurative disease of the tubes impair health; and many suppurative conditions imperil life; and I have made this distinction the primary basis of the classification of my cases. Being relieved by foregoing considerations from the necessity for pleading justification for surgical treatment, it is not necessary that I should present a detailed review of the cases; it will be sufficient if I present, as a text, a tabular statement of them, referring more fully to such as illustrate my observations in some special fashion.

The classification of the cases on the list is as follows:—

I.—Non-Suppurative Conditions.
1. Salpingitis.
(*a*) Unilateral disease 11
(*b*) Bilateral disease 16 (1)
———27 (1)
2. Hydrosalpinx and Tubo-ovarian cyst.
(*a*) Unilateral disease 3
(*b*) Bilateral disease 10 (1)
———13 (1)
3. Tuberculous salpingitis 6 (1)
—— 46 cases. 3 deaths
II.—Suppurative Conditions.
(*a*) Unilateral disease 12 (2)
(*b*) Bilateral disease 62 (2)
———— 74 cases. 4 deaths
Total .. 120 cases, 7 deaths

I realise that against any scheme of classifying such cases some objection could be urged; this one is a clinical classification based on operative diagnosis, and I have adopted it because it is a simple one, and because it shows sufficiently the type of cases dealt with. I propose to make some preliminary observations on each group before passing on to the consideration of some questions of operative treatment.

I.—Non-Suppurative Diseases.

1. *Salpingitis.*—The cases under the heading of unilateral disease present several points of interest. The main indication for operation was pain. It is noteworthy that a unilateral salpingitis is rare, as a primary condition; in Case 1. there was a return of the disease in the opposite side, and a second operation had to be undertaken (Case 2) a year and a half after the first. In Cases 7, 8 and 10 an ovariotomy had previously been done on one side, and in Case 5 a ventrofixation had been done; and it is possible that the salpingitis was a post-operative result. Case 11 was a hæmatosalpinx discovered accidentally in the course of an operation undertaken primarily for chronic retroversion. Case 3 was, judging from the history, undoubtedly gonorrhœal in origin; it is well known that gonorrhœal salpingitis is almost invariably bilateral. In the remaining three cases in this group, the origin of the salpingitis was unexplained; the remaining tube was obviously not seriously damaged, because two of the patients became pregnant subsequently. This fact has an important bearing on the question of conservative procedures, which I shall discuss later.

The cases of bilateral disease presented, on the whole, similar characteristics; the tubes were enlarged, occluded and adherent; in half the cases the uterus was in a condition of retroversion with fixation; and in several of the cases there were bowel adhesions. All the patients complained of frequent or constant pain and chronic disablement. In cases 5, 12 and 16 the appendix was involved, probably secondarily. Case 3 presented a remarkable condition, which I have not met with before or since; each tube had a distal blunt end, exactly like a vermiform appendix, and a little further out was found the proper distal end of the tube, with its fimbriæ. The appearance suggested that the tubes had been constricted and divided by adhesion bands; but no such bands were present. There was no evidence of inflammation in the tubes and I made an artificial ostium in each by making a longitudinal incision and suturing the mucous to the serous layer.

2. *Hydrosalpinx and Tubo-Ovarian Cyst.*

Hydrosalpinx, like salpingitis, is rare as a unilateral affection, and it is rather a curious instance of cases occurring in groups that three cases in this list were operated on within a few days of each other. In all three cases operation was undertaken primarily for uterine displacement, namely, for chronic retroversion, for fatal procidentia, and for fixed retroversion respectively, and the hydrosalpinx was discovered incidentally.

There were 10 cases of bilateral hydrosalpinx and tubo-ovarian cyst. I have grouped the two conditions together, inasmuch as a tubo-ovarian cyst may be regarded as originating from the fusion of the hydrosalpinx with an ovarian cyst. Operation in these cases was undertaken on account of chronic pain and disablement associated with obvious enlargement of the uterine appendages; the diagnosis before operation was "chronic disease of the appendages," for it is not possible before operation to make a definite diagnosis of hydrosalpinx or tubo-ovarian cyst. The physical signs are identical whether the tubes are distended with clear fluid or contain pus; in some acute cases with febrile symptoms it is possible to diagnose pyosalpinx, but in chronic cases of this condition there is usually no rise of temperature, and the presence or absence of pus is a matter of surmise. These cases did not present any features calling for special comment, except No. 3, which will be referred to when discussing the mortality of the operation, and none of them admitted of the carrying out of conservative procedures.

3. *Tuberculous Salpingitis.*

In the paper previously quoted, Dr. Cullingworth advocated the removal of tuberculous tubes when there was no evidence of the disease elsewhere in the system; and though some speakers in the discussion dissented from this view, it is the accepted teaching at the present day. That it may have excellent results is illustrated by the first case on the list; I saw her recently, 10½ years after the operation, and she was well and strong in every way, and had shown no further signs of tuberculosis. Case 3 was in an advanced cachectic state, with a sinus in the loin; and operation was undertaken rather with a view of giving her some relief than with the hope of cure; but she rapidly sank from exhaustion and systemic infection. Case 6 was a remarkable one, in that the disease appeared to be confined to the pelvis; the tubes were enormously distended with caseous material. But within a few weeks of the operation she developed all the symptoms of acute miliary tuberculosis, from which she died not long afterwards. The disease was bilateral in every case save one (No. 4); as the left tube in this case appeared to be quite healthy I decided to leave it, and I have not so far heard her later history.

II.—Suppurative Diseases—Pyosalpinx and Suppurating Ovarian Cysts.

Suppurative, like non-suppurative disease of the appendages, is much more common as a bilateral than as a unilateral condition; it will be observed that only 12 out of 74 or 16.2 per cent. of cases of suppurative disease were unilateral. Taking the whole series of cases, 27 out of 120 or 22.5 per cent. were unilateral.

Taking the unilateral suppurating cases first, it is rather a remarkable fact that five of them, namely, Cases 5, 6, 7, 9 and 11, were *post-partum* cases in which operation was done from three to six weeks after confinement. Yet in none of these five was there any evidence of septic infection from without conveyed during labour; they all appeared to be instances of the recrudescence of tubal disease antecedent to the labour; but I think it probable that the recrudescence was due to the disturbance of anatomical conditions produced by the rapid change in position of the fundus from the epigastrium to the hypogastrium. Such cases, of course, give the medical attendant the gravest anxiety, and may cause him to be unjustly blamed for a condition of puerperal sepsis over which he had no possible control. Another striking fact is that in 9 out of 12 cases there was suppurating ovarian cyst or ovarian abscess complicating the pyosalpinx. The cases of bilateral suppurative disease form just over a half of the whole series of cases of tubal inflammation. I cannot give precise particulars concerning the bacteriological origin of these conditions, but from clinical data I can safely say that the great majority were due to gonorrhœal infection.

Most of the cases presented somewhat similar characteristics; there was pain and disablement of long standing with subacute exacerbations from time to time, and a condition of chronic pyosalpinx was found on operation. Some of the cases, however, presented points of special interest. Only two of the cases, Nos. 25 and 36, were *post partum*; in neither of them was there any evidence of infection from without during labour. Case 36 was already in a septicænic condition when operation was undertaken as a last resource; the origin of the disaster appeared to lie in a dermoid cyst which suppurated after delivery, and perforated into the peritoneal cavity, leading to a large retro-uterine abscess. Counting this case there were in all 15 out of 62, or 25 per cent., in which pyosalpinx was complicated by a suppurating ovarian cyst or tubo-ovarian abscess. One case, No. 22, was complicated by a retro-cæcal abscess and acute peritonitis, in a young girl of 17; the association of the different conditions was difficult to explain. Case 30 was remarkable in that the uterine wall contained an abscess, and the whole uterus was in a septic condition and so rotten that it was with great difficulty that sutures could be got to hold. In Case 18 the double pyosalpinx was complicated by an extra-uterine gestation, the sac lying in the pouch of Douglas, and closely incorporated with the uterus. All the structures were in an extraordinary tangle, and the only way out was to do a total extirpation of uterus, sac and appendages. Case 44 led to an erroneous diagnosis. A few years previously I had removed by vaginal myomectomy a large fibroid lying in the vagina with a pedicle attached to and partially inverting the fundus, and completely filling the pelvis. When she presented herself again with a large pelvic tumour, apparently incorporated with the uterus, I diagnosed uterine fibroids; but it turned out that the swelling was due to greatly distended pus-tubes closely adherent to a normal-sized uterus. Case 51 was remarkable in that she was seized with sudden pain and collapse exactly like that produced by a ruptured tubal pregnancy, and that was the diagnosis on which I was sent for to operate. The physical signs were consistent with that diagnosis, but the menstrual history was not characteristic. In Case 53 a pelvic abscess was opened by the abdomen and drained by my colleague, Mr. Walter Edmunds, the patient's condition being too bad to admit of exact location and removal of the source of the abscess; a discharging sinus persisted for some time, and Mr. Edmunds asked me to take over the case as he considered that the abscess had a tubal origin. I was able to trace the sinus down to the left tube and remove the tube and sinus in one piece. The right tube was also affected. In Cases 54 and 56 the tubes presented the naked-eye appearances of caseous tuberculous pus-tubes. I had a pathological report on both cases from the West End Pathological Laboratory, to the effect that there was no evidence of tuberculosis. The condition is so unusual apart from tuberculosis that I have brought the specimens to show to the Fellows of the Society.

This group contains some of the most difficult and anxious cases in which I have had to operate; one is always confronted by the danger of injury to adherent bowel, and by the fear of infection from pus sacs rupturing during the operation. Fortunately, the latter danger is minimised by the fact that in many cases the pus is sterile; but it is not always so and in some cases conditions of acute peritoneal infection prevailed. The comparative safety with which many of these may be dealt with may properly be regarded as one of the triumphs of modern surgery.

Mortality. This question of safety leads me to speak of the mortality attendant on these operations. Taking all the cases together without regard to the question whether the deaths were preventible or not, the tables show a mortality of 7 cases in 120, or 5.8 per cent. Taking the individual fatal cases in chronological order, the first was No. 3, Table II a, in May, 1900; death resulted from septicæmia, probably to be attributed to contamination of the field of operation by the pus that was present; drainage was done through the vagina, by an opening in the pouch of Douglas. The second case was in the tuberculous group (No. 3, Table I., 3). I have mentioned the fact that the patient was already in an advanced and hectic condition. This death occurred in October, 1900. The third was in January, 1902 (No. 3, Table I., 2*b*), and may be described as a death from misadventure; the patient developed post-operative mania and while she was being fed, some food entered the trachea and she died almost at once.

The fourth was in January, 1903 (No. 5, Table II*a*). The patient was in a condition of septicæmia before the operation, and from this she died. The fifth was in March, 1903 (No. 4, Table I., 1*b*); there was a good deal of oozing from the site of adhesions, and as she was showing signs of collapse some hours after operation, transfusion was resorted to. I think it probable, looking back on the case, that this transfusion was ill-timed, and started fresh bleeding, which led to a fatal syncope. The sixth case was in May, 1904 (No. 30, Table II*b*), and death resulted from the shock of a severe operation, associated with a good deal of hæmorrhage; the difficulty in hæmostasis arose from the fact that all the structures in the pelvis were inflammatory and rotten. The seventh death, which occurred in November, 1904 (No. 36, Table II*b*), was in a case where septicæmia was present before operation, as the result of a suppurating dermoid perforating into the peritoneal cavity.

In operations of this kind some deaths are inevitable, particularly when the operation is undertaken too late, as was clearly the case in the second, fourth and seventh cases. It is probable that experience and improved technique tend to a lower mortality; at any rate, the tables show six deaths among the first sixty cases operated upon, and one death in the second sixty cases. The 74 cases of suppurative disease compare favourably with the others as regards the mortality, with a fatal percentage of 5.4 against 5.8 on the whole series. The last fatal case was just 2½ years ago; but just as I do not seek to extenuate the failures, so I do not claim credit for the successes, for I recognise that there are times when one is aided by good fortune, just as there are times when one may have a succession of cases foredoomed to failure. While on this subject I may express my conviction that if one's work is done with an eye to statistics, it is conceived in a wrong spirit and will prove faulty in practise. I take it that all that is required of us is that we should treat each individual patient in such a way as seems likely, taking all circumstances into consideration, to give the best chance of saving life and restoring health in that case, remembering that the issues of life and death are not given unreservedly into our hands.

The Scope of Conservative Surgery.—On this important question I accept it as a fundamental axiom that every operator must be allowed complete discretion as to how much or how little he will do in any case ; and so I will here give only my own impressions and practice without pretending to lay down the law for others. My first belief is that it is not necessary to remove the uterus in every case in which both tubes and ovaries are removed. In most cases the removal of the uterus means a more prolonged and severer operation ; and if the uterus is not seriously affected, it does not harm when left *in situ*, but, on the contrary, helps to preserve the integrity of the pelvic floor. In some cases in which endometritis has been present, curetting has been subsequently required ; this was done in several of my cases, and I do not regard the possibility of this contingency as a sufficient reason for a routine removal of the uterus. I shall refer to this point again when speaking of technique. In the second place I have but little confidence in the value of salpingostomy in cases where the tubes are occluded by the inflammatory process ; and even when the abdominal ostia are still patent, I prefer not to leave tubes that are obviously in a condition of chronic or sub-acute salpingitis ; because it appears to me that such tubes have lost the power to be functionally useful, and if they are left behind, a probable source of future trouble remains. I regard such tubes as I regard the appendix, and consider that the patient's interests are best safeguarded by their removal. Thirdly, when the appendages of one side are not obviously diseased I prefer to leave them untouched, even though the opposite tube may contain pus. It is true that this course may occasionally necessitate a second operation ; but on the other hand there is a definite chance that the appendages that are saved may be serviceable, as in two of my cases where pregnancy followed the operation. I think that the value of conservative surgery in these cases is not nearly so problematical as it is when applied to tubes that are obviously affected.

Fourthly, it seems to me to be good practice to leave the ovaries whenever it is possible, even when the corresponding tubes are so diseased as to require removal. For although the possibility of child-bearing may be gone, convalescence goes on more smoothly when a normal ovary is left, and the patient is saved the disagreeable sequelæ of an artificial menopause. In many cases, of course, both ovaries are so intimately involved in the inflammatory process affecting their tubes, that to leave even one of them is out of the question. But in such cases there is also less reason for saving them, because I believe that the removal of diseased ovaries has far less effect on the system than the removal of healthy ones.

Technique of the Operation.—In most of these operations the most serious difficulty that presents itself is the *separation of adhesions*. Coils of intestine, both small and great, may be intimately adherent to pus-tubes and to the back of the uterus. Sometimes the peritoneal surface of the bladder is involved, and the utero-vesical space is completely obliterated ; and, indeed, the summit of the bladder may overlie the fundus and be so adherent to coils of bowel behind it that the uterus is quite buried. The adhesion of bowel to pus-tubes sometimes represents an attempt at the evacuation of the abscess cavity through the intestine, and the wall of the tube may be, in fact, perforated, so that the separation of adhesions may be the signal for a copious discharge of pus into the field of operation. As a preliminary step, therefore, before the separation of adhesions is commenced, swabs should be packed round in such a way as to shut off as much as possible of the peritoneal cavity from the field of operation; and if a pussac is tapped, the pus should be mopped up as quickly as possible. In separating adhesions, the body of the uterus should always be taken as the starting point ; by working down behind it the best planes of cleavage will be reached. When the bowel has been cleared off from the back of the uterus and tubes, the next thing is to peel off the tubes from the back of the uterus and broad ligaments, and this is best done by working from below upwards. Before this is begun, it is often a good thing to isolate the outer extremity of the broad ligament and place a clamp on the ovarian artery, because the structures are often brittle, and it is easy, when peeling the tubes off from below, to tear through the ovarian artery, which then retracts in such a way as to make it a very difficult matter to secure it, and meanwhile troublesome hæmorrhage goes on, which obscures the field of operation and causes great delay. When the tubes and ovaries have been freed, the way of dealing with the pedicle may vary according to the extent of the disease in the tubes and the amount of infiltration of the broad ligament. When the uterine end of the tube is relatively unaffected, and the broad ligament is not infiltrated, it is often sufficient to treat the pedicle by transfixion, as in ovariotomy, leaving a short stump of the tube. As a precaution the tubal stump may then be swabbed over with some antiseptic, to minimise the chance of infection. When the uterine ends of the tubes are distended with pus, and the broad ligaments are infiltrated, it is a good plan to cut through the broad ligament from without inwards, each cut being preceded by the application of a clamp below the line of division. When the tubal attachment to the uterus alone remains, it should be cut right out of the uterine cornu by a V-shaped incision, and the edges of the wound in the uterus brought together by mattress-sutures. This process of *resection of the tubes* was adopted in nine of my more recent cases. A chain of sutures is then passed along the broad ligaments below the series of clamps.

When the tubes have been enucleated from the back of the uterus there is apt to be some troublesome oozing, which often arises from some vertical tear in the angle between the uterus and broad ligament. This is best dealt with by a mattress suture bringing the edges of the tear together ; and it should be done before the rest of the broad ligament is sutured because otherwise the tear is buried in a hollow and is very difficult both to see and to sew.

When the uterus is so adherent to the tubes that the removal of the latter leaves a badly damaged and bleeding uterine surface it is often both safer and quicker to remove the uterus than to attempt to stop the hæmorrhage merely by ligatures. The uterus will also require removal in certain other conditions, such as when it is septic or the seat of fibroids. I had occasion to remove the uterus as well as the appendages in five cases, one of which was the case of septic uterus before-mentioned. In one case (No. 11, Table II *a*), there was an abscess cavity involving the right tube and a part of the right uterine wall ; and the whole of the right cornu of the uterus was removed with the tube.

When the tubes have been removed, there is sometimes a tendency for the uterus to fall back into the pouch of Douglas ; and a good deal of subsequent pain and discomfort may be avoided by fixing the fundus to the anterior abdominal wall.

Injuries to bowel may require to be dealt with, by carefully suturing a rent in the serous coat when this is alone involved ; or by more extensive suturing or even by resection of a piece of bowel when the cavity of the bowel is opened up. Even when every precaution is taken, a fæcal fistula may follow ; of this I had several experiences. Such fistulæ almost invariably heal spontaneously. Less frequently the bladder wall may be damaged and require suturing.

There are only two other points of technique to which I wish to refer, namely, *flushing* and *drainage*. The conclusion at which I have arrived with regard to flushing is that its use should be limited to cases of tuberculous salpingitis with hydroperitoneum. Here the whole peritoneal cavity or such part of it as is involved in an encysted collection of fluid, is affected, and flushing with saline solution can do no harm, and I think it is likely to do good. In all other cases I believe that flushing entails extra risk, by conveying septic matter to non-infected regions. With regard to drainage, I have come to the conclusion that it is best avoided in tuberculous cases ; after the flushing out, I think it is well to mop out the fluid and close the abdomen. In other cases, drainage has a decided field of usefulness, but there are cases where it is better omitted. The practice which I have formulated for myself is that when there has been no contamination by pus, and adhesion sites are not oozing, and the bowel has not been damaged, the abdomen can be safely closed. When there is a tendency to oozing, I put in a gauze drain to serve as a warning in case of bleeding; it is removed at the end of twenty-four hours if no bleeding has occurred. When bowel has been damaged, a gauze drain is left in for forty-eight hours or a little longer, so that if a fæcal fistula should become established there will be a means of exit for the fæcal matter. In cases of acute septic peritonitis, I use a large rubber-drainage-tube, which is left in for forty-eight hours, and at the end of that time a smaller one is put in if necessary. In cases of this kind we have a valuable help to treatment in what is known as *Fowler's position.* Almost as soon as the patient has recovered consciousness she is placed in as upright a sitting position as possible; by this means the septic matter has the least chance of reaching the vulnerable area of the peritoneum, which is the under-surface of the diaphragm; and the success of the treatment is further assured by repeated rectal injections of saline solution. I do not wish to discuss at any length the after-treatment of these cases, but I should like just to say that in my opinion the best results in cases of septic peritonitis are obtained by the administration of calomel in small repeated doses of $\frac{1}{6}$ of a grain given every hour for five or six hours, on the day after the operation; and by the most strict abstention from morphia in any form.

In order to be really complete, a consideration of the surgical treatment of inflammatory diseases of the uterine appendages should comprise a statement of after-results; but this is in itself such a large and important question that it requires to be dealt with separately. If further apology be needed for leaving it out of present consideration, I may say that for many years I have been collecting data on this subject, which I hope to deal with on some future occasion.

In conclusion, if the personal note has been rather too dominant in these remarks, I can only plead as my excuse that the scope of my paper and the time at my disposal did not admit of much more than a narration of my own experience.

A MEDICO-LEGAL DEFINITION OF INSANITY.

By CLEMENT H. SERS, M.R.C.S., L.R.C.P.,

Brighton.

THE opinion entertained by so many that there exists an insuperable difficulty in rendering a satisfactory definition of insanity requires qualification, as the idea may after mature thought turn out to be untenable. That the question is one of paramount importance in a medico-legal sense, so as to prevent confusion of thought when the alienist and jurist are confronted one with another, and hence to induce mutual understanding there can be no gainsaying.

It will be observed that the real or imaginary difficulty in defining the word insanity, assuming there is a difficulty, is by no means limited to this identical word, and this, for the obvious reason that very many other qualifying words (if indeed, not all) admit of two or more meanings, on account of which any given word generates different ideas according to the grade of mind. For example, the common conventional term "Christian," one person will insist upon defining this as one who believes in the christian creeds as propagated by an exclusive sect. Another, as in the case of the late Mr. Gladstone, would define it as a belief in the founder, and yet a third probably endowed with nothing beyond a philanthropic and benign disposition, and may be, morally speaking, as sound as a roach, equally insists that he too is embraced by the same definition, although concerning any actual belief in creeds, he may be next door to an infidel. We may also remember the difficulty in defining midwife. Thus we see what different shades of thought give colour to the same expression.

It should, perhaps, once for all be admitted that no scientific or psychological definition could be advanced which would ensure general assent. Neither would it serve any useful purpose. Certainly not for medico-legal purposes. The reason whereof as everybody knows is that mental processes are so complex and incomprehensible in health. Moreover, the connection between what we call mind and matter so inseparable and subtle, that it would be an impossible attempt to unravel these in diseases, or to express in the same breath the numerous phases of mental aberration. This consideration affords no reason why a medico-legal definition cannot be formulated which, except amongst sophists and strawsplitters, might create mutual understanding between lawyers and medical men.

Now a definition after all said is no more or less than an attempt at the most lucid explanation of a general term or word according to the definer's meaning and within compass of as few other words as possible. Consequently our aim is, or should be, to achieve this. By insanity is meant in its *broad* acceptation (and in this respect jurists, alienists, and even the general public are on equal ground) to denote the distinction in conduct and ideas of one or more individuals compared to others, of course of the same nationality, some of whom in contradistinction, are designated as sane, and others insane. The fact that jurists and legislators will not altogether agree to our selection or classification; on the contrary arrange their own category, regarding some sane whom alienists regard as insane, is no fault of ours, and is altogether another question, otherwise some crimes, needless to specify, might by the general consensus of expert medical opinion absolve the culprit from moral responsibility. For this there is no remedy, so if jurists in their wisdom think wise to overrule those who have made mental conditions their special study and avocation, indeed, who may be said to have spent their lives in company with the insane, we can only hope more enlightened times may turn such from the error of their ways.

Now to come to the point as to a medico-legal definition, the writer might refer to a correspondence in the MEDICAL PRESS AND CIRCULAR of July 13th, 1904, under the headline "Insanity, a practical definition," in which he then attempted to define insanity for the purpose in question *as a morbid condition of mind requiring supervision*, but which might perhaps be better described as a *morbid condition of mind subject to legal intervention.* Several notorious cases concerning abnormal minds have since occurred. Moreover, Dr. Savage, in his lecture before the Royal College of Surgeons, published in the *Lancet*, March 30th, offers some significant and noteworthy remarks, both of which circumstances, indeed, appear to give countenance to the suggested definition, and, indeed, revived the subject in the writer's mind. Thus Dr. Savage, without discussing the question of definition, although incidentally criticising the articles of the *Times* writer on insanity says, "The true difficulty is that the disease insanity as a definite entity does not exist, yet one might almost conclude from the elaborate articles which have appeared in our leading daily journals that it does, and that it is as definite in its symptoms and origin as cancer and pulmonary consumption."

It will be observed, therefore, that the definition advanced makes no pretence of revealing any specific disease or "definite entity." Nor does it refer to causation or pathology, and so far conforms to Dr. Savage's enunciation and teaching. Indeed, for purely medical purposes it might almost suffice to define insanity as *a mental symptom of disease*, somewhat analogous to jaundice, regarding both as mere symptoms. Neither does the definition necessarily imply personal restraint, so would include the recent case of a nobleman, when the law intervened with regard to direction of affairs, at the same time granting personal freedom. Further, as in the case of a very intelligent bachelor lawyer, a landowner, who was prepossessed with the idea that there was an intrigue to poison him, who nevertheless conducted his own household and affairs with admirable circumspection, the law might, in such a case, and no doubt would, under favourable circumstances, remain inert. Supposing, however, such a man executed a will depriving his next-of-kin of their natural expectations, the intervention of the law might be sought, and the will invalidated in favour of the surviving heirs, the definition meeting the exigencies of the case. The report in the daily papers of a medical witness having been asked "What is insanity?" and expressing his inability to reply, would probably prejudice a jury as to the value of the evidence which might be tendered, whereas an answer to the question "I mean by insanity a morbid condition of mind subject to legal intervention" might release a witness from the loophole leaving him free to explain the morbid conditions.

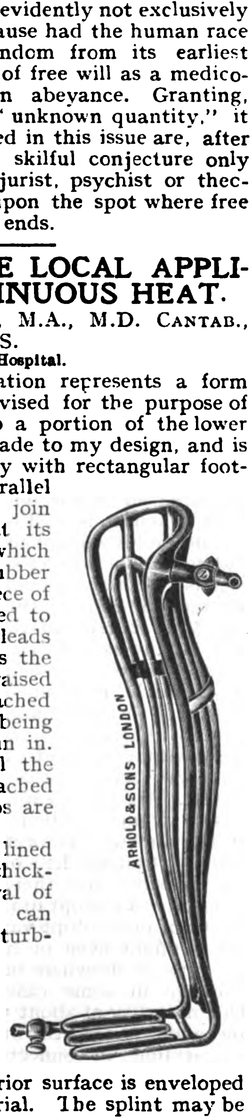
In conclusion, there can be no doubt that the most thorny point within the whole range of medical jurisprudence a witness may be called upon to speak definitely is: Is, where no definite delusions exist, the supposed insanity hinging upon moral responsibility? That this responsibility or will power is a limited capacity there can be no two questions, as numbers of crimes are committed through the influence and persuasion or instigation of others, but for which such crimes had never been committed. Further, the law recognises this limitation in placing meditated and unpremeditated crimes in different categories. Moreover, freedom of will power is evidently not exclusively a theologian's hypothesis because had the human race maintained complete heathendom from its earliest transit till now, the question of free will as a medico-legal one would still be in abeyance. Granting, therefore, this freedom an "unknown quantity," it follows all cases solely involved in this issue are, after all said, subject to the most skilful conjecture only because neither the alienist, jurist, psychist or theologian can place his finger upon the spot where free will begins, neither where it ends.

A SPLINT FOR THE LOCAL APPLICATION OF CONTINUOUS HEAT.

By J. F. HALLS DALLY, M.A., M.D. Cantab., M.R.C.S.

West London Hospital.

The accompanying illustration represents a form of splint which has been devised for the purpose of supplying continuous heat to a portion of the lower limb. The splint has been made to my design, and is of the posterior gutter variety with rectangular foot-piece, and is made of parallel lengths of lead piping, which join a marginal tube, having at its proximal extremity a tap, to which may be attached an india-rubber tube and funnel. Another piece of indiarubber tubing is attached to the tap on the foot-piece, and leads into a receiver which catches the overflow. The funnel is raised above the level of the tap attached to the foot-piece, both taps being open, and boiling water is run in. As soon as the splint is full the water runs out of the tube attached to the foot-piece. Both taps are then closed.



The splint is previously lined with flannel to the required thickness, and by periodic renewal of the hot water supply, which can be accomplished without disturbing the patient, the flannel is heated, and continuous dry heat thus applied to the limb. This latter is immobilised in the splint by some form of suitable appliance, and, if necessary, its anterior surface is enveloped in some non-conducting material. The splint may be also used for the continuous application of cold after the manner of Leiter's coil. Reference to a case of post-typhoid venous thrombosis, under the care of Mr. Keetley, in which this splint was used with advantage for the purpose of supplying continuous heat, will be found in the *West London Medical Journal*, Vol. XI., 1906, p. 330.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

Tuberculous Epididymitis with affection of the vesicula seminalis.

By Joseph Cunning, B.S., F.R.C.S.

Amongst the out-patients was a man, æt. 19, who complained of a swelling in the left testicle. He was quite well until nine weeks before, and since then he had noticed a gradual painless enlargement; there was no history of urethral discharge or of any injury. On examination the epididymitis was enlarged to about two inches in length; it was hard and nodular. The testis itself was apparently not affected. There was no fluid in the tunica vaginalis and the scrotal tissues were not adherent to the epididymis. The structures of the cord were thickened but no special thickening of the vas could be detected. The rectum was then examined, and the left vesicula seminalis was found to be thick, hard and nodular. Mr. Cunning said that the diagnosis of swellings of the testicle usually rested between three things: tubercle, syphilis and new growth, excluding of course acute inflammatory affections. With regard to new growth, such enlargements were more commonly found in the body of the testis, were uniform in shape rather than nodular and, of course, do not affect the vesiculæ seminales; the same remarks would apply to syphilis, excepting that in this disease the swelling was generally a localised one in the testis and not a general enlargement of the whole organ, and besides, other signs of syphilis were always present. With reference to tubercle, it could be laid down as a dogmatic law that chronic enlargement of the epididymis was always tuberculous. A point to be considered in differential diagnosis was the thickening of the vas; if this were thickened the symptom generally meant that the cause of the testicular swelling was tubercle, but it had been found in a good many cases that, although the vas was found to be uninvolved, the vesicula seminalis was already diseased; for this reason a rectal examination should never be omitted. To examine the vesiculæ seminales the knee-elbow position would be found the most suitable, for, with one finger in the rectum and the other hand on the abdomen, the vesiculæ seminales can be felt very thoroughly. It would be found useful, he pointed out, in a doubtful case to express the contents of the vesicula seminalis into the prostatic urethra and then into the membranous urethra; next to get the patient to stand up, and then express the secretion into a clean test tube and examine the contents for tubercle bacilli. On inquiry into the symptoms of the case under consideration there was no pain or frequency of micturition, which roughly indicated Mr. Cunning said, that there was no spread of tuberculous disease to the base of the bladder. The treatment of such cases was, he remarked either palliative or operative: if the disease was confined to the epididymis it was reasonable to try the effects of hygiene and tonic treatment, which would consist in the patient living in the fresh air and sunshine and having at least three pints of milk per day, added to the ordinary diet; in addition, the patient ought to be inoculated with tuberculin R. 1–800 to the milligramme, according to the method of Sir Almroth Wright. Some cases certainly improve under this treatment, but a careful watch must be kept for any signs of extension of the disease; if this occurred no more time should be wasted, but resort should be had to surgical means, for the path of extension from the vesicula seminalis is to the bladder, and the tuberculous bladder is a much less hopeful case to treat than disease that is limited to the genital tract. In the present case Mr. Cunning proposed to at once excise the testicle, and the vas, as far as possible, and then proceed by a transverse perineal incision to excise the left vesicula seminalis. This latter part of the operation, he said, involved a very deep incision in the perineum, separating the prostate from the rectum until the vesicula was reached; the operation was helped by the presence of the disease, as the thick hard nodular vesicula was so much more easily recognised than the normal one.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Strangulated Congenital Inguinal Hernia in an Adult.—Mr. **Willmott Evans** operated on a man, æt. 42, who had been admitted for severe pain and vomiting. He had suffered for several years from an inguinal hernia on the right side, and he had worn a truss; the hernia had always come down when the truss was removed, but had been readily kept up as long as the truss was in good condition. A few months before admission the truss had become worn out, and though the patient still wore it, it did not suffice to retain the hernia when he made any great exertion; he was careful, however, to return the hernia as soon as possible after it came down. On the morning of admission, he had strained at stool, and whilst straining he had felt a sudden sharp pain in the hernia which came down in spite of the truss. When he attempted as usual to return the hernia, he found it would not go back; he had repeated two or three times the attempts at reduction. Within three or four hours vomiting commenced, though it was never urgent. As the pain continued, he came to the hospital in the afternoon, and was at once admitted. On examination there was found in the right groin a very definite swelling about the size of a hen's egg, with its long axis extending downwards and inwards internal to the pubic spine. There was no impulse on coughing, and the swelling was irreducible. The bowels had acted at the time of the onset of the symptoms, though the motion was constipated. The patient said he had passed no flatus since the initial attack of pain. The vomiting was slight, but it was readily evoked at any attempt at taking fluid. The man having been anæsthetised, a two-inch incision was made over the external ring; the intervening structures were cut through and the hernial sac was laid bare. When this was opened, the bowel was seen to be markedly congested, but it was readily returned after the neck of the sac had been enlarged by means of a herniotome. It was then seen that the cavity of the sac extended downwards by a narrow channel into which it communicating with the cavity of the right tunica vaginalis. The upper portion of the sac was dissected out, separated from the tunica vaginalis, and ligatured as high up as the internal ring. It was then cut through a short distance below the ligature. The skin wound was closed and dressed. Mr. Evans said that the anatomical arrangement of the hernial sac showed clearly that its presence was due to the non-obliteration of the funicular process, although attempts had been made at closure by the process, as was shown by the narrowing of the channel for an inch and a half above the testis, and the narrowness of the internal ring. When strangulation occurs in inguinal hernia, he pointed out, it is not rare to find that the hernial sac is really a partial or complete variety of congenital inguinal hernia, and not acquired, and the cause of this special proclivity to strangulation observable in congenital inguinal hernia of adults is, without doubt, chiefly due to the spontaneous attempts at closure of the funicular process; though these attempts have not sufficed entirely to obliterate the process, they are sufficient to lead to such narrowing of the canal that strangulation of the bowel passing through it is very liable to occur. When the sac of an inguinal hernia is entirely "acquired," the neck is certainly wider and strangulation is much less likely to occur; In the child, too, the softness of the surrounding parts tends to prevent such firm nipping of the included bowel as is needed to produce strangulation, therefore strangulation of congenital inguinal hernia is most commonly seen in the adult. With regard to the treatment pursued after the strangulation had been relieved and the bowel returned, he thought it worth while to say a few words. In his opinion it is not necessary in these cases to perform any of the recognised methods of radical cure, for, if the sac be ligatured as high as possible and the stump pushed back, recurrence does not occur, as the hernia itself was the result not of any true weakness of the abdominal wall, but it was induced by the presence of the unobliterated process. As soon as that process is removed no inducement for the recurrence of the hernia exists; therefore complete removal of the sac is amply sufficient for a radical cure.

The further progress of the case was uneventful, the patient leaving the hospital in the third week.

TRANSACTIONS OF SOCIETIES.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

Meeting held Thursday, May 9th, 1907.

Dr. Heywood Smith in the Chair.

Dr. A. E. Giles demonstrated two specimens of salpingitis referred to in his contribution and containing caseous pus. At the operation he thought the condition was due to tuberculosis as he had on non-tuberculous tubes. The pathological report, however, showed no sign of tuberculosis.

Dr. **Giles** then read his paper entitled

OBSERVATIONS ON THE SURGICAL TREATMENT OF INFLAMMATORY DISEASES OF THE UTERINE APPENDAGES,

based on a series of 120 cases, which will be found in full on page 560.

The **Chairman** said when papers were read giving details of work done, the personal element necessarily entered largely into the matter. Practitioners of the speciality learnt from each other, according to their personal idiosyncrasies and aptitudes, the ways of doing the operations, and in that way surgery was advanced in minor details.

Dr. **Machan** desired to express his thanks personally for the tables which had been placed before them. He had found the author's paper much more interesting because he had been able from time to time during the reading of it to turn to particular cases referred to. With regard to the ultimate results, there was no reason to expect that they would be less favourable. There was no doubt that gonorrhœa was the cause of an immense number of the cases of suppurative disease of the appendages. At the same time the difficulty of diagnosis in some of the cases of salpingitis or pyosalpinx and ectopic pregnancy had been insisted upon in various cases, and was a very important matter. He was disappointed to find that the author was so strong an adherent to the method of drainage by the abdomen in preference to that by the vaginal route. Drainage had of late been discarded in every case possible, but there were cases in which it was imperative to adopt drainage, and in certain cases one must not only adopt vaginal and abdominal drainage, but it might even be necessary to make incisions in the loins or elsewhere in order to secure perfectly free drainage in some cases of suppurative peritonitis. The mortality of about 5.8 per cent. seemed to be very low, and it was worthy of remark that this low mortality was attained in connection with conservative surgery. With regard to the remark about liberating adhesions from below upwards, he had noticed in recent literature that the difficulties were greatly removed if we began from below and then worked upwards. With regard to excision instead of simply cutting off the tube, excision of the tube from the cornu of the uterus was a most important point, and it rendered operation much safer for the patient. In reference to the remarks concerning hæmorrhage, sepsis, the healing of a fæcal fistula and especially about the use of calomel immediately after abdominal operations, he thought we all agreed about those points. There could be no doubt that the danger of "peritonism" was much less if calomel was administered comparatively early after the operation.

Mr. CHARLES RYALL said he discarded the suprapubic method of drainage some years ago, and resorted to vaginal drainage because whenever a drainage tube was left in there was weakness in the abdominal wall, where there might be a post operative hernia. He had seen so many cases in the past in which drainage was resorted to, by the abdominal wall and was followed by hernia, that he decided after some experience to give it up. It was easy to make a counter opening, and the simplest way was for the surgeon to do it himself, placing the scalpel flat on the fingers and passing it into the vagina. The danger of the vaginal route was that there was liability to sepsis, and that the vagina could not be kept aseptic. In a normal individual, if a posterior colpotomy were performed, there was no reason why sepsis should spread from the vagina into the abdomen.

Dr. SMALLWOOD SAVAGE said he had seen many post-operative herniæ, and his opinion was that if there was any other way of draining than by the abdomen such should be adopted. He believed that some cases as those of acute pyosalpinx should be treated by vaginal incision and drainage, because in a certain number of these cases the tubes and ovaries would assume normal functions, and many cases when treated in that way had had children subsequently. So that the sacrifice implied in a radical extirpation of ovaries and tubes was not in all cases necessary in pyosalpinx. There was a valuable medical treatment which Prof. Taylor brought before the Society some years ago, in 1899 he thought, and was still practising it with good effect. A great many cases of salpingitis were due to either pure gonorrhœal infection, or to a mixed infection of gonorrhœa and syphilis. Professor Taylor had found by experience that by giving mercury with iodides, a certain number of such cases, if not all of them, could in a reasonable time be cured. Of course, it was necessary to use care in the treatment because it was possible to miss a case of pyosalpinx. But where a patient could be given that medical treatment and there was improvement, how much better to leave that woman who was probably young with her tubes and ovaries. The author had said that pyosalpinx was probably the cause, or might possibly be the cause, of lighting up an inflammation *post partum*. He would suggest that inflammation of the pelvic peritoneum and of the different parts in the pelvis, was due either to gonococcus, or to a mixed infection, subsequently, or an infection *post partum* from the staphylococcus, which had passed through the uterus. The infection due to the gonococcus affected chiefly the tube, and might seal it up, when it became thickened, and then perhaps formed a pyosalpinx. But the infection which came *post partum* travelled through the uterus and through the lymphatics to the ovaries, and the appearance seen at operation was quite different. In the one case the tube was perhaps quite closed and contained pus, whereas in the other case the ovaries might be enlarged with follicular cysts, or it might be œdematous, and if there are any adhesions it was apart from the tube, rather attaching the ovary to the back of the uterus, or perhaps even the ovarian abscess was found. Those two clinical conditions were distinct.

Dr. MCNAUGHTEN-JONES said the battle was being waged with regard to pelvic surgery generally and that battle centred round one figure, whose name at that time was in every mouth, and who long before the period referred to by Dr. Giles,—nearly twenty-five years ago, after his classical paper was read in London on diseases of the ovaries and tubes—advocated removal of the adnexa for certain conditions. He referred to the late Mr. Lawson Tait. He liked always to pay his tribute of admiration to Mr. Lawson Tate, to whom was due the initiative in the surgery of the ovaries and the Fallopian tubes. The author referred to hæmatosalpinx, but he did not say in the paper whether that was in his opinion associated with ectopic gestation, or state that there was no evidence that it was, and he took it that Dr. Giles held the view that hæmatosalpinx occurred apart from ectopic gestation, a view in which he himself concurred, and in support of which he had several times brought forward cases to prove. Others were of opinion that hæmatosalpinx never occurred without ectopic gestation. Several times throughout the paper he noticed that Dr. Giles used the term "tubo-ovarian." He would like to hear whether those were true tubo-ovarian cysts. He thought the term should be limited distinctly to those cases in which there was a sac into which the Fallopian tube directly opened. He (Dr. Macnaughten-Jones) had met with one case of primary tuberculosis of the ovary without any affection of the Fallopian tube; he had met with two cases of primary tuberculosis of the tube and both women were alive now, though both were operated on several years since, and one of them had had children since. In each of those cases only one side was affected. The point made by Dr. Giles about the blunt end of the tube was a very interesting one. He had himself figured and shown at the Society a tube exactly similar to that, a constricted tube with a blunt end such as Dr. Giles had described, and in which there was no evidence of adhesion causing contraction of the tube. In Dr. Giles's case he took it there was an extension beyond the abdominal end, which was remarkable. Those cases where the tube was inverted on itself were very interesting and rare. In old interstitial salpingitis with great thickening of the tube, we had the same blunting and closure. In the cases he referred to there was not fluid in the tube. In some there was a hæmatosalpinx, the outer end of the tube being closed in the same way.

With regard to gonorrhœa, he believed that in many cases, assuming a married woman, neither husband nor wife had any suspicion of any infective condition arising from gonorrhœa, it had been a latent gleet which possibly had lasted for several years. With regard to all that had been said as to the difference between *post partum* gonorrhœa and gonorrhœa arising from direct infection, of that he had no experience in regard to the exact pathological distinction, but in a case which he brought forward at the Obstetrical Society he had the opportunity of seeing in the living what occurred in a case of recent gonorrhœal infection. It was a case in which he emptied the uterus for profuse gonorrhœa, and removed an encephalic fœtus; after dressing the uterus for some time, and when he thought she was well, she developed general peritonitis. He found the two Fallopian tubes full of pus. Of course the presence of the gonococcus had been previously determined. Lining the peritoneum on either side and parts of the broad ligaments was a soft layer of lymph, which was proved to be gonorrhœal, and which he peeled off with gauze. The tube was afterwards examined and found to contain a quantity of gonorrhœal pus. He could then see the pus exuding from the fimbriated ends of the tube. That was the only case in which he had the opportunity of seeing the pus exuding from the tubes. He removed both tubes and ovaries. The patient recovered and had no subsequent trouble. He next referred to Dr. Giles' seven deaths, because that was a matter of great importance. One took it for granted, and in fact one knew that every aseptic precaution which was possible or conceivable was taken. Still, sometimes it happens that a patient is lost, and it is always satisfactory to hark back in such an event and see if possible whether there has been any hitch from beginning to end in connection with the operative technique, which might account for the sepsis which was present. He confessed that generally in cases in which he had lost a patient he could detect some flaw or other in some detail on the part of either himself or assistant or the nurses. Sometimes it was the post-operative management which led to sepsis. Still we are able to console ourselves with the reflection that these are autogenetic cases in which we can trace no cause for the onset of septic conditions. But it was a remarkable fact that Dr. Giles recorded among his cases of seven deaths three that were directly attributable to septic peritonitis. With regard to the case of acute mania, it was possible that in that case also the mania had a septic origin. If so, that would give four cases of death from sepsis out of seven fatalities. In one case no cause of death was given. There was also one case of shock. What did Dr. Giles think led to the shock there? Shock was a general term, and it was difficult to say precisely what it was and what it was not. It must be understood that he was confining his observations to operations on the adnexa and the pelvis, in which one source of sepsis was the freeing of some septic fluid in the pelvic cavity. That was unavoidable, and the precaution which Dr. Giles referred to, of carefully packing off and so isolating any possible diffusion of fluid from the pelvis to the general peritoneum, was one which every gynæcological surgeon adopted. Still he thought that often by means of needles or the gut, or whatever suturing material was used, the operator carried sepsis to the peritoneum. But apart from those unavoidable sources, there was one which he thought was a frequent source of pelvic sepsis. This occurred where one had to deal with adhesions at the left side of the pelvis, and where we encroached on the sigmoid and injured it, thus opening up sources of contagion from the sigmoid and rectum and transudational conditions in which the bacterium coli passed into the pelvis and gave rise to sepsis. He quite agreed with Dr. Giles with regard to the technique which he described. Much had been said about drainage. He (Dr. Macnaughten-Jones) hardly ever drained. With regard to the cases themselves it appeared that in only a few cases of the series did Dr. Giles remove the appendix. There was another most important point connected with pelvic surgery. When he was in Frieburg last year, he found it to be the practice of Krönig in every case to remove the appendix unless by doing so the operation was unduly prolonged and that it added thus to the risk. It had certainly occurred to him (Dr. Macnaughten-Jones) that it was better to do so than to have subsequently to remove an adherent appendix in a case in which there did not appear to be any necessity for touching it at the time of operation. To examine the appendix in every case where we have to remove the adnexa was a most important step, and he thought that in any case where there was reason for suspicion of danger, such as a long appendix dropping into the pelvic cavity, it was most important to remove the appendix. There were so many points in connection with the paper which it was tempting to dilate upon that he had to apologise for taking up the time of the Society to the extent he had. He joined with what Dr. Macan had said respecting Dr. Giles's paper: it was one of those valuable contributions in which actual facts were recorded, and the remarks which the author made on the cases were thoroughly practical, and he was certain they would be endorsed by any abdominal or gynæcological surgeon.

Dr. R. T. SMITH desired to ask the author about the three cases in which the operation was done *post partum*. Those were exceedingly important, and it would be better if cases of that sort were published *in extenso*; they were cases which caused regret to the surgeon whenever they occurred in practice. With regard to case 5, in Table II., left tubo-ovarian abscess, adhesion and ulceration of sigmoid, septic peritonitis, removal of left appendages, suture of sigmoid, death from septic peritonitis, he asked whether those abscesses existed before the labour or whether they were in consequence of the labour, or was it known in that case that there was disease of the pelvic appendages before the confinement. He wished to know whether serum was used? He had also felt that the one case of tuberculosis was particularly interesting, and he noticed that Dr. Giles said he removed the tube on only one side. He would like to know whether, in that case there was any ascites, and also whether the case was drained. He did not believe leaving a tube in for purposes of drainage for twenty-four hours would cause a hernia.

Dr. SLIMON said he would like to mention a case which he had seen during the last two or three weeks which bore upon the author's Table II. Three weeks ago he was asked to see a lady fifteen days after her confinement. She had a normal labour, and up to the fourteenth day her temperature had been normal. On the fourteenth day her temperature rose to 102°, and on the morning of the fifteenth day it was 104°. He examined the patient and found her uterus quite normal for the time; there was no discharge, the lochial discharge having ceased seven days before. The uterus was one inch longer than it should have been, but on the left side she had a distinct swelling, with tenderness. Per vaginam there was felt to be distinct fulness and tenderness, and as he considered that the case was urgent he advised the friends to permit him to open her abdomen. This he did, and found the left Fallopian tube full of pus, almost close to the uterus, and he removed it and the ovary. He drained it for twenty-four hours, and then removed the drain. That occurred three weeks ago. He saw her last Saturday and she was practically well. In twenty-four hours the temperature had dropped to 101°, and in the second twenty-four hours it had fallen to normal.

The CHAIRMAN said it would be interesting to know what was the proportion of gonorrhœal cases in those that were unilateral. One supposed that the virulent infection of gonorrhœa passing into the uterine cavity attacked both tubes with equal facility. With regard to the question of the removal of the uterus, he thought there was another reason why the uterus should be preserved if possible. He had known cases in which ovaries had been removed only and in which the patients had retained their sexual function and sensations quite as much as they had them before. Some of them have said that it had been increased thereby. But when the uterus had been removed as well as the ovaries the sexual appetite was almost entirely or completely obliterated. With regard to double ovarian trouble even where there might not be enlargement, but where there was suppuration, there arose the question of excision of some portion of one ovary even if the patient came before one with the idea that both ovaries might be advantageously removed, because in young people even a scrap of ovarian tissue left behind was able to give rise to an ovum which might possibly become fertilised. With regard to choice of route for drainage, he had only to say that the vaginal route seemed to be a little more risky. One cut into the vaginal areolar tissue, and that tissue was very liable to take up septic inflammation, and therefore it was rather an additional source of mischief.

Dr. GILES, in reply, said he preferred the abdominal route for drainage, but admitted he might be wrong in so doing. The main reason he did not like vaginal drainage was on account of sepsis. His second objection was the difficulty there was in keeping a drainage tube in the vagina, and passing it into the place where it was wanted. But after a tube was placed in the abdomen it remained there until it was desired to remove it. He had practised drainage in only two or three cases in his whole series, *i.e.*, in cases of definite septic peritonitis of the acute type. For the rest the drainage he used was for cases in which there had been oozing or where there had been injury to bowel. The gauze was removed in twenty-four to forty-eight hours, and then the abdominal wound was closed up completely. Sometimes he put in a loose stitch to be tied when the gauze was taken out. A plan which was sometimes useful was before taking the drain out to drop a little peroxide of hydrogen on it, which seemed to free the gauze in a remarkable fashion. He much appreciated Dr. Macan's remarks, as there was no man in the Society who had a more comprehensive and profound knowledge of current literature. Dr. Macan as long as required, the milk being supplied in individual feeding bottles, which are returned the following day. An experienced nurse or a physician is in attendance at each station, and in general an admirable dispensary system has been arranged to supplement the work of the sanatorium, which, during the summer months, each year, cares for a number of children suffering from intestinal disorders. The possibilities of more searching preventive work through a dispensary system will be given a thorough test.

Pamphlet on Tuberculosis.

The State Board of Health recently gave out a prize for the best pamphlet shortly to be issued, written especially for the laity, and intended for distribution broadcast, in which consumption is described, its ravages clearly pointed out, and rules for its prevention and limitation of its spread detailed. The State Board of Health announces that it will make free examinations, too, of sputa in needy cases.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

Cerebro-Spinal Meningitis.—There were 29 cases of this affection reported last week, as compared with 30 the week before; the total number up to date is 420. There were 16 deaths reported, bringing the number up to 295. There are 90 patients in the Purdysburn fever hospital, 43 of whom are suffering from cerebro-spinal meningitis. At the last meeting of the Public Health Committee some discussion took place as to the wisdom of allowing visitors into hospital, and Dr. Gardner Robb said that he believed nearly 1,500 persons had visited the hospital to see patients or remove the bodies of dead friends, and none of these visitors had received any harm from doing so. In one case in which it was supposed that a case of cerebro-spinal fever had arisen in this way, it was found that the supposition was not justified. He was confident the visitors ran no risk, but overalls were being provided, and would perhaps allay any alarm that might be felt.

The Health Commission.—The meetings of the Health Commission have been resumed in the past week, and some interesting evidence has been heard. One whole day was taken up by the assistant city surveyor, who gave many particulars about the houses in the poorer districts of the city, and the efforts that have been made to improve their sanitary condition. One fact is quite clear, that all the efforts of the civic authorities will be unsatisfactory in their results as long as the people generally have such exceedingly elementary ideas of cleanliness. For instance, where baths are provided in some of the newer working-class houses, it is common to find them in a filthy state, and used for anything except for personal ablutions. In one of the very worst streets, where the people seem to be in dire need, the agent stated that there were tradesmen earning good wages among them, and labourers earning 24s. a week, but that they "drank too much." The question of pig-keeping excited a good deal of interest. It appears that large numbers of pigs are kept in the poorer parts, and if the styes are more than fifteen feet from the living rooms, they are not objected to by the authorities. Dr. Henry O'Neill, who has been a member of the Public Health Committee for fourteen years, gave evidence as to his efforts to promote reform. His chief complaint was that when by-laws pressed hardly on anyone, that person would bring influence to bear on the Committee whose duty it was to see the law administered, and would get it relaxed to suit them. He gave several instances of this being done to allow building to proceed on sites which had at first been refused as unsuitable. Mr. P. J. Kelly, inspector of National schools, gave most interesting evidence as to the 194 city schools, in which the number of scholars exceeds those in the National schools of Dublin, Cork, Derry, Limerick and Waterford combined. The schoolrooms have generally been built to be used as lecture or meeting-rooms in the evenings, and often five or six teachers have to teach in the one room for want of proper accommodation. Only 24 of the schools are heated by hot water, and in the others the heating is often most inadequate, and in cold weather the windows are closed to keep in the heat. Forty per cent. of the schools had no playgrounds, and 20 per cent. only moderate ones. The witness considered the whole system in great need of revision.

Medical Benevolent Fund.—The annual meeting of the Belfast branch of the Royal Medical Benevolent Fund Society of Ireland was held in the Medical Institute, Belfast, on May 17th, Professor Lindsay presiding. Dr. Purdon, the hon. secretary and treasurer, read the annual report, which stated that the contributions amounted to £157, the local expenses were £10, and the balance was remitted to the central fund. Unfortunately, over 70 of the 200 medical men in Belfast contributed nothing. The report was moved by the President, seconded by Dr. R. W. Leslie, and passed. Dr. Victor Fielden was elected to succeed Dr. Purdon, who resigned his office, and was accorded the warmest thanks of the meeting for his many years of active and unselfish efforts on behalf of the fund.

LETTERS TO THE EDITOR.

THE MEDICAL DEFENCE UNION AND ITS WORK.

To the Editor of The Medical Press and Circular.

Sir,—The Union has to thank you for your report of its work. I must, however, ask to be allowed to correct one statement made in your editorial. You write that law costs are "a variable and controllable factor." I can only say that we wish this was so. It is impossible to estimate the costs in any legal action, and, as no legitimate expense can be spared by the Union in the defence of its members, we have to incur necessary risks. One case alone cost over £700, and in another the expenses will be even more than this amount; and yet not one single penny of such expense could have been avoided. Cheap law, like cheap medicine, is not an element which makes for success, and it is proverbial that law is a luxury but a luxury which at times becomes a necessity. No case is handed over to our solicitor which could possibly have been dealt with by the lay executive, and hundreds of pounds are saved each year by checking threatened litigation at the onset. There is one other statement which you make in your leaderette to which I must make a reply. You state that the holding of the annual meetings in the provinces is "hardly calculated to secure a proper control of the affairs of the society by members." I fail to understand this criticism. Our members are drawn from the provinces in a far larger proportion than from London, and it is only fair to give our members outside London a chance of attending annual meetings by holding these in centres nearer than London. In this we follow the example of the British Medical Association, and the value for recruiting purposes has been widely proved. There is a tendency amongst some to imagine that everything connected with the medical profession should be dealt with in London. It is true that the actual work is in the case of the Union accomplished here, but in order to give the provincial member an opportunity to attend the annual meetings, we have decided to select a centre each year outside London. I only wish we could extend our area to hold one meeting at least in Scotland, Ireland, and Wales, but am afraid this would not be convenient. If all our members belonged to London, it would be, of course, imperative to hold our general meeting here, but that not being the case, it is surely right and proper to allow our provincial members an opportunity of control and criticism.

I am, Sir, yours truly,
A. G. Bateman,
Gen. Sec.
4 Trafalgar Square, London, W.
May 17th, 1907.

LONDON HOSPITALS AND GENERAL PRACTITIONERS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent "R.L." takes the philosophical and experienced view that readers of your esteemed journal must have learned to associate with those initials. To my mind the teaching at most of our London hospitals is of an unequal and amateurish kind. The great teacher is born not made, but under present conditions any man who has the special intellectual faculty necessary to pass a high standard examination, and the necessary resolution and means to wade through the probation of a teaching hospital staff appointment, necessarily becomes at the same time a "teacher" (save the mark!) It is just as necessary for a man to learn how to teach as it is for a carpenter or a watch-maker to undergo an apprenticeship. I have seen something of all sorts of practice in all kinds of London hospitals. It is my deliberate opinion that all men on hospital medical staffs should be paid for their services to the hospital, and much more so for the time and labour expended on teaching students. Any capable man should command a liberal salary—as much, say, as the income of an average good benefice, or a county court judge, or a barrister in fair practice. As things go the teacher who gets fragmentary glimpses at disease in scattered consultations can hardly impart a view of disease in the broader continuity that will be required by the student in later life. This subject is well worth prolonged discussion in your columns, and I trust some others will come forward with their opinions.

I am, Sir, yours truly,
Maidenhead. GENERAL PRACTITIONER.

CHILDREN'S HOSPITALS AND MILK.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With reference to the paragraph in last week's MEDICAL PRESS AND CIRCULAR, I beg to inform you that restrictions were imposed upon the milk contractors very similar to those recommended at the Conference held at this hospital, but that the object of the Conference was to insure the uniformity of these restrictions and unity in action.

I am, Sir, yours truly,
STEWART JOHNSON, Secretary.
The Hospital for Sick Children,
Great Ormond Street, London, W.C.,
May 18th, 1907.

OBITUARY.

WILLIAM T. GIRDLESTONE, M.R.C.S., L.S.A.

WE regret to record the death of Mr. William Theophilus Girdlestone, late of Rhyl, on May 11th, at his residence at Kensington, in his seventy-fifth year. The fourth son of the late Rev. Charles Girdlestone, vicar of Sedgley, Staffordshire, he was born in 1832, and received his professional education at St. Bartholomew's Hospital. He was admitted a member of the Royal College of Surgeons, England, in 1856, and a licentiate of the Society of Apothecaries in 1857, and long practised at Rhyl, where he was honorary surgeon to the Royal Alexandra Hospital and Convalescent Home. Mr. Girdlestone, who had retired from practice, was a magistrate for Flintshire.

ALEX. McLAGAN WEDDERBURN, M.D.Aber.

THE death will be regretted of Dr. McLagan Wedderburn, Forfar, lately Medical Officer of Health for the County of Forfar, who died on May 15th in Edinburgh, where he had gone for the benefit of his health. Dr. Wedderburn was partly educated in Aberdeen and Blair College, near Polmont, and afterwards studied at Aberdeen University, where he graduated. He went to Forfar about forty-five years ago as assistant to Dr. Steele, and became his partner in the following year. On December 16th, 1890, he was appointed Medical Officer of Health for the county, retiring from the post in May last year. He had attained his 67th year, and leaves a widow, five sons, and five daughters.

SPECIAL ARTICLE.

PROPOSED CHANGES IN THE BRITISH PHARMACOPŒIA.

WE are favoured with an advanced Report to the Pharmacopœia Committee of the General Medical Council on the changes in the next issue of the *British Pharmacopœia* that will be necessary to give effect to the International Agreement (1906).[a] (Adopted by the Committee of Reference in Pharmacy, March 4th, 1907.)

Aconiti Radix.—The restriction limiting the drug to roots that have been kept not longer than one year could be introduced by a statement to that effect, but no description could be framed that would exclude roots more than a year old. To be in strict accordance with the letter of the Agreement, the name should be altered to "Aconiti Tuber."

Aconiti Tinctura.—There would be no difficulty in preparing a tincture containing 0.05 grammes of total alkaloid in 100 grammes of tincture. The average alkaloidal strength of the present tincture would probably have to be ascertained in order that the dose might be adjusted accordingly.

(The Provisional Agreement of 1902 gave an alkaloidal strength of 0.025 per cent.)

Belladonnæ Folium.—The drug can easily be restricted to the dried leaves (*i.e.* not branches, flowers, &c.).

Belladonnæ Tinctura.—Tincture of Belladonna made from the leaf instead of the root would, of course, be totally different in appearance from the present tincture. A 10 per cent. tincture made from leaf of good quality would be approximately the same alkaloidal strength as at present. It should certainly be standardised to 0.05 per cent. of alkaloid (as at present).

Belladonnæ Extractum.—This would also differ in appearance from the extracts at present official. It should certainly be standardised, as the unstandardised extract has been found to vary in alkaloidal strength from 1.5 to 4.5 per cent. This variation would be very dangerous. The extract, standardised to 1.0 per cent. of alkaloid, might well take the place of both the present official extracts of Belladonna.

With regard to the other preparations of Belladonna, the liniment is probably best made from the root, and if the present standardised liquid extract of the root were retained, then the liniment, plaster, ointment, and suppository could all be made from it as at present, and thus comparatively little alteration would be necessary; otherwise a standardised liquid extract of the leaf would have to be introduced, from which the other preparations could be made. The liniment would in this case be very highly coloured and unpleasant to use. It will probably be necessary to have standardised liquid extracts of both leaf and root, from which the other preparations can be made.

The use of an extract containing, as it might, 4.5 per cent. of alkaloid in the place of the present green extract, which often contains less than 1 per cent., might be attended by very serious results.

Colchici Tinctura.—According to the Agreement this tincture is to be made in the proportion of 100 grammes of seed to 1,000 grammes of 70 per cent. alcohol (specific gravity 0.890). The most convenient method for British pharmacists would probably be to use 89 grammes of seed to 1,000 c.c. of menstruum, which would be the same proportion. The new tincture would be nearly half the strength of the present, and the dose might have to be correspondingly increased.

Digitalis Tinctura.—The tincture of the Agreement would be about three-fourths the strength of the present (1,000 : 730); the dose might have to be proportionately increased.

(a) **Treaty Series No. 10. International Agreement respecting the Unification of the Pharmacopœial Formulas for Potent Drugs. Signed at Brussels, November 29th, 1906. Presented to both Houses of Parliament by Command of His Majesty, March, 1907. His Majesty's Stationery Office. [Cd. 3392.] Price 1½d.**

Ipecacuanha.—The powder is to be prepared from the bark only of the root, and contain 2 per cent. of alkaloid. This can easily be done, and the powder will be about the same strength as the present.

Ipecacuanhæ Tinctura.—Prepared according to the Agreement, this should contain 0.2 gramme of alkaloid in every 100 grammes of tincture (assuming that the drug is exhausted). A standardised liquid extract similar to that at present official, but made (as it should be) without the aid of lime, might be used for making this tincture, which would then have the advantage of being standardised.

Hyoscyami Folium.—Only the leaf is to be used.

Hyoscyami Tinctura.—This would be approximately the same strength as at present, and no change would be necessary beyond the alteration of the quantity of leaf for every 100 c.c. of tincture.

Extractum Hyoscyami would be made in the same manner as Extractum Belladonnæ. It would be necessary to determine the relative average alkaloidal strengths of the old and new extracts, and adjust the dose according. In all probability an inconvenience and even danger, similar to that mentioned under Belladonna, will result in this case also.

Nux Vomica.—The standardisation of the seed to 2.5 per cent. of total alkaloid as required by the Agreement can easily be complied with, but the step is a very retrograde one, as the proportion of strychnine to brucine in the total alkaloid has been shown to vary from 1 : 1 to 1 : 1.8. Hence genuine seed passing the test of the Agreement may vary as much as from 1.0 to 1.4 in their toxicity. Moreover, standardisation to total alkaloid does not ensure the presence of any strychnine whatever. It seems essential that these seeds, or at least preparations of them, should be standardised in terms of strychnine.

Assuming that the Agreement considered that the proportion of strychnine present varied but little from one-half the total alkaloid, which, however, is not in accordance with the results of recent investigations, compliance with the spirit of the Agreement would be attained by standardising Nux Vomica to 1.25 per cent. of strychnine, instead of 2.5 per cent. of total alkaloid. It would in all probability be impossible to devise a means of standardising to 2.5 per cent. of total alkaloid, of which one-half should be strychnine. Compare *Reservation IV* of the Agreement, by which Great Britain reserves the right to make such modifications in detail as the progress of science may from time to time render necessary.

Nucis Vomicæ Tinctura.—Similar observations apply to the tincture. It might be standardised to 0.125 per cent. by weight of strychnine, instead of 0.25 per cent. of total alkaloid. As the tincture would then be approximately one-half the strength of the present, the dose might require adjustment.

Nucis Vomicæ Extractum.—It might be possible in exceptional instances to produce an extract with 8 per cent. of strychnine, but the average of good commercial seeds will yield a *dry* extract containing considerably less than that amount. Probably it will be practically impossible to produce an extract of the strength demanded by the Agreement. The natural standard for Nux Vomica extract is undoubtedly 5 per cent. of strychnine.

Opii Pulvis.—The temperature at which opium is dried for standardisation will require changing from 100° C. to 60° C.

Opii Tinctura.—This will be one-sixth stronger than the present tincture; the dose may require adjustment accordingly.

Opii et Ipecacuanhæ Pulvis Compositus.—This name will have to replace, or be given as a synonym of, Pulvis Ipecacuanhæ Comps

Strophanthi Tinctura.—The new tincture will be nearly four times as strong as the old; the dose may have to be diminished to about 1 to 5 minims, which would be inconveniently small, and the great difference in the dosage might produce very untoward results.

Ergotæ Extractum.—The new extract will be a different preparation from the old. Its suitability for making the Hypodermic Injection will have to be ascertained.

Ergotæ Extractum Liquidum.—Neither the menstruum nor the mode of procedure is specified, so that apparently no change will be necessary.

Sodii Arsenas.—The crystalline salt would have to be described. The Agreement does not refer to Liquor Sodii Arsenatis, so that this preparation could be left unaltered.

Liquor Arsenicalis.—The present strength would require slight alteration to bring it to 1 per cent. by weight.

Liquor Arsenici Hydrochloricus would in this case probably be brought into line with Liquor Arsenicalis.

Ferri Iodidi Syrupus.—The present strength would be considerably diminished.

Cantharidis Tinctura.—The strength of the new tincture would be 1 in 10, instead of 1 in 66.7; the dose might require adjustment.

It is doubtful whether 1,000 grammes of 70 per cent. alcohol would retain in solution the cantharidin extracted from 100 grammes of cantharides, which might easily exceed 0.8 gramme; this point should be ascertained by experiment.

Iodi Tinctura.—The tincture of the Agreement would contain 10 in 100 (by weight); the present tincture contains 10 in 333.6. Alcohol of 95 per cent. is not official. The dose (if a dose were given) would have to be diminished to about one-third. Apart from this inconvenience, much trouble may result from the large increase in strength of a preparation so widely used for external application.

Lobeliæ Tincture is not at present official. Tinctura Lobeliæ Ætherea is nearly twice as strong.

Hydrargyri Unguentum.—A considerable reduction in strength would have to be made (by rather more than one-third). Account would have to be taken of this in those preparations into which Unguentum Hydrargyri enters.

Vinum Antimoniale.—An unimportant alteration in strength would take place owing to the wine being weighed instead of measured.

REVIEWS OF BOOKS.

VARIATION, HEREDITY, AND EVOLUTION. (a)

THE cares of this world are apt so exclusively to engage the attention of the medical man in practice that he perforce loses touch with the recent developments of the pure sciences, although it is eventually on these that the art of medicine is based, and on their successful pursuit that progress in the science of medicine depends. In few subjects of late years has such extraordinary activity taken place as in the study of variation and heredity, and though we still see through a glass pretty darkly, we have already glimpses which promise early visions of things undreamed of ten years ago. Indeed, it is hardly too much to say that the salvation of mankind depends on the scientific comprehension of the factors that produce variation, of the use that can be made of these with regard to heredity, and of the employment of them for the attainment of physical and moral advance. In a word, the future of the race lies rather in the shaping of heredity than in the production of an environment, though all our modern humanitarian, sanitarian, and democratic aspirations take only the latter into account. It is true that till lately "Genetics"—as the science is now termed—has attracted little public notice, and that so far as it is known it is misunderstood; but though it is not yet able to take its place in the hierarchy of the practically useful sciences, the day is fast coming when it will. To what, then, is this new over-enthusiasm due to? Theories of heredity are at least as old as Aristotle, and for more than half-a-century the battle of the transmission of acquired characters has been in full force, the champions on both sides equally distinguished for learning and sagacity. Of course, the new school of "Genetics" has not been born of a single circumstance, but there is no denying that the re-discovery of Mendel's law has given the whole question a certainty, an interest, and a prestige which have attracted many inquirers. As was the case with physiology in the seventies, the school where there is most of life and enthusiasm is at Cambridge, in which, under the inspiring influence of Mr. Bateson, a band of workers are learning and teaching. The book that lies before us is from the pen of one of the latter, and its object is to place before people in popular language and in simple form, the present position and acquirements of the science, and its prospects for the future. Mr. Lock has certainly produced a most interesting and suggestive volume, but how far it is likely to attract non-scientific students we should hesitate to express an opinion. To take the chapter on Biometry, for example, we should fancy few not in extreme earnest would strive to master the plan of the mathematical curve, which may seem simple enough to the mathematician under such a formula as "$Y = E - X^2$," or the theory of the pure line and its possible developments with regard to a mixed population. Nor is the theory of that "important kind of discontinuous variation" known as homœsis, nor even Mendel's law itself, that "the gametes of a heterozygote bear the pure parental allelomorphs completely separated from one another, and the numerical distribution of the separate allelomorphs in the gametes is such that all possible combinations of them are present in equal numbers," the sort of light reading that can be indulged in at disjointed intervals. But the whole subject is one of immense importance, and medical men who want to keep abreast of modern knowledge have no alternative but to give it close and strenuous application. For "genetics" in the course of this generation is likely to transmute many of our most cherished ideals.

(a) "Recent Progress in the Study of Variation, Heredity, and Evolution." By Robert Heath Lock, M.A., Fellow of Caius College, Cambridge. London: John Murray. 1906. 7s. 6d. net.

INDEX CATALOGUE OF THE SURGEON-GENERAL'S LIBRARY, U.S.

We have received the eleventh volume of the second series of the Index Catalogue of the Library of the Surgeon-General's Office, United States Army. It extends from Mo. to Nystrom, and consists of 858 double-columned pages containing 8,023 author's names, 5,034 book titles, and 24,211 journal articles. The library now contains 155,292 bound volumes and 271,851 pamphlets. Including this, the eleventh volume of the second series, the Index-Catalogue contains 256,008 book titles and 846,271 pamphlet titles. Members of the medical profession engaged in literary work know how valuable this great index is, especially those engaged in historical research. Its pages reflect the opinions of each school of medicine and every fashion on therapeutics.

In producing this great work, and in giving it as a free gift to our public libraries and medical journals, the U.S.A. Government has made medicine their debtor for all time.

McMURRICH ON THE DEVELOPMENT OF THE HUMAN BODY. (*a*)

A knowledge of the main facts of embryological science is not only interesting to the pure physiologist, for it is, indeed, by the aid of the study of the development of the various organs and tissues of the body that new light is frequently shed upon morbid processes in general. The present volume before us, which has reached a second edition in a comparatively short time, has incorporated within some of the more recent work of Professor Hertwig, which should render it of greater value than ever to students and teachers of embryology. The book is divided into two main portions, the first dealing with the development of the germinal layers and the fœtal membranes, while the second treats with that of each system of the body in detail. The style is not too heavy, and there are nearly three hundred illustrations, many of which are from photographs. Recognising the important fact that "development does not cease with birth," the author has added a chapter on "Post-Natal Development." A bibliography is also added after each chapter, and there is a copious index. Dr. McMurrich is to be congratulated upon a thoroughly useful text-book.

PRACTICAL SANITATION (*a*).

This volume deals with the subjects that are usually included under the comprehensive title of "Sanitation," in a manner that is satisfactory on the whole, but there are several points on which the book is not up to date, and others where the accuracy might be questioned. The dilution for use of "Cyllin," "Chinosol," and formalin is given as 1 in 100 in each case, disregarding the fact of the very different efficiencies of the three disinfectants. In dealing with the subject of tuberculosis in a book recently published, one would naturally expect to find a reference to the first Interim Report of the Tuberculosis Commission (the book was published before the second Interim Report was issued), but instead we find the Commission referred to as being "recently appointed," and the subject is thus only brought up to the position of 1901. One might also reasonably expect a reference to the Glover Lyon method of ventilation, which so far as we are aware is the most satisfactory. These small omissions detract from what otherwise would be an admirable volume, and which even as it stands is one that can be recommended to those desiring to gain an acquaintance with sanitation. The fact that twelve editions have been issued in fourteen years is proof of its popularity, and the present edition is a great improvement on the previous one, as the chapter on "Sewage Disposal" and the Appendix on "Sanitary Law" have been revised and re-written.

THE STUDY OF CHILDREN'S DISEASES. (*b*)

Judging by this volume, the sixth year of the society's existence has been one characterised by useful work. The articles and cases are all of interest, and in many instances of great permanent value. In the opening pages there are records by Drs. Whiphoun, Parkinson, and Cautley of a series of cases of splenomegaly, and these are followed by a highly-instructive discussion on this obscure disease. Congenital hypertrophy of the pylorus continues to excite much attention among physicians and surgeons to children's hospitals, and the best method of treating it is by no means yet settled. It is not surprising, therefore, that several papers on this subject appear in the volume; they are contributed by Drs. Carpenter and Cautley. One of the chief items is a series of papers on serous and purulent pleural effusion, by Drs. Emanuel, Dudgeon, Bythell, Carpenter, Sutherland, Hobhouse, and Lockhart Mummery, in which the important subject is exhaustively treated of from various points of view. The Reports are also a mine of wealth in short notes of rare cases; they are becoming year by year more valuable in this respect, and one turns to them, seldom in vain, when anxious to find records of out-of-the-way diseases. This year we may note, among others, Dr. Guthrie's notes on lipomatosis and fragilitas osseum, Dr. Hay's case of achondroplasia, Dr. Lett on precocious development, and Dr. McCaw's case of chlosoma. In the last, unfortunately, there was no autopsy. Enough has been said to show the value of these Reports; and we have only again to congratulate the Editor on the appearance of the annual volume.

(*a*) "The Development of the Human Body." By J. Playfair McMurrich, A.M., Ph.D., Professor of Anatomy in the University of Michigan. Revised and enlarged. Pp. xix., 539, with 272 illustrations. London: Rebman, Limited.

(*a*) "Practical Sanitation: A Handbook for Sanitary Inspectors and others interested in Sanitation." Thirteenth Edition. By George Reid, M.D., D.P.H., Medical Officer of Health, Staffordshire County Council. With an Appendix on Sanitary Law by Herbert Manley, M.A.Cantab., M.B., D.P.H. Pp. 352 and viii., with 106 illustrations. London: Charles Griffin and Co., Ltd. 1906. 6s.

(*b*) "Reports of the Society for the Study of Disease in Children." Vol. VI. 1906.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

Protection of Rheumatic Children.—Hawthorne (*The Brit. Journ. of Children's Diseases*, March, 1907) discusses the possibility of the prevention of cardiac disease in children suffering from rheumatism, He points out that it is the non-arthritic forms of rheumatism which are most frequently followed by cardiac complications, but that it is this very form of rheumatism which is so common in children. In the case of adults, where the disease usually shows itself as a painful polyarthritis, the patient is driven by the pain to rest in bed, but the rheumatic child, even during an active phrase of the disease, suffers little or no pain, and thus the circumstances, permit him to escape the rest which an acute polyarthritis invariably demands. The public are not yet sufficiently aware of the dangers of this so-called ambulatory rheumatism in children, and so the necessary rest is not insisted on. The remedy for this lies in the education of parents, and Dr. Hawthorne concludes that "the discovery of signs or evidences of rheumatic disease in any family ought to be the occasion, as an imperative professional duty, to convey to the parents information and warning of the special risks which even the apparently slight illnesses of their children may involve, and of the importance of complete rest as a means of avoiding these risks." K.

Pericolic Inflammation.—Newton (*The Med. Chronicle*, April, 1907) discusses the varieties of this condition, first described in 1890 by Windscheid. Pericolitis may occur anywhere along the course of the large intestine, but by far the commonest site is in connection with the descending colon, especially low down near the commencement of the sigmoid flexure. Many explanations have been offered of the pathology of the condition, but none can as yet be said to be completely satisfactory. All are agreed that in the majority of cases constipation plays a very prominent part, though there are some instances in which there was no previous history of this trouble. The hypothesis which seems to explain best the condition and which is best supported by the available *post-mortem* data, is as follows:—In a certain number of subjects of chronic constipation are found after death to have sacculi of varying sizes in the walls of the large intestine. It is suggested that in chronic constipation the action of the accumulated fæcal material on these small protusions of mucous membrane causes them to enlarge and become definite sacculi comparable to a small appendix. In these sacculi hard fæces accumulate, and by irritation set up an inflammation of the mucous membrane, which allows the bacteria of the intestine to invade the peritoneal covering of the colon with the resulting pericolitis. Perforation of the intestine by small foreign bodies ingested with the food, injuries received from without and finally leakage from typhoidal, stercoral and other ulcers have been known to cause the condition. As regards treatment many cases may be cured by rest in bed and relief of the constipation by enemas. The recumbent position is of considerable importance, as it favours the passage onwards of the contents of the ascending colon. In some cases, however, it is necessary to open the abdomen and divide the adhesions, being very careful afterwards to keep the bowels acting freely, for if constipation occur again the adhesions are likely to reform. In some intractible cases anastomosis of the ileum with the sigmoid flexure has been advised. In any case of chronic constipation in which the constipation is not relieved by enemas, rest or other methods, some operation appears to be necessary. K.

Treatment of Chronic Morphinism.—Dixon (*The Practitioner*, May, 1907) is decidedly opposed to the sudden withdrawal of the drug in these cases, except where very small doses have been taken. With patients in the habit of taking large doses he advocates the diminishing of the morphine in the first twenty-four hours to half the usual quantity taken, and then the gradual reduction during the next eight or ten days to a vanishing point. In Dixon's experience it has been the withdrawal of the last two or three grains that has proved especially difficult, and he believes with Dr. Jennings that at this stage the substitution of opium per rectum for morphine injections is often useful. The use of hyoscine has many advocates, but the writer of the paper does not give any details of the treatment by it. The after-treatment of these patients is of great importance, and the general opinion is that they should not be permitted to return home till after the lapse of about a year.

K.

Progress of Anti-Typhoid Inoculation in the Army.—Leishmann (*R.A.M.C. Journ.*, May, 1907), reviews the history and progress of this method of prophylaxis, which has been recently again introduced into the army as a voluntary measure. The experiences during the Boer War were so unsatisfactory and so much diversity of opinion existed as to the merits of the method that it was for a time abandoned. The chief stumbling block was the danger connected with the negative phase. The method of inoculation was then abandoned, and a committee was appointed by the Army Council to re-investigate the whole matter. This committee is still in existence, and it is upon its recommendation that the typhoid inoculation has again been adopted. At present two inoculations are given with an interval of ten days between the first and second, and the dosage for these inoculations has been fixed at 500 million bacteria for the first and 1,000 million for the second inoculation. A very considerable amount of work has also been done with regard to the preparation and standardisation of the vaccine, but in connection with this much yet remains to be done. The question as to whether a virulent or non-virulent strain of typhoid bacilli should be used for the preparation of the vaccine is not yet definitely settled, and it has not been found possible up to the present to do away entirely with the local reaction. The results so far are very encouraging, and Leishman looks forward with confidence to the method being firmly established within a short period. K.

Irrigation Treatment of Gonorrhœa.—Purdy (*The Scottish Med. and Surg. Journ.*, May, 1907) relates the results of some experimental and clinical work on this method of treatment. From experiments on the cadaver he has found that with an ordinary 4 drachm syringe it was not possible to inject fluid beyond the membranous urethra, but with a douche an elevation of three feet caused the fluid to pass into the bladder. In the living subject he found it necessary to use an elevation of at least 5½ feet in order that intra-vesical irrigation should be effective. In practice Purdy uses a double channel nozzle consisting of two tubes concentrically placed so as to allow the fluid to flow through the inner and return by an outlet placed at an obtuse angle in the outer. With such a nozzle attached to the tube of an ordinary douche-can elevated three feet, the urethra is washed out, using warm boracic lotion, followed by a solution of 1 in 5,000 of potassium permanganate. The patient is then directed to inject himself three times a day with a 10 per cent. solution of argyrol, which he retains in the urethra for a period of from five to seven minutes. The irrigation is repeated every second day until all obvious discharge has ceased, when an injection of sulphate of zinc, one grain to the ounce, is ordered for a few days. In this way Purdy has cured an ordinary gonorrhœal anterior urethritis in about a week. With posterior urethritis the treatment may have to be prolonged over a much longer period, and the douche-can must be raised to a height of about five feet. K

Treatment of Disease by Passive Hyperæmia.—Dr. Schmieder contributes to the current number of *Folia Therapeutica* (April, 1907, p. 48) an account of Bier's treatment of various morbid conditions by the induction of a condition of passive hyperæmia in the diseased part. Three principal methods are employed to secure this result, viz., (1) hyperæmia by means of a compression bandage placed above the diseased part and so adjusted to prevent venous return without completely obstructing arterial flow; (2) by suction apparatus, represented in its simplest form by cupping glasses. This method is particularly suitable for circumscribed abscesses, boils, and sinuses; (3) by hot-air chambers, which are specially applicable to chronic joint diseases. The writer points out that the treatment was chiefly used for tuberculosis up to the year 1905, and states that since that time it has been applied with success to almost every variety of localised suppurative process. M.

Toxins of Tubercle Bacilli Present in Individuals Suffering from Tuberculosis.—Rappin has examined the milk obtained from eleven women in different stages of tuberculosis (*La Province Med.*, January 12th, 1907), and has shown the presence of tuberculous toxins within it. Having obtained the milk under careful aseptic precautions and having boiled it for ten minutes, he injected some into tubercular guinea-pigs, keeping under control healthy animals under observation. He found that after three or four hours, there was produced in the diseased animals a reaction similar to what is produced by the injection of small doses of tuberculin. The author regards this demonstration as most important, and points out that it may help to explain the apparent hereditary character of the disease. At first sight it might appear that the continuous injection of small doses of tuberculin would gradually cause immunisation, but all the known facts of anti-tubercular sero-therapy are opposed to this view, and serve to show that the continuous injection of the toxins rather tends to lower resistance than otherwise. Their presence in milk is an additional argument against phthisical patients nursing their children. M.

The Communicability of Cerebro-spinal Meningitis..—Bolduan and Goodwin make a preliminary report of the work which they have been doing for the Special Commission on Cerebro-spinal Meningitis in New York (*Indian Med. Record*, March 28th, 1907, page 1). The work was principally directed towards the discovery of the probable source of contagion, and included an investigation of the bacteriology of the disease. They formulate the following conclusions: (1) The disease hitherto always occurred in epidemics, more or less linked by intervening sporadic cases. (2) The epidemic form always, and the sporadic form usually, is associated with the presence of the meningococcus of Weichseltaum. (3) During the first week of the disease, the meningo-coccus is present in the nasal mucus in fully half of the cases; later in the disease it is found in a small fraction of the cases. It also occurs in the nasal mucus of about 10 per cent. of persons who are in close contact with cases of cerebro-spinal meningitis. (4) The disease seems distinctly communicable in the sense that the organism is transmitted from the nasal secretion of one person to another, but the transmission of the organism is not synonymous with transmission of the disease. (5) The organism is rapidly killed by drying and by sunlight, facts which make dust infection improbable. (6) There is no evidence to show that the disease is carried by vermin or by insects. M.

Reflexes in Cases of Complete Transverse Section of the Spinal Cord.—According to Lapinsky (*Archiv. fur Psych. und Nervenheilk*, Bd. 42, Heft 2), the disappearance of the reflexes in paralysed parts after complete division of the spinal cord, should not be attributed to a removal of the reflex controlling properties of the cerebellum, since the existence of such properties has never yet been proved. In many cases of flabby paralysis, the cause is rather to be sought in some organic change in the reflex arc. The cause of such a change may be effusion of blood into, or œdema of the grey matter of the spinal cord; a possibly swelling up of the myelin in the degenerating tract of the cord. Furthermore, an increase of the cerebro-spinal fluid may play a part, by causing compression and interfering with the nourishment of the cord. M.

Hysterical Insanity.—Raecke (*Berlin Klin. Woch.*, March, 1907) describes several forms of hysterical psychosis which are important because they are easily mistaken for incurable mental or nervous disease, such as dementia precox and apoplexy. Three types can be distinguished: (1) The excited, stuporous form in which outbreaks of mania alternate with periods of retardation; delirium and attacks of somnambulism may occur. (2) The depressive form, with attacks of anxiety, stupor, confusion, and melancholia. (3) The paranoid type with systematic delusions of persecution. The diagnosis is made partly on the previous history, partly on the general hysterical behaviour of the patient, while the hysterical stigmata are often absent. The prognosis is always favourable as to the eventual outcome, but the course is often tedious. The treatment is that of hysteria in general. D.

The Diagnosis of Infantile Scurvy.—Von Starck (*Mun. Med. Woch.*, March, 1907) considers the following symptoms of infantile scurvy as most important. (1) Increasing anæmia, (2) hæmorrhagic swelling of the gums, (3) pain on motion, (4) periosteal swellings, (5) hæmaturia, and (6) exophthalmus and hæmorrhagic swelling of the eyelids. It should be noted, however, that anæmia is not necessarily present in the early stages. The swelling of the gums may be slight, but the characteristic purple discolouration is almost always present. X-ray examination may be important showing a dark transverse shadow at the end of the diaphysis and at times also periosteal swellings due to hæmorrhage. The prompt response to treatment with fruit juices and raw milk may be of diagnostic aid in obscure cases. D.

The Value of the Benzidin Test for the Demonstration of Minute Hæmorrhages.—Schlesinger and Holst (*Mun. Med. Woch.*, March, 1907) report results with the benzidin test for blood in the fæces and urine. As performed by them, the test is never positive in persons on a meat free diet, unless there is blood present. A piece of fæces the size of a pea is used for the test; the reagent consists of a mixture of ½ cm. of a freshly prepared solution of benzidin in glacial acetic acid, with 3 cc. of a 3 per cent. solution of hydrogen peroxide. The bit of fæces is stirred up in one-fifth of a test tube of water, the reagent is added, and the whole shaken. If blood is present a handsome blue colour appears, or if the amount is small a clear green. When urine is to be tested, it should be treated first with a small volume of glacial acetic acid and extracted with ether. The ether extract is cleared with a few drops of absolute alcohol, removed with a pipette, and added to the benzidin reagent. The test is especially valuable in hæmoglobinuria, where the microscopic examination for microcytes is negative. D

Owing to an epidemic of measles and whooping-cough, five schools, attended by nearly 2,000 children, have been closed at Finchley for three weeks.

Medical News in Brief.

The German Hospital.

The 62nd anniversary festival dinner in aid of the funds of the German Hospital, Dalston, was held on May 11th at the Hotel Métropole, Baron von Stumm, the German Chargé d'Affaires, presided, and the company included Prince William von Stolberg-Wernigerode, Herr A. von Goldschmidt-Rothschild, Captain Ostertag, Prince Emil zu Fürstenberg, Consul-General H. S. J. Maas, Consul-General Daniel Danielson, Sir Julius Wernher, Mr. Alexander Siemens, and Mr. W. F. Cochrane, secretary. The chairman, in proposing "The German Hospital, coupled with the Duke of Connaught, the president," said the hospital contained 130 beds, which were, as a rule, always occupied; indeed, it frequently happened that patients had to be refused admission for want of room. The benefits of the institution were not confined to Germans. It was largely used by English patients living in the district in which it was situated, and all cases of accidents, no matter what the nationality of the injured persons might be, were at once admitted and treated with the utmost care. Last year 1,824 in-patients were treated, an increase of 65 over the previous year. Of the total number 216 were cases of accident, nearly all English. During the same period the number of new out-patients was 27,072, and the attendances 67,580. To maintain the hospital about £11,000 a year was required, and last year, but for some legacies, there would have been a deficiency of £350. The cost per occupied bed was the lowest of any hospital of the same size in London. Additional accommodation was urgently needed. Alluding to the announcement by the chairman of last year's festival that one or two friends intended to present the hospital with a new convalescent home at Hitchin, he said the donors, Mr. Fritz König and Mr. Hans König, had accepted plans for a handsome building to contain about 50 beds, and building operations would begin in a few weeks. Other toasts followed, that of "The Chairman" being proposed by Sir Julius Wernher. Donations and subscriptions were announced amounting to £3,758, including £200 from the German Emperor and £500 from the Emperor Francis Joseph.

Vivisection Commission.

Another volume of evidence taken before the Royal Commission on Vivisection has been issued. It contains statements made and presented by Mr. W. H. Power, C.B., principal medical officer to the Local Government Board, Dr. A. R. Cushny, professor of pharmacology and materia medica, University College, London; Lord Rayleigh, president of the Royal Society; Sir Douglas Powell, President of the Royal College of Physicians; Dr. F. Taylor, senior physician to Guy's Hospital, and also those by Miss Arabella Kenealy, L.R.C.P. (Dublin) and Mr. J. W. Graham, principal of Dalton Hall, Victoria University, Manchester, represented the Parliamentary Association for the Abolition of Vivisection.

After Care of Surgical Cases.

Alderman Sir Walter Vaughan Morgan presided at a meeting held on May 8th at the Mansion House in furtherance of the movement for establishing a "home of recovery" for surgical patients who when discharged from the London hospitals as convalescent require a further period of surgical care. To the committee which has been formed with this object in view Charing Cross, Guy's, University College, Middlesex, London, King's College, and St. Thomas's Hospitals have elected representatives, and it is proposed to erect and endow a home of recovery in which, on the recommendation of these general hospitals, the surgical treatment of convalescent persons can be effectively carried on. The home has been incorporated, and the President is her Royal Highness Louise Duchess of Argyll. Those present included the Earl of Lytton (chairman of the committee), the Countess of Lytton, Sir Richard B. Martin (hon. treasurer), Sir Alfred Fripp, the Archdeacon of London, the Archdeacon of Westminster, the Rev. F. Whyley (hon. secretary), Mr. W. J. Lancaster (assistant secretary).

Sir Walter Vaughan Morgan pointed out that though many of the hospitals possessed convalescent homes these were unable to admit patients unless they were actually convalescent. There was, therefore, plenty of room for the home of recovery. It would be an immense relief to the hospitals to make use of it, because not only would patients recover much more quickly than in London, but their removal to the home would make room for others who were waiting to come in for the purpose of undergoing surgical treatment. The committee had wisely decided not to start the home of recovery until they could see their way to building a suitable home and to keep it going. For this an appeal for £30,000 was being made.

Mr. Mayo Robson moved a resolution approving the objects of the home of recovery, as described in its trust deed, and expressing the hope that the committee would meet with adequate support in their efforts to alleviate much unnecessary suffering in cases which are unavoidably discharged from London hospitals in order to make room for more urgent cases awaiting admission. Sir Alfred Fripp seconded, Archdeacon Wilberforce and the Hon. Mrs. Campion supported, and the resolution was unanimously carried.

Royal College of Surgeons of Edinburgh.

The following gentlemen, having passed the requisite examinations, were, at a meeting of the College, held on 16th inst., admitted ordinary Fellows:—A. G. Bate, M.B., Ch.B.; J. H. M. Bell, M.B., Ch.B.; T. W. Eden, M.D., F.R.C.P.Lond.; W. Hume, M.B., Ch.B.; B. Ingram, L.R.C.S.E.; E. C. Lomas, D.S.O., M.B., M.R.C.S.Eng.; F. W. Lundie, M.B., Ch.B.; E. G. E. O'Leary, M.R.C.S.Eng., L.R.C.P. Lond.; W. H. Parkes, M.B., C.M.; A. M. Pollock, M.B., Ch.B.; C. H. Thomas, M.D., L.R.C.S.E.; R. S. Roper, M.R.C.S.Eng., L.R.C.P.Lond.; C. R. Whittaker, L.R.C.S.E., and J. C. Wilson, M.D., D.P.H. The medal and set of books presented to the College by Colonel William Lorimer Bathgate, in memory of his late father, William McPhune Bathgate, F.R.C.S.E., Lecturer on Materia Medica in the Extra-Academical School, was awarded after the usual Winter Session competitive written examination in Materia Medica, etc., to Miss Alice E. M. Babington, B.A., Greenfort, Fahan, Co. Donegal.

Soot and Cancer.

A more or less important contribution to the study of the mysteries of cancer has been made by the report of the departmental committee on compensation for industrial diseases. It is mentioned in this official document that the mortality from cancer among chimney-sweeps is twice that among ordinary males following an occupation. During the three years 1900-1-2 the number of chimney-sweeps who died of cancer was 133, as against 63 among occupied males of the same ages. It seems to follow, therefore, that soot has the quality of setting up an irritation of the skin liable to develop into cancer, but before holding soot altogether responsible it might be safer to examine a little more closely the conditions in which chimney-sweeps perform their work. It appears, at any rate, to be fairly established that the trade of cleaning chimneys involves more risks than had hitherto been supposed.

Royal Army Medical College.

The office of the Commandant of the Royal Army Medical College from No. 68, Victoria Street, Westminster, and the Laboratory from the Examination Hall, on the Thames Embankment, have been removed to the new College, in Atterbury Street, Millbank.

Queen's University, Belfast.

Sir Donald Currie has offered £10,000 towards a new recreation ground for the Queen's University, Belfast, for which a grand bazaar is to be held at the end of the month. Amongst the stallholders will be the Marchioness of Dufferin, the Countess of Shaftesbury, and the Countess of Annesley.

NOTICES TO CORRESPONDENTS, &c.

Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Tropics.—The summer session of the London School of Tropical Medicine began on the first of this month, but it may not be too late if you apply at once. There is a hostel attached to the school, where you can obtain board and residence on reasonable terms, and if you have only four months of your leave to run, you had better write to the secretary without delay.

J. B. Foster (Melbourne).—The question had better be addressed to the Registrar of the Royal College of Physicians, Pall Mall East, London. We have no knowledge of anything of the kind having arisen before.

Pensator (London).—We shall be glad to deal with the matter editorially on receipt of the necessary papers.

S. B. J.—We cannot open our columns to the discussion of a subject which is more a personal one than one of public interest.

House Surgeon.—The Committee could be approached and asked to allow a personal explanation to be given.

F. W. E.—The fee of £2 2s. in each case for each medical man is, we consider, the correct fee to name, and is one which may legally be paid by the Coroner. There is, however, no fee named in the Act, so far as we are aware, save a maximum fee, and below that maximum the amount paid is left to the discretion of the Coroner.

F.R.C.S.—Keratoplasty, or corneal grafting is not a new method of treating leucomata. It was suggested as long ago as 1824, by Reisinger.

Meetings of the Societies, Lectures, &c.

Wednesday, May 22nd.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. P. Paton: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. H. French: The Vaccine Treatment of Acne and Some Points in the Treatment of Some other Common Maladies.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Thursday, May 23rd.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. A. P. Beddard: Diabetes.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel) 4.30 p.m.: Special Demonstration of Skin Cases (Dr. G. N. Meachen).

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. Parsons: Convergent Squint.

Friday, May 24th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.—4 p.m.: Mr. E. Clarke: Clinique (Eye).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—9.30 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Clinical Society of London (20 Hanover Square, W.).—Papers:—Dr. F. de Havilland Hall; Two Cases of Prolonged Pyrexia.—Dr. Gossage: A Case of Partial Heart Block.—Dr. F. W. Price: Foreign Bodies in the Bronchi. 9.30 p.m: Annual General Meeting.

British Electrotherapeutic Society (11 Chandos Street, Cavendish Square, W.).—8 p.m.: Council, 8.30 p.m.: Dr. Doumer (Lille): The Fundamental Principles of Electrotherapy. An Extraordinary General Meeting will be held for the purpose of winding up the Affairs of the Society.

Saturday, May 25th.

Ophthalmological Society of the United Kingdom (University of Edinburgh).—9.30 a.m.: Card of Specimens and Cases will be shown. 10 a.m.: Papers will be read and Demonstrations given.

Monday, May 27th.

Odontological Society of Great Britain (20, Hanover Square, W.).—8 p.m.: Mr. W. Sampson Handley, M.D., M.S., F.R.C.S.: "Lymphoid Degeneration of Salivary Glands." Mr. J. H. Badcock, L.R.C., M.R.C.S., L.D.S. Eng.: "Interim Notes on Orthodontia."

Vacancies.

Joint Counties Lunatic Asylum, Carmarthen.—Assistant Medical Officer. Salary £200 per annum, with board, lodging, washing and attendance. Applications immediately to W. Morgan Griffiths (Solicitor), Clerk to the Visitors, Carmarthen.

Joint Counties Lunatic Asylum, Carmarthen.—Medical superintendent. Salary £450 per annum, with unfurnished house, garden produce, fire, light, and washing. Applications immediately to W. Morgan Griffiths (Solicitor), Clerk to the Visitors, Carmarthen.

Royal Albert Edward Infirmary, Wigan.—Junior House Surgeon. Salary £100 per annum, with apartments, washing, and rations. Applications to Will. Taberner, General Superintendent and Secretary.

Oldham Union.—Resident Medical Officer. Salary £120 per annum, with furnished residence, coal, gas, rations, washing and attendance. Applications to Horace A. Quarmby, Clerk to the Guardians, Union Clerk's Office, Oldham.

Liverpool Hospital for Consumption and Diseases of the Chest.—Stipendiary Medical Officer and Assistant Pathologist. Salary £150 per annum. Applications to Alfred Shawfield, Secretary, 77a Lord Street, Liverpool.

Walsall and District Hospital.—Senior House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to E. J. Brookes, Chairman.

Bridgnorth and South Shropshire Infirmary.—House Surgeon. Salary £100 per annum, with board and lodgings in the Infirmary. Applications to the Hon. Secretary, the Infirmary, Bridgnorth.

Staffordshire General Infirmary, Stafford.—House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to Richard Battle, Secretary, 7 Meyrick Road, Stafford.

Rochdale Infirmary.—House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to Henry Booth, Secretary, Infirmary Office, 58a Yorkshire Street, Rochdale.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary £160 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26 Mosley Street, Newcastle-on-Tyne.

West Bromwich District Hospital.—Senior House Surgeon. Salary £110 per annum, with board, residence, and washing. Applications to T. Foley Bache, Esq., Churchill House, West Bromwich.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon. Salary for six months £20, washing allowance £2 10s., with board and residence in the Hospital. Applications to Stewart Johnson, Secretary. (See advt.)

Alnwick Infirmary.—House Surgeon. Salary £140 per annum, with furnished apartments, attendance, coals, and gas. Applications to Wm. T. Hindmarsh, Honorary Secretary of the Alnwick Infirmary, 26 Bongate Without, Alnwick.

Bradford Royal Infirmary.—House Surgeon. Salary £100 per annum, with board and residence. Applications to John J. Barron, Secretary.

London County Asylums, Bexley, Kent, and Claybury, Woodford Bridge.—Junior Assistant Medical Officer. Salary £150 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6 Waterloo Place, S.W.

Appointments.

Carrol, Denis J., L.R.C.P. and S. Irel., Medical Officer to the Clonmel Dispensary, Co. Tipperary.

Corbett, William Edward Manderson, L.R.C.P. and S. Irel., Medical Officer to the Stonehouse Branch of the Provident Dispensary in connexion with the Royal Albert Hospital, Devonport.

Croudace, J. H., L.R.C.P. and S.Edin., Medical Officer to the Stafford Workhouse.

Marson, F. H., M.D. Durh., Medical Officer and Public Vaccinator for Stafford District.

Paton, Leslie, B.A., M.B., B.C. Cantab., F.R.C.S., Assistant Ophthalmic Surgeon to the National Hospital for the Paralysed and Epileptic, Queen's Square, W.C.

Births.

Cameron-Young.—On May 14th, at Brightwell, Woodbridge Road, Ipswich, the wife of A. Cameron-Young, M.R.C.S., of a daughter.

Dwyer.—On May 14th, at 69 Middleton Road, Banbury, the wife of Hubert de Burgho Dwyer, M.R.C.S., L.R.C.P. Lond., of a son.

Hichens.—On May 14th, at Northampton, the wife of Peverell S. Hichens, M.D., M.R.C.P., of a daughter.

Spurrier.—On May 17th, at Pinehurst, Maidenhead, the wife of H. Spurrier, M.B., B.C. (nee Mary Cato), of a son.

Yin.—On May 12th, at Lydia, Leonie Hill, Singapore, the wife of Dr. S. C. Yin, M.B., M.R.C.S., L.R.C.P. (nee Bowyer), of a son. (By cable.)

Marriages.

Clatworthy—Gooding.—On May 15th, at St. Margaret's, Lee, John Hunter Clatworthy, M.D. Lond., of 145 Denmark Hill, London, younger son of Augustus R. Clatworthy, of Beccles, to Ethel Maud, younger daughter of Ralph Gooding, M.D., D.L., J.P., of 13 Church Terrace, Blackheath.

Huey—Jardine.—On May 15th, at Hampstead, Dr. J. Mackay Huey, 75, Holland Park Avenue, Kensington, late Med. Off. in Charge Staff and Dept., Castle, Cape Town, to Ethel Halliday, seventh daughter of the late Wm. Jardine, of Cape Town.

Longhurst—Jarratt.—On May 15th, at St. Peter's Eaton Square, Bell Wilmott Longhurst, Surgeon-Major R.A.M.C., eldest son of Sir Bell Longhurst, of The Woodlands, Barnes Common, and 28 Old Burlington Street, London, to Eleanor (Nellie), youngest daughter of the late William Otley Jarratt, Esq., of Hilderthorpe Lodge, East Yorks.

Deaths.

Legge.—On May 12th, at 45 Friar Gate, Derby, William Legge, M.R.C.S., J.P., aged 75.

Owen.—On May 18th, of post-influenzal disease of the heart, Annie Laura, wife of Edmund Owen, F.R.C.S., of 64, Great Cumberland Place, London, aged 45 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, MAY 29, 1907. No. 22

NOTES AND COMMENTS.

Telephones and Infection.

THE French Government have drawn a good deal of attention to the telephone as a possible source of infection by ordering all public telephones to be disinfected. This command followed a complaint made by a gentleman that he had contracted "skin trouble" from using the public instruments; but as we are not informed what the skin trouble was, nor what evidence connected it with the telephone, one cannot attach great importance to the mere assertion. Still a good journalistic sensation is being made of the fact, and the Post-Office and National Telephone Company in this country are being called upon to act in the matter. While, of course, it is eminently desirable that ordinary cleanliness should be maintained at all public call offices and in all instruments, the risks to users must be infinitely small, or a great deal of complaint would have been heard ere this. It is easily possible that one might contract scabies from the handle of an ear-piece of a telephone, but then one might contract it equally easily from any railway door handle or omnibus rail, and the people who would be likely to infect a telephone would be far less numerous than those who use ordinary public vehicles. The mouth-piece of the telephone, too, does not come in contact with the mouth, and though there may be an infinitesimal danger from the inhalation of dried secretions, it is a far smaller one than is incurred in a hundred other ways in pursuing the day's avocations. The telephone authorities should certainly see that their instruments are frequently washed and polished, and indeed since some representations were made to them by Dr. Collingridge, we believe they do so, but there is nothing in the conditions of the telephone service to make the skin creep.

Ambulance Accident.

THERE is a spice of irony in the unfortunate accident which happened at Hampstead Heath on Whit Monday, when the horses drawing a St. John's Ambulance Brigade waggon bolted into a crowd and injured eleven persons in various degrees, one child, alas! fatally. That the Brigade's emissaries should have been the cause of this series of mishaps when they went out to succour the injured is one of those sarcasms of nature which seem particularly undeserved. The voluntary organisation of persons into Samaritan corps to supply the place that State organisations should take redounds highly to their credit, and we are sure that no one will have anything but sympathy with them in this terrible contretemps. It might, however, be advisable to secure a more docile type of animal to draw the ambulances, as the conditions of such pleasure-resorts as Hampstead Heath on Bank Holiday are calculated to try the mettle of most horses pretty severely.

Raw Sausage for Delicate Children.

THE necessity for a little primary instruction for mothers in the feeding of their children was startlingly illustrated by a fact which came out in evidence at an inquest at Hackney last week. The subject of the inquiry was a three-year-old child who had always been delicate, and for whom the family doctor had advised a diet consisting principally of rice and milk. The child, however, seems to have had carnivorous instincts, and seeing her mother preparing some raw sausages, she clamoured to such purpose that the mother to satisfy her gave her half a one to eat. Asked by the Coroner whether she was in the habit of giving her children such delicacies, she replied that she did so when they cried, although she would not eat raw sausages herself. The jury returned a verdict of "Natural Death," but we cannot help thinking that the point in civilisation has been arrived at when it would be well to bring such actions as this of the mother under the head of culpable neglect. It is no compliment to the humanity of society that medical advice should be so glaringly neglected without some sort of penal consequence to the responsible person. The "Cry of the Children" is gaining much response just now; their cries for raw sausage might be included in the purview of the leaders of the movement.

Advantage of Co-operation.

ANOTHER example of what may be accomplished by the combined action of medical men was furnished at Banbury the other day. Dr. Innes Griffin, of that town, was called into consultation by the workhouse medical officer, Dr. Dwyer, to consult over the case of a pauper patient. The recognised fee in such cases was a guinea, but the guardians by way of economy, tendered only half that sum. A County Court action was brought by Dr. Griffin, who, however, found that he had no legal claim, and agreed to settle the matter out of court, as a guinea was tendered by defendants.

Subsequently a meeting of the profession was held, and a letter written to the Board of Guardians saying that as they had been informed that medical men had no legal claim against the guardians for consultations, they must decline to meet the workhouse medical officer till a satisfactory arrangement was arrived at. A discussion ensued at the Board meeting, and in the end a reply was sent to the profession that in future a guinea would be paid in all cases in which a consultation was invited. We cordially congratulate the profession of Banbury on the result of their action and in the method adopted. The bare-faced underpaying of medical services which public boards indulge in on one ground and another can only be stopped by the profession presenting a united and dignified front.

Doctor and Matron at Highfield Infirmary.

We have had reason several times to comment on the dangerous and pernicious doctrine held by some local authorities in the country as to the relative positions that should be occupied by the medical officer and the matron of a hospital or infirmary. The Workhouse Committee of the Liverpool Select Vestry is one of the said authorities whose action we have had to criticise on account of the unsatisfactory position which they accord to their medical officer at the Highfield Infirmary. We are very glad to see that the matter has not been allowed to drop, for in a re-organisation scheme which they have before them it is proposed that the chief executive officer of the infirmary shall be the medical officer, and that the matron shall be his subordinate. The point has not yet been definitely solved, but considering the evidence that one of the members has collected on the subject, and the prejudicial influence on the conduct and discipline of an institution which the placing of a matron in a position of authority superior to the medical officer always exercises, we fancy that there can be little doubt as to the final decision. Indeed, we are surprised at the Local Government Board sanctioning any other arrangement, because their views formed as the result of many years' experience are both strong and well known. The Highfield Infirmary, it is proposed, shall take the definite place of a hospital for sick paupers, instead of being as at present a kind of home, and such a change makes the change in constitutions we have indicated all the more imperative.

Protection of the Innocents.

If laws for the preservation of children were as many and as rigorously enforced as those for the preservation of game, a great national disgrace would soon be wiped off the slate, but in this country by ancient custom we have learned to value our pheasants more than the children of the nation. Some of the most pitiable of the cases helped by the Society for the Prevention of Cruelty to Children are the babies of young unmarried women, as these fall into the hands of unscrupulous persons; but in many instances information is received too late to save the innocent victims. There was a considerable diminution last year in the number of assaults and ill-treatment, but from carelessness and ignorance, overlying, burns, and so on, 1905 saw no fewer than 1,527 deaths. A memorial has been sent to the Prime Minister and the Home Secretary expressing a hope that facilities will be granted for the passing of the Prevention of Cruelty to Children Bill now before Parliament.

LEADING ARTICLE.

TRADES UNIONISM OR—AN ALTERNATIVE.

There are many manifestations of discontent abroad among the main body of the medical profession. Among the more significant of these is a growing tendency to protest against the payment of inadequate fees by public bodies. In several instances a strong stand has been successfully taken by local medical bodies against the under-payment of resident medical officers holding Poor-law appointments. Then there is the great question of the medical aid societies which seek to make a direct profit out of the services of their medical officers. The facts of the latter case have been so long before our readers that there is no need to do more than refer to them here. There is one point, however, in common, not only to both the foregoing matters but to others of the same kind, and to this point it is the present purpose to call attention. This special feature is the action of local professional bodies not only in issuing their protest against any particular contract of employment, but in warning medical men generally against applying for such posts. Indeed, a list of appointments vacant under such circumstances is now published week by week. The principle adopted in this instance is nothing more nor less than that of "picketing," which forms one of the most powerful weapons of trades unionism. It may be well, therefore, to remind ourselves that the weapon is used to maintain a recognised scale of wages at or about a level mutually agreed upon as a fair one by the parties to an employment contract. Should any dispute occur as to the fairness of the remuneration, then the trades unionist, failing other adjustments, ceases work. Should the vacant posts be sought by other men at a lower rate than that demanded by the strikers, then the latter are now legally entitled to warn the newcomers as to the terms of the dispute and bring reasonable persuasion upon them to stand aloof. Now, to all intents and purposes, *mutatis mutandis*, this is what medical men are now doing in various directions. They have adopted the principles, and, to some extent, the tactics of trades unionism. In so doing they have, in our opinion, done nothing derogatory to the traditions of the profession to which they belong. By a close and practical application of similar trades-unionism principles, the lawyers have attained a security of their professional interests that is simply phenomenal in its strength and comprehensiveness. For a layman to trespass on the province of a solicitor is to court speedy and condign punishment, whereas to act as an unqualified medical practitioner is in many instances to amass a large fortune at the cost of a deluded public and a wronged profession.

Under such circumstances, it is surely somewhat squeamish to raise the cry of trades unionism against men who are attempting the collective defence of their professional interests in a perfectly straightforward and honourable way. That accusation has been brought against the Wandsworth Branch of the British Medical Association because they have attempted to secure a just scale of fees from the local board of guardians. At a recent meeting of the last-mentioned body, the action of the local medical association formed the chief subject of discussion. The original dispute arose in consequence of a midwife having called in a medical practitioner to a difficult case and, the patient being totally unable to pay the doctor's fee (£2 2s.), application for it was made to the guardians. The gentleman called in was not, it appears, an officer of the guardians, who thought the fee rather high, and in consequence sent a communication to the local Association concerned asking if they were willing to accept a fee of 15s. for attendance in similar circumstances. In answer to this, the Medical Association asked the following fees: Visit (including any necessary prescription), day (7 a.m. to 7 p.m.), 3s. 6d.; night (7 p.m. to 7 a.m.), 7s. 6d.; attendance at cases of operative interference, £2; administration of anæsthetic, £1 1s. The *Tribune* in commenting upon this incident, says that it has created strong feeling on the part of some medical men in the district, who have condemned the tactics adopted by the Wandsworth branch of the British Medical Association as bringing the profession "to the level of a trade union." The sneer is characteristic of the attitude of a certain section of the medical profession who deal simply in destructive criticism with any proposal for collective defence. The cry of "trades unionism" has often been raised by such men, and has hitherto served its purpose. Now that the principles of that movement have been frankly adopted by so many medical bodies, the reproach implied by the application of that term is likely in the future to be considerably curtailed if not altogether abolished. Call the modern movement for collective defence and reform amongst medical men what we may, its advent should be hailed with acclamation by the members of a sorely-tried profession. In the meantime, local associations of medical men in various parts of the United Kingdom will do well to note the firm attitude taken by their Wandsworth brethren in the matter of Poor-law fees and emergency attendances under the Midwives' Act.

CURRENT TOPICS.

Law for Lawyers and Law for Medical Men.

IN our correspondence columns of the present issue appears a letter from Mr. Henry Sewill, pointing out the inequality of the law controlling qualified medical men as compared with that applied to solicitors. His letter is somewhat strongly worded, but not more so than is warranted by the facts of the case. The injury done to the public by the inditing of a business letter in legal form is infinitesimal. On the other hand the actual damage inflicted upon the health, the productive capacity, the happiness and, in some instances, the lives of His Majesty's lieges by a single specious quack advertisement may be incalculably great. Take the case of patent medicines claiming to cure chronic kidney disease, cancer and locomotor ataxy. None of these diseases are curable by any means known to scientific medicine, and any claim to effect a cure by any particular nostrum is necessarily based upon a falsehood and must therefore be fraudulent. Yet the law punishes vigorously and mercilessly the least infraction of a solicitor's province, while it permits the quack to go scot free on his evil career, in spite of the deadly havoc he is working on all hands. In this connection we include any person who advertises a drug or combination of drugs for the cure of specific maladies as an unqualified practitioner of medicine. Some day society will doubtless learn to appreciate at their proper value these will-o'-the-wisp remedies, and will exact from every man who professes to cure disease adequate proof of his special knowledge in the most difficult of all arts and sciences. Meanwhile, the most feasible way of informing the community as to the precise facts of quacks and quackery is by the agency of that truly British institution—a Royal Commission.

A Crimean Medical Hero.

ON the 12th of the present month the ranks of the few survivors of the immortal Charge of the Light Brigade were still further lessened by the death of Surgeon-Major Lancelot Armstrong. He belonged to the old 13th Light Dragoons, and as an army surgeon served throughout the Crimean war. He actually rode with the rest of his comrades when the order was given by Lord Cardigan to charge the Russian batteries. He stopped short of the guns to attend to the men of his regiment who were falling on all sides. In the face of a murderous fire Surgeon Armstrong did his duty to the wounded with a coolness and courage that should have gained for him the well merited distinction of the Victoria Cross. It seems unaccountable that such splendid heroism should have been overlooked in the distribution of honours, both at the time of the war and subsequently. Armstrong's name, however, is indelibly inscribed on the roll of medical men who have done their work nobly and well when called upon to do so in the service of the State.

Doctors' Mistakes.

WITH the issue of the annual report of the Metropolitan Asylums Board we are accustomed to see articles in various papers complaining of the high ratio of errors of diagnosis to the total admissions to the Board's infectious hospitals. The doctors who sign the notification certificates are supposed to be very stupid people not to be able to recognise scarlet fever, diphtheria, and typhoid fever when they are called in, and members of the Board themselves are often to blame for making censorious remarks on the subject. It is, however, one of the necessary conditions on which an isolation hospital works that it should receive cases, especially diphtheria cases, early, and if the medical men delay till all the symptoms of a disease are well established they will often be compelled to keep a patient at home for days or weeks. The returns this year show figures much the same as in other years, namely, a percentage rate of error for scarlet fever of 5.2, for diphtheria of 18.3, and enteric fever of 33.7 Medical men in practice know the enormous difficulties in diagnosing enteric fever in its early stages, and also the importance of removing a patient to hospital as early as possible, and they will not be disposed on the whole to think a ratio of a third particularly high, whatever laymen who glean their information after the event may believe. The necessity of early administration of antitoxin in diphtheria is shown by the figures which the Brook Hospital has kept from the beginning of the antitoxin period. These record that of 235 cases treated in the first day of disease, no cases died; of 1,441 on the second day, 4.3 per cent. died; of 1,600 on the third, 11.12 died; of 1,276 on the fourth, 17.2; and of 1,645 on the fifth day or after, 18.72 died. If these figures do not justify an error ratio of 18.3 in the diagnosis of diphtheria, it is difficult to say what would.

Red Cross Organisation.

THE unsatisfactory and disjointed condition of the voluntary societies formed to aid the sick and wounded in time of war has always been apparent in the past, but since 1905 the work of co-ordination and organisation has been going on so steadily that if a war were to break out it is probable that the charity of people at home would be administered in a more scientific way than ever before. The prime mover in this matter is the Queen, who has personally taken the question up, and after securing that there should be an amalgamation of all bodies into one society, and that that society should be the only channel between the public and the War Office, she has set to work to engage the support of the Lords Lieutenant and the leading people in every county. According to a speech made by Sir Frederick Treves at Lincoln at a meeting to inaugurate a branch of the society in that county, it appears that the Red Cross Society is about the only charitable body that does not require money, for the Committee have £172,000 invested, and the income produced thereby is ample for their wants in time of peace. But what is needed is to have a branch of the society in every place so that the money subscribed by people in time of war may be properly spent and applied to the best advantage. As examples of the waste of energy and philanthropy in the South African War, Sir Frederick instanced two experiences of his own, namely, that certain boxes sent out to him circulated round and round South Africa all the time he was there, and reached him only after his return to London, and again, that at Ladysmith, when the temperature was 103° and 105°, a large box of warm woollen mittens was sent him for the troops. But now that the society is really likely to be managed in a workmanlike way and the fullest play is to be allowed for local patriotism, it will be a great reproach to the practical genius of the race if the organisation is not well and truly laid in every corner of the land; all the more so as, at the Conference of the Red Cross Societies from all countries which is shortly to be held in London, we shall propably hear again the wonderful tale of how the Japanese made such Red Cross arrangements as succeeded in alleviating and succouring over a million patients during the war wth Russia.

Post-Graduated Work in Dublin.

IT is a matter for congratulation to all interested in the intellectual activity of the Dublin School of Medicine and the profession in Ireland to see the keen way in which facilities for post-graduate work have been made use of in the past few years. It is only three years since Trinity College led the way by organizing for the first time in Ireland a course of study for medical practitioners. The services of capable and inspiring teachers were secured, and the success attending their efforts has been shown by the increasing number of medical men who attend the successive courses. Last year, the Royal College of Surgeons arranged two courses of lectures and demonstrations, one in June and one in October. This year they have announced similar series, the material of nearly all the clinical hospitals being made available. The Catholic University School has followed suit; lectures will be given in Cecilia Street, and clinical teaching in the Mater Misericordiæ and St. Vincent's Hospitals. From Belfast also there comes news of the arrangement of a post-graduate course. The advantage to a busy practitioner of a few weeks at one of these centres of learning, seeing new methods, meeting old friends, and renewing old associations, is incalculable.

Sterilisation of Certain Degenerates.

THOSE having this subject at heart will be interested to learn that a Bill was introduced into the Legislature of the State of Indiana, read a first time on January 29th, 1907, and referred to the "Committee on State Medicine, Health, and Vital Statistics," and on February 6th, referred to the "Committee on Benevolent and Scientific Institutions;" passed by the Senate on February 27th, and finally approved by the Governor. The text of this Act is as follows:—"An Act entitled an Act to prevent procreation of confirmed criminals, idiots, imbeciles, and rapists, providing that superintendents and boards of managers of institutions where such persons are confined, shall have the authority and are empowered to appoint a committee of experts, consisting of two physicians to examine into the mental condition of such inmates.

Whereas, heredity plays an important part in the transmission of crime, idiocy, and imbecility. Therefore, be it enacted by the General Assembly of the State of Indiana, that on and after the passage of this Act, it shall be compulsory for each and every institution in the State, entrusted with the care of confirmed criminals, idiots, rapists, and imbeciles, to appoint upon its staff in addition to the regular institution physician, two skilled surgeons of recognised ability, whose duty it shall be, in conjunction with the chief physician of the institution, to examine the mental and physical condition of such inmates as are recommended by the institutional physician and Board of Managers. If, in the judgment of this committee of experts and the Board of Managers, procreation is inadvisable and there is no probability of improvement of the mental condition of the inmate, it shall be lawful for the surgeons to perform such operation for the prevention of procreation as shall be decided safest and most effective. But this operation shall not be performed except in cases that have been pronounced unimprovable. Provided, that in no case shall the consultation fee be more than three ($3.00) dollars to each expert, to be paid out of the funds appropriated for the maintenance of such institution.

Housemaid's Knee.

Of all the long list of trade maladies known to the public, there is probably no single one more popular than "housemaid's knee." The name goes straight to the very inwardness of the thing, and its mention flashes a vivid image upon the mind of the all-important man in the street. Instantly he pictures to himself a maid-of-all-work with a huge swelling in front of the knee as the result of washing many floors and front door steps. He knows the malady to be painful and crippling, but at the same time absolutely preventable. Give her a proper mat to kneel upon, and the hard-working maidservant will avoid what the doctors describe as "a painful inflammation of the bursa in front of the ligamentum patellæ." Curiously, the Departmental Committee of Inquiry into the question of compensation for industrial diseases has reported dead against housemaid's knee. Chimney sweeps may claim for cancer, stablemen for glanders, and many scores of other workers for various forms of damage arising out of their occupation. But the housemaid is left out in the cold, the chief reason being that the "knee" is avoidable "by the simple method of kneeling on a proper mat." Suppose the employer does not provide that mat and housemaid's knee ensues, why should not the employer be held responsible? If such a liability were enforced, it is clear that all decent householders would escape, inasmuch as they would be careful to provide kneeling mats for their servants' use. It is to be presumed that the Departmental Committee do not suggest that housemaids should, if necessary, buy their own mats. This decision runs counter to the humane tenor of the extension of employer's liability to domestic servants.

PERSONAL.

We have reason to believe that the health of Princess Victoria is causing her parents much anxiety. Now that the Princess has returned to this country a consultation will be held by several medical men of high standing.

Sir Thomas Naghten FitzGerald, C.B., of Victoria, who has lived in Australia for nearly half a century, is returning to his colonial home at Melbourne this week by the *Orontes*, accompanied by his daughter, Miss Kathleen FitzGerald.

Dr. Bertram Abrahams occupied the chair at the dinner of the Society of professional men, known as the Maccabeans, on May 22nd.

Professor G. H. F. Nuttall delivered yesterday the first of two lectures at the Royal Institution on "Malaria, Sleeping Sickness, Tick Fever and Allied Diseases."

At the Stepney Coroner's Court, on May 22nd, the late deputy coroner, Dr. King Houchin, was the recipient of a handsome testimonial, which had been subscribed for by the medical men in the East End of London, as a recognition of the manner he had carried out his duties for thirteen years.

The Postmaster-General has appointed Dr. W. B. Crawford Treasure Post Office Medical Officer for the western division, and Dr. W. J. D. Morris, for the eastern division, of Cardiff.

Dr. William MacLeod, M.B., Ch.B., has been appointed medical officer for Strath.

Dr. A. T. Stanton, demonstrator at the London School of Tropical Medicine, has been appointed second assistant at the Kuala Lumpur Laboratory, in the Straits Settlements.

Dr. St. George Gray, medical officer of Sierra Leone, has been transferred to Southern Nigeria as senior medical officer. Prior to proceeding to West Africa, Dr. Gray served in the West Indies for eleven years.

Dr. R. H. Kennan, medical officer of the Gold Coast Colony, has been promoted senior medical officer of Sierra Leone in place of Dr. T. Hood, who has been transferred.

Dr. E. Ryan, of Crumlin, was last week presented with an address and a purse of gold by the colliers of the neighbourhood. It bore the following inscription:—"Presented to Dr. E. Ryan, L.R.C.S.E., L.R.C.P.E., Crumlin, by the Llanhilleth Colliery workmen and others of Crumlin and District."

Dr. Donald MacAlister opened the session of the General Medical Council yesterday, at 2 p.m.

Professor Nuttall delivered his inaugural professional lecture at Cambridge on May 22nd, in the Armstrong Theatre.

Sir John Batty Tuke has been unanimously re-elected representative of the Royal College of Physicians of Edinburgh on the General Medical Council for the next five years.

At the memorial service on Saturday last for the late Sir Joseph Fayrer, physician to the King, His Majesty was represented by Sir Arthur Ellis, and among those present were Lord Strathcona, Sir Frederick Treves, Sir R. Douglas Powell.

Dr. J. Coote Hibbert, assistant medical officer of health for Newcastle, has just been appointed medical officer of health for Warrington.

A CLINICAL LECTURE

ON

THE TREATMENT OF PNEUMONIA. (a.)

By Sir JAMES BARR, M.D., LL.D., F.R.C.P., F.R.S.E.,

Senior Physician, Liverpool Royal Infirmary; Chairman of the Medical Faculty of Liverpool University; President of the Lancashire and Cheshire Branch, British Medical Association.

PART II.—(*Conclusion.*)

SLEEP.

It is most important that the patient should have a fair amount of sleep from the very commencement; there is nothing lessens the patient's chance of recovery so much as the exhaustion of the nervous system from want of sleep. There is no objection to opium in the early stage, and two or three 10-grain doses of Dovers' powder during the night often answer admirably. In alcoholic subjects a combination of opium and antimony answers well. Professor Waymouth Reid and Professor Macdonald have shown that morphine lessens the nerve impulse travelling along the phrenic nerve; when, therefore, the lung is engorged and the right side of the heart handicapped, I would avoid all preparations of opium, or only use morphine in combination with hyoscine and atropine, or strychnine. If sleep has been obtained in the early stages it is not difficult to induce it in the later. Sleep is absolutely necessary for the patient, and the sooner it is procured the better. A quiet restful sleep tends to lower the temperature, and on the other hand a high temperature is very inimical to sleep. The delirium of a low muttering character which frequently accompanies this disease is usually controlled by free ventilation, and the reduction of the patient's temperature, which is best effected by large ice-bags to the abdomen. Pneumonia complicated with delirium tremens is a very fatal malady. It is often difficult to draw a distinction between the delirium of pneumonia and alcoholic delirium complicating pneumonia; and acute or late delirium, by which appellation the complication is known nowadays, is more euphonious to the public ear than delirium tremens. These cases are marked by active, often violent delirium, delusions of sight and hearing, great tremor, irritability of the nervous system, and the knee jerks are generally absent. In such cases it is essential to keep the nervous system quiet and obtain sleep, but this is often a most difficult problem to solve, especially when the delirium tremens arises late in the pneumonic attack. There must be no mechanical restraint or any struggling with the patient, as thus fatal syncope is readily induced. I have often seen these patients become quiet when they were allowed to stand or walk about in a well-ventilated room. Under these circumstances the fall in the blood pressure and the lessened blood supply to the brain has a calming effect. When the patient has been induced to go back to bed, if it be in the early stage of the disease, and the pulse full and bounding, or small and firm he should have repeated doses of antimony and opium. If in a later stage with the pulse small, short and feeble, and with the lungs engorged and skin very moist, a hypodermic injection of hyoscine, morphine, and atropine answers better. A few whiffs of chloroform or the A.C.E. mixture often gives the sedative an opportunity of acting. To these patients I frequently allow two pints of beer or stout in the twenty-four hours as a sedative. It is not wise to entirely cut off alcohol from a patient bordering on delirium tremens. Under no other circumstances do I prescribe alcohol in pneumonia. Alcohol does not increase the power of the cardiac muscle, but merely lessens the peripheral resistance by producing vaso-motor paresis, an effect which cannot often be required, as the systemic blood pressure is usually too low without any assistance from alcohol. It also increases the diastolic tension within the ventricles and leads to cardiac dilatation. Alcohol dries the tongue, increases the delirium, and makes the sleep more perturbed. The good effects of abstention are well seen in those cases who have been overdosed when you abruptly cut off all alcohol. The delirium, restlessness, and parched mouth are replaced by quiet sleep and moist tongue. During the convalescence the patient may, if thought necessary, revert to his accustomed use of alcohol, but in great moderation.

DRUGS.

If the illness began with nausea or vomiting, it is well to wash out the stomach with a few tumblerfuls of hot water to which an equal number of teaspoonfuls of mustard have been added. The bowels should be cleared with a brisk calomel purge. In sthenic cases antimony is useful, and if there be much restlessness or delirium antimony and opium is a good combination. In no case should an acid mixture be given at the commencement. Quinine as an antipyretic agent has been very much over-rated, but in hectic temperatures due to mixed infection it is a valuable agent in large doses, and during convalescence it is a good tonic in small doses. If the pulse tension be very low, the expectoration liquid and profuse or prune juice in character, a mixture of chloride of calcium and perchloride of iron is suitable. The more scanty and sticky the expectoration at the outset the better the outlook, hence you should never give agents in the early stages to increase or loosen the expectoration. The phlegm comes from the spreading area, and not from the consolidated lung, hence I prefer the lime salts to increase the coagulability of the secretion and limit the spread of the mischief. In pneumonia in a case of bronchitic asthma with marked emphysema and abundant muco-purulent expectoration, I have had good results from a mixture of chloride of calcium and tincture of iodine. If there be a tendency to cardiac failure the best remedies are strychnine, caffeine, and digitalis. The latter drug has been vaunted as a specific in pneumonia, but I have never found it such, and

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(a) Delivered at the Liverpool Royal Infirmary, May 7, 1907.

very rarely prescribe it during the acute stage of the disease. An antidote for the pneumotoxin would be much more valuable than any of the antiseptics, but unfortunately we do not possess such. In cases of mixed infection with streptococci I have found anti-streptococcal serum valuable. If there be any danger of collapse with profuse perspiration atropine should be injected. If there be any tendency to the formation of cardiac thrombi remedies which keep the blood liquid should be freely administered, such as a mixture of equal parts of liquor ammonii fort. and spiritus chloroformi, 5 to 10 minims every half hour or hour; also decalcifying agents such as citric acid, citrates of sodium and ammonium, lemon squash, &c.

The views which I have propounded regarding drug treatment in pneumonia do not command universal acceptance, and I have recently taken part in a controversy on the subject in the *British Medical Journal*. Dr. William Ewart in an interesting article on the "Principles of Treatment of Pneumonia," (*a*) holds that you should endeavour to keep the secretion in the air cells and bronchi as liquid as possible, so as to avoid as far as possible consolidation of the lung. In opposition to this view I hold that, *cæteris paribus*, in the acute stage of pneumonia, the more scanty and more sticky the expectoration, the more viscous the blood; the more lime salts and leucocytes it contains, the more favourable the prognosis; on the other hand, the more fluid and hæmorrhagic the expectoration, the more liquid the blood; the less the lime salts and leucocytes, the worse the prognosis. Acting on these views I have long ceased to prescribe carbonate of ammonia and other expectorants during the acute stage of the disease. Those cases of creeping and influenzal pneumonias where there is no proper consolidation are most fatal. The cardiac thrombosis is more frequently a sequel than a cause of cardiac failure; occurs chiefly in the right auricle and ventricle; is due to cardiac weakness, blood-stagnation, leucocytic destruction, and fibrin ferment, rather than to any great excess of lime salts. When the febrile process is over it is then well to use some agent to lessen the viscosity of the blood and liquefy the effusion in the alveoli. You all know how much importance I attach to the calcium salts in this disease, and for many years I have had to be content with clinical evidence as to the indications for their use, and the amount in the blood by the state of the expectoration and the coagulability of the blood, but now Dr. Blair Bell has provided us with an excellent and accurate method for determining the quantitative amount in the blood. So far as our observations have gone with this correct method it has supported my previous practice.

Similar views have been ably expressed by Dr. Auld (*b*) "that the pneumonic consolidation is Nature's method of localising the morbid process, and of curing the disease . . . Moreover, in cases of pneumococcus infection showing little or no tendency to pulmonary hepatisation—when the pneumococci run riot in the organism, so to speak, —the result is always grave, and indeed generally fatal." Dr. Auld writes me that "the results of his experiments on animals corresponded to those observed on man. It was only in those cases where a culture of moderate virulence was employed that hepatisation of lung was obtained in animals —a very virulent culture failed to give hepatisation, thus showing that when the organism of pneumonia freely enters the circulating blood, it prevents the pulmonary coagulation, whereas when it is capable of being localised coagulation follows. These injections were also made into the pleural cavities with the same results. The time element was also considered, as when the animal was killed after a moderately virulent culture hepatisation was observed to have begun, but after a very virulent culture this feature was absent, being replaced by a sanguineous serum." I consider these experiments of Dr. Auld of extreme value.

If the lung pass into the stage of grey hepatisation, with purulent infiltration and profuse expectoration, there is no remedy like terebene or some of the turpentine series. I have also found it invaluable in cases of abscess and gangrene of the lung and in bronchiectasis. During convalescence tonics are required.

The teeth, tongue, mouth, and even the nose should be kept clean with some antiseptic throughout the illness. The importance of keeping the mouth clean as a preventive measure is well exemplified in the so-called ether pneumonias which are due to the aspiration into the trachea and bronchi of foul secretions from the mouth. Before the administration of an anæsthetic the mouth should be well cleaned with some strong antiseptic. Pure brandy or whisky answers very well, but this mouth-wash should not be swallowed. An excellent mouth wash can be made with formalin, glycerine of carbolic acid, and eau de Cologne.

Pneumonia is a self-limited disease, and as a rule if we can only keep our patients alive for seven or eight days they get well. We must therefore inquire what are the causes of death in pneumonia in order to obviate them. It is well to see the danger signals ahead and try and steer the patient clear of them. We will now consider the class of patients who die from this disease.

There is a very heavy mortality during the first five years of life, and more especially during the first year. No doubt the vast majority of the cases included in the Registrar-General's returns are cases of broncho-pneumonia or capillary bronchitis, but yet after the second year true croupous pneumonia is not at all uncommon. The case mortality is variously stated from 30 to 50 per cent., and I have a shrewd opinion that the bronchitis kettle is to a considerable extent responsible for this excessive mortality. But independently of treatment, many of these little patients, after a long struggle, gradually succumb from failure of the right side of the heart. Why should this be? Their young hearts are healthy, and particularly sensitive, so that they will not stop on a slight provocation. In health the respiration affords great assistance to the right side of the heart in carrying on the circulation, but in diseases affecting the respiratory pump this assistance is diminished or cut off. If you observe a young child suffering from laryngeal diphtheria you will see that the resilient chest walls cannot expand against the atmospheric pressure; the diaphragm is pulled down, but the lower part of the sternum and the costal cartilages are pushed in so that the heart gets comparatively little assistance from the respiratory pump.

(See my paper on "The Effects of Respiration

(*a*) *Lancet*, Vol. I., p. 138, 1905.
(*b*) *Lancet*, Vol. I., p. 254, 1905.

on the Circulation," *British Medical Journal*, April 20, 1907.)

In capillary bronchitis and pneumonia where there is little variation in the dimensions of the lungs between expiration and inspiration, the same conditions apply though to a less extent.

The situation of the heart when the soft cartilages are easily pushed in by the atmospheric pressure prevents the blood vascular cavity from obtaining much relief. Moreover the stomach and bowels are frequently so much distended with gas, owing to too much food of an improper quality, that the diaphragm has got very little play, and thus the respiratory pump is still further thrown out of action. However, there is one point in favour of these young children, and even of those of less tender years suffering from pneumonia: their inspirations may appear short, shallow, and catchy, but there is frequently a considerable pause between the end of inspiration and the commencement of expiration which enormously assists the pulmonic circulation.

In children after the age of five years with strong chest walls, and in young adults, the surplus vital capacity, even when a whole lung is involved, is usually sufficient to tide the heart over its difficulties until resolution takes place. In women—and especially in pregnant women—the vital capacity is less and the mortality is greater than in men. With advancing years and rigid chest walls there is a gradual failure in the respiratory pump, and a corresponding increase in the mortality. However, there is a great difference in individuals, and some spare men keep a good pump even up to old age. In very old people, as was pointed out by Sir William Gull, pneumonia is frequently a mode of dying, and they die as comfortably from it as from any other disease.

The big, plethoric, pot-bellied man succumbs rapidly to an attack of pneumonia. How is this? Such men are not particularly prone to the disease; the pneumococcus has no special predilection for fat; the disease is not more intense than in lean persons, except that the non-conducting layer of fat is apt to maintain a higher internal temperature. The typical John Bull is never ready for a fight of any kind, and although, as Lord Rosebery says, the Englishman generally tumbles on his feet, in this process of tumbling an enormous number go under the sod. These fat, flabby men cannot bear to be hit either under or over the belt, as their wind is easily knocked out, and a moderate attack of pneumonia throws the respiratory pump out of gear. The best treatment for these individuals is prophylactic; you should start months or years beforehand to reduce their corporations, and strengthen their fat, flabby right hearts.

There is another condition where the individual has got a fatty degenerated right ventricle, but a good respiratory pump. I have known many such cases going about their ordinary business for years with an extremely irregular pulse and a barely appreciable first sound over the right ventricle. Of course such patients are apt to succumb to any acute illness, but it is marvellous how their good respiration carries them safely even through a mild attack of pneumonia.

Patients suffering from emphysema are not good subjects for an attack of pneumonia, but the right side of the heart is usually hypertrophied, and does not stand in much need of respiratory assistance, so if there be no accompanying bronchitis, it may suffice for pneumonia of one lobe.

In diabetes there is frequently much emaciation of the chest muscles, a feeble respiratory pump, and a weak heart, conditions which favour a fatal determination.

In advanced kidney disease there is uræmic poisoning, a tendency to pulmonary œdema, indicative of right cardiac failure. Both acute and chronic alcoholism lead to cardiac asthenia, and the frequently associated abdominal distension interferes with the respiratory pump, so such cases are very liable to rapidly succumb from cardiac failure, accompanied by a large *ante-mortem* clot in the right side of the heart. The case is quite different with the gouty individual, his heart is usually hypertrophied and healthy, and if there be no kidney mischief he stands an attack of pneumonia well

There are certain cases which seem to fall victims to the intensity of the poison, but the vast majority of the deaths are due to cardiac failure arising from want of proper care and assistance owing to a defective respiratory pump. Mere carbonic acid poisoning is scarcely ever a cause. In bad cases of emphysema with bronchitis the patient is often livid for weeks, but so long as the right heart does not fail there is no danger from the mere lividity. It is true that in carbonic acid poisoning there is a general rise of arterial pressure and secondary overloading of the right side of the heart, but in pneumonia this sequence is prevented by the vaso-motor paresis. The overloading of the right side which takes place is due to failure of the heart and of the respiratory pump. At the very commencement of an acute pneumonia, with a severe stabbing pain in the side, the patient's face is often extremely purple and congested. This is not due to any obstruction in the lungs, as is shown by the large, full, bounding, relatively high tension pulse, but arises from the fact that the patient cannot use his respiratory pump owing to the sharp pleuritic pain. These are the cases where the removal of 10 to 20 ounces of blood from the arm affords immediate relief, but *Cui bono*? A good dose of opium or opium and antimony has a similar salutary effect by relieving the pleuritic pain and enabling the patient to put his pump in action.

PREVENTION OF CARDIAC FAILURE.

Cardiac failure is the proximate cause of all cases of somatic death; anyhow we would scarcely say the patient was dead until the heart ceased to beat. What are the causes of cardiac failure in pneumonia? A certain number of hearts have such degenerative vessels and muscle walls that they fail under the slightest stress, or cease to beat under any marked inhibition. We are never likely to be able to prevent such deaths unless by prophylactic measures. The large majority of hearts, however, make a desperate struggle for continued existence; the failure takes place from (*a*) granular degeneration of the muscular fibre induced by continued high temperature and toxæmia; (*b*) low arterial pressure which prevents proper nutrition of the heart, and produces a syncopal condition, the interference with the proper action of the respiratory pump from any cause leads to overloading and ultimate failure of the right side of the heart. Our indications for treatment, therefore, are (*a*) to lower the temperature and control the inflammatory process at the earliest possible period before great stagnation of the blood and extensive hepatization have taken place, and thus preserve as far as possible the integrity of the respiratory apparatus; (*b*) to maintain the systemic blood pressure; and (*c*) to keep the respiratory pump in action by lessening the frequency and increasing the depth of the respirations.

The diet should be extremely light and consist chiefly of milk; about two pints of milk, two or three pints of barley water, or whey, or plain water and about six ounces of syrup of glucose make an excellent diet in the acute stage. One of the greatest difficulties in private practice is to control the diet; the public have been educated in the belief that great quantities of nourishment and stimulants are necessary, and consequently you frequently find the abdomen enormously distended with flatus which prevents free play of the diaphragm.

In conclusion I wish to strongly impress on you that pneumonia should always be looked upon as a serious disease. I know of nothing more terrible than to see the breadwinner of a large family cut off in a few days by this dire malady, so every medical man in dealing with this affection should feel the responsibility of a human life in his hands. Unfortunately some men never see a danger signal until the patient is dying, and then they get thoroughly alarmed when it is too late to avert the catastrophe. Early recognition and prompt treatment would save many a valuable life.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Arthur E. Giles, M.D., B.Sc. Lond., F.R.C.S., Surgeon to the Chelsea Hospital for Women; Gynæcologist to the Prince of Wales' Hospital, Tottenham. Subject: "The Developments and Dangers of Extra-Uterine Pregnancy," with illustrations.*

ORIGINAL PAPERS.

THE TREATMENT OF ALBUMINURIA AND ECLAMPSIA OF PREGNANCY. (*a*)

By ED. OCTAVIUS CROFT, M.D.,
President of the North of England Obstetrical and Gynæcological Society.

THE author, after reviewing the various methods of treatment which had been carried out from time to time, said he considered that we had not yet the materials at hand for a scientific basis of classification of the causes and indications for treatment. Further advances, he thought, must be made by the pathologist and obstetrician in conjunction. Our present position as regards treatment is somewhat more advanced than twenty years ago, in that we pay more attention to the presence of an unknown toxæmic condition which we attempt to deal with directly. He ventured to hope that ultimately the medical treatment of the disease will improve in efficiency to the extent of largely diminishing the necessity for active obstetric interference in most cases, and mere palliative treatment of the convulsions when such supervene. In speaking of pregnancy associated with pre-existing nephritis, he urged that the pregnancy should not be interrupted, until very thorough general treatment had been adopted, as many cases improved rapidly and completed the pregnancy without serious trouble. Cases of chronic Bright's disease with pregnancy were quoted, in whom treatment was not attempted, and who developed serious eclamptic attacks.

In considering *Albuminuria of pregnancy apart from eclampsia*, he urged the importance of complete recumbency, warmth, milk diet, and eliminative measures. The pregnancy need not be interrupted until indications were present that the disease was not under control. Spontaneous abortion from death of the fœtus often rendered operative interference unnecessary. In the event of the necessity arising, then Dr. Croft advocated the gentlest method. Rapid dilatation and evacuation under deep anæsthesia (especially ether) he thought was bad practice.

The treatment of the pre-eclamptic state required more vigorous attention to elimination, and rectal and gastric lavage, followed by saline injections, and hot packs, were useful. Pilocarpine might also have its use in this stage, but it was dangerous during the eclamptic attack. Diaphoresis was more safely produced by the hot pack. The recognition of the pre-eclamptic stage gave us warning and time to adopt energetic measures. There is now no doubt that the pregnancy should be terminated by rupture of the membranes. In the absence of convulsions time may be given for dilatation to occur. Accelerative measures may be employed if necessary.

The author discussed the *Treatment of the eclamptic attack*, and the various methods directed towards (1) the elimination of the poison; (2) controlling the actual convulsions; (3) the obstetric procedures for emptying the uterus. He asked for opinions on venesection, followed by saline infusion, intravenous or subcutaneous. He approved of these, as well as purgation by saline rectal injections and subsequent lavage. He had not found thyroid effectual, but more evidence was required in this respect. For pyrexia, he preferred the application of cold to antipyretic drugs. He instanced two cases where the temperature rose to 107° in a few hours. The operation of renal decortication required further evidence to justify its employment.

He thought the control of the convulsions by chloroform as a routine practice required reconsideration. He did not agree with its prolonged administration. The indications for morphia also should be clearly defined. It undoubtedly in many cases controlled the convulsions, but he doubted whether it should be given when coma is well marked.

Regarding obstetric measures, he did not favour accouchement forcé, nor was Cæsarian section in his opinion ever necessary. Rupture of the membranes, dilatation of the cervix, preferably with the fingers if the dilatation did not occur naturally, and accelerative measures, forceps rather than version, was good practice.

He did not advocate mechanical dilators on the Bossi principle. He thought they were clumsy and dangerous substitutes for the trained and sensitive fingers of the obstetrician. Dr. Croft illustrated his remarks by notes of a series of cases.

(*a*) Abstract of paper read before the North of England Obstetrical and Gynæcological Society, May 10th, 1907.

ON THE EXAMINATION OF THE URETHRA AND BLADDER BY THE ELECTRIC LIGHT. (a)

By ANDREW FULLERTON, M.D., F.R.C.S.,
Hon. Assistant-Surgeon to the Royal Victoria Hospital and to the Belfast Hospital for Sick Children.

PART I.

THE urethroscope consists essentially of a metal tube with a pilot to facilitate its introduction. The light from a small electric lamp is reflected by a mirror on to the surface to be examined. By means of a small glass door, armed with a bayonet catch attached to the tube end of the instrument, the latter can be rendered air-tight and the urethra can be distended beyond the end of the tube by a bellows such as is used for administering chloroform by means of Junker's apparatus. This bellows is attached to a lateral tube placed on the distal side of the glass window. By unlatching and turning this back, applications can be made to or operations performed on any portion of the urethra. Two varieties of instruments have been used in these observations, the aero-urethroscope of Hurry Fenwick, and a modification of the same by Wyndham Powell. The latter instrument is provided with a condensing lens placed between the electric lamp and the mirror, and gives a much greater illumination than is possible with the former. The older instruments were devoid of the inflating mechanism, but distension of the urethra gives such an immensely superior view that most surgeons prefer this important modification. Several sizes of specula are necessary. For the examination of the urethra in front of the membranous portion, tubes about 4½ inches long are used. A shorter speculum, suitable for the first few inches of the urethra (about 2½ inches long) is very convenient for operative work in this region. For the urethra behind the compressor muscle a longer tube is necessary, and for this purpose Mr. Fenwick's instrument, curved somewhat like a large and short catheter, is used. This has a fenestra just proximal to the bend, which allows the verumontanum and neighbouring portion of the posterior urethra to be seen. This prostatoscope, as it is called, is more easily introduced than a long straight tube. The greater the calibre of the speculum, the better, of course, is the view obtained. If the meatus externus is very small, it can be enlarged in a downward direction by a tenotomy knife, after thoroughly cocainising the part. This causes very little discomfort to the patient. The same procedure may be adopted prior to using the cystoscope, if necessary. I would remind you that the urethral canal is far from being uniform in calibre. On examination with the aero-urethroscope, a number of annular constrictions can be clearly seen. These may readily be mistaken for commencing strictures instead of the normal condition. The electric current for the small lamps may be supplied by a battery, and the form I have used with much satisfaction is a lithanode accumulator with six cells, four of which are sufficient for ordinary purposes. A rheostat is necessary to regulate the strength of the current. The lamps for the urethroscope take a current of about 8 volts, while a current of about 7 volts is usually sufficient for those of the cystoscope. If the current from the main is used a resistance box or a transformer is required to reduce the current to the necessary strength. For myself, I prefer the lithanode battery, which works well if charged regularly about once a month. It is portable, simple, and convenient, and has not once failed me. To examine the anterior urethra, a speculum of suitable size, armed with its pilot, is selected and lubricated with sterilised vaseline, oil, or a preparation of glycerine, water and gum tragacanth. It is carefully passed down to the membranous urethra, and the pilot withdrawn.

The light-carrying portion of the instrument is now attached to the speculum, and the orifice of the membranous urethra can be seen, after mopping out excess of fluid, as a small depression with folds radiating from it. Under ordinary circumstances air will not easily pass beyond this point. If gonorrhœa has been present, however, air will often pass very readily, and, reaching the bladder, produce a characteristic sensation to the patient which causes him to start, more from surprise than pain. The bulbous urethra and occasionally the orifices of the ducts of Cowper's glands may be seen on withdrawing the instrument a little, and admitting a small quantity of air. The mucous membrane can be carefully inspected from behind forwards, and any abnormality noticed. The ducts of Littré's glands will be seen, especially along the roof towards the anterior half of the penile urethra. These are sometimes infected in gonorrhœa and discharge pus from their interior. This form of urethritis is very difficult to cure. Further forward you will observe a ring or fold of mucous membrane at the base of the glans, situated either in the roof or circularly. This is the valve of Guérin. In front of this and situated in the roof, about half an inch from the meatus, is the so-called lacuna magna, the duct of a gland similar to those seen further back. The portion of the urethra in the glans penis is somewhat dilated, and forms what is known as the fossa navicularis. This fossa can be easily inspected by placing the nose of the urethroscope, without a cannula, just over the meatus and distending gently with air. By this means I have recently seen two cases of stricture in the fossa navicularis preventing the introduction of the smallest catheter. Along the course of the urethra in cases of chronic gleet will frequently be found thick, vascular, inelastic areas, and more rarely granular patches, or papillomata. To deal with these they are first accurately located. The window is then unlatched, so as to allow of the passage of the appliances necessary for treatment. A few cases will better illustrate what I mean.

Case 68, a male, æt. 32, with a history of gonorrhœa ten years ago, suddenly began to bleed from the urethra, and to pass dark, porter-coloured urine. This continued for six days, when he was admitted to the Royal Victoria Hospital. On the night after his admission, he lost a large quantity of blood, and showed the constitutional symptoms of severe hæmorrhage. Next morning, after injecting adrenalin into his urethra, I passed the urethroscopic speculum and discovered several small papillomata, about 2½ inches from the external meatus. With a short speculum, and a curette such as is used by ophthalmic surgeons for cysts of the eyelids, I was able to nip the growths between the two instruments and so remove them. There was a large calibre stricture immediately behind the papillomata. The bleeding ceased immediately, and has not recurred. The blood had also passed back into the bladder, which was seen by the cystoscope to be healthy. Note that the colour of the urine was dark, and that it did not come from the kidney as dark blood is usually supposed to do.

Case 64 is a troublesome patient. He is æt. 26, and has suffered for many months from chronic gleet. With the urethroscope, Littré's glands are seen to discharge pus through their open and inflamed ducts. He is being treated as follows: Nitrate of silver is fused on the end of a fine wire and passed into the ducts. He improves slowly, but at the end of six months' treatment he is still a patient. He had also a posterior urethritis, which appears to be now quite well as the result of instillations of nitrate of silver directly to the part. The long prostatic tube is rather a dangerous instrument, as its fenestra tends to injure the verumontanum and the delicate mucous membrane of the prostatic urethra. The following cases illustrate its use:—

Case 73, a male, æt. 34, fell six months ago on a nail which penetrated his perineum for an inch or more. Three or four weeks later an abscess formed and burst. Shortly after this urine began to leak from the perineal wound during micturition, and has continued to do so every since. He passes curdy matter in his urine, and lately he has noticed swelling of his legs, and puffiness about his eyelids. For the latter condition he was admitted under the care of Dr. Calwell. On examination there was found a fistula in his perineum, just behind the scrotum. The prostatoscope showed pus welling up from the floor of the prostatic urethra through an opening there. The prostate *per rectum* could be felt hard and nodular on both sides. No tubercle bacilli have been discovered in his urine, though Dr. Houston found his opsonic index below normal (.6). The pus could be seen with the cystoscope to fall back into the bladder in flakes and to lie in a heap at the base. Dr. Houston suspected tuberculous bladder or kidneys, but before injecting tuberculin, asked me to catheterize the ureters. Clear urine, loaded with albumin and casts, was obtained from both sides, showing the case to be one of chronic Bright's disease, with the complication in the prostate above referred to. Injections were therefore not advised.

(a) Being a paper read before the Ulster Medical Society on February 28th, 1907.

Mr. Hurry Fenwick mentions some cases of chronic posterior urethritis aggravated by an enlarged verumontanum, which he removes in selected cases. I have, following his directions, in a very protracted and obstinate case, removed such an enlarged verumontanum, and examined sections of it microscopically. It resembles Mr. Fenwick's case figured in his book on "Obscure Diseases of the Urethra." The patient states that he is much improved since the operation. I need hardly say that cases in which this procedure is necessary are rare. It does not seem to interfere with the sexual apparatus.

I have seen one case of ulceration of the prostatic urethra due to tubercle extending from the epididymis of the right side.

Case 61, a male, æt. 22, began to have frequency of micturition five years ago. He has become progressively worse and has now to pass water almost every half-hour. He occasionally passes blood and slimy matter, and his prepuce is macerated from constant dribbling of urine. His prostatic urethra is raw and bleeding, rendering it difficult to see the surface except for a second or so. I can find no evidence of tubercle in the bladder itself. *Per rectum*, the prostate and right vesicula seminalis were felt nodular and thickened. As tuberculous ulceration of the urethra is exceedingly rare, I have thought it desirable to mention this case.

Having mentioned these few cases to illustrate the lines on which investigation may profitably be conducted with the urethroscope, I now pass on to the consideration of the main part of my subject, namely, the examination of the bladder and ureteric orifices with the cystoscope. The instrument consists essentially of a lamp placed in the beak of a tube shaped almost like a Coudé catheter, with a prism placed on the proximal side of the bend, and a telescope which transmits the image. The prism serves to reflect the rays of light from the object examined so that they pass through a system of lenses and are easily perceived by the observer's eye. The lamps which are now used are the so-called "cold lamps," invented by Löwenstein, of Berlin. They appear to be ensheathed in asbestos, and, if used with ordinary care, do not burn the mucous membrane of the bladder, as the older variety were very apt to do. The current is supplied by a battery or from the main, with the same precautions as is the case of the urethroscope. Before introducing the instrument it is necessary to render it as aseptic as possible. As boiling ruins the cystoscope, some other method must be adopted, and the following may be relied upon to accomplish the desired result. The instrument is placed beak down in liquefied carbolic acid contained in a narrow vessel which allows the fluid to reach almost, but not quite, to the ocular end. It is then immersed in methylated spirit, which removes the carbolic acid. Finally it is washed with boiled water and dried with sterilized wool or gauze. For lubricating, oily material must not be used, as that would tend to grease the prism and obscure the view. The lubricant must mix readily with water, so that it comes off easily when the bladder is reached. Glycerine is an unsatisfactory lubricant, and I have therefore substituted for it a mixture of glycerine, water and gum tragacanth the consistence being about that of treacle. A similar mixture, containing in addition oxycyanate of mercury and called Melzer's catheter purin, is used by Professor Casper, of Berlin. The parts should be rendered thoroughly clean before the cystoscope is passed to minimise the ever-present danger of microbic infection. Even with the precautions just described, I have several times seen rigors, happily evanescent, occur, especially if there has been any source of infection in the urethra or bladder. In cases of tubercle of the bladder the danger of setting up a fatal cystitis is not inconsiderable; and much manipulation or examination of these cases is unnecessary and harmful. In retention of urine in patients æt. over 50, and in carcinoma of the bladder, the risks of infection are so great that extra care, if that is possible, should be taken, if it is found necessary to use the cystoscope.

As to the use of a general anæsthetic, I am opposed to it, except in rare cases, for the following reasons: (1) The risks of the anæsthetic itself. (2) The subsequent discomfort and sickness which are frequent. (3) Under an anæsthetic the secretion from the kidneys is disturbed, and, if it is necessary to catheterize the ureters, the antecedent starvation alters the character and amount of the urine secreted. (4) Many patients will hesitate, especially in private practice, to submit to an examination under an anæsthetic, unless they are satisfied that the latter is absolutely necessary for manipulation, which I hold is not the case in the large majority of instances. (5) The pain inflicted upon the patient is, as a rule, insignificant. I have the testimony of a young medical man, whose ureters were catheterized, to prove that, beyond an unpleasant sensation in the urethra, no pain was experienced. In some difficult cases, and perhaps in young girls, it may be advisable, but is rarely absolutely necessary. Local anæsthesia is, however, very useful and desirable. For this purpose cocain may be applied to the meatus in both sexes, but I rarely inject cocain into the urethra. In the *British Medical Journal* of a few weeks ago, a case of death from this cause was reported, and I have seen in my own practice alarming symptoms follow its use for this purpose. Eudrenine, a mixture of eucaine and adrenalin, is much safer and is efficient. It is prepared by Parke, Davis, and Co., and put up in small sealed glass tubes. The preparation of the bladder is the next step in the examination. If the urine is clear, it forms an excellent medium in which to examine with the cystoscope. I have frequently catheterized the ureters in the patient's own urine, without washing out, thereby simplifying very considerably the operation. In most cases, however, it will be necessary to wash out, using for this purpose sterile water or boric lotion. If cystitis be present, or if pus or blood be present in any quantity, it will require much care and patience to render the bladder sufficiently clean to obtain a satisfactory view of its walls and the ureteral orifices. If there is much hæmorrhage from the urethra or bladder, I usually inject adrenalin and water and leave it in for about fifteen minutes. There may be some blanching, but definite information is often afforded, and the ureteric orifices can usually be seen. The proper quantity of fluid to be left in the bladder for cystoscopic purposes may be stated as from five to ten ounces. If more is introduced, the apex of the bladder will disappear from view, and the ureteral lips become thin and stretched; if less, the folds of the lax mucous membrane may obscure the openings of the ureters or other objects which it is desirable to see. I have, however, frequently had to be satisfied with a distension of from two to three ounces, and in one case I succeeded in passing a ureteral catheter in a female bladder which would hardly retain even three ounces. The position of the patient may be the recumbent, with a hard pillow under the pelvis, or the lithotomy. I have become accustomed to the former and therefore prefer it; but the latter is, perhaps, more convenient for the surgeon.

The instruments which have been used in these observations are those of Nitze, and they answer all practical purposes. I hope, however, in the near future, to make a trial of some of the newer makes, which have recently been placed on the market. In the meantime, I can recommend Nitze's instruments, which I have used now for several years. For catheterizing the ureters a modification of the ordinary cystoscope is used. A channel is attached to the instrument, so that a small catheter may run in it and project under the eye of the operator when the cystoscope is in the bladder. The angle at which the point of the catheter projects can be regulated by a screw at the ocular end, which raises or depresses a small metal lever at the distal end of the instrument. I have used Nitze's catheterizing cystoscope in forty-two cases during the last twelve months, and have to record only one failure. This was in Case 59, a male, æt. 55, whose bladder wall was becoming invaded in a late stage of cancer of the rectum. The point of the ureteral catheter would only just engage the openings of the ureters. By no manipulation could I get it to proceed further. In all the other cases the operation was satisfactorily accomplished usually in a few seconds.

(*To be concluded in our next issue.*)

THE TREATMENT OF GOUT BY THE INGESTION OF COMMON SALT-CONTAINING WATERS. (*a*)

By Leonard Williams, M.D., M.R.C.P.,
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It would seem necessary to begin this paper by explaining what I mean by gout, and what I mean by common salt-containing waters. By gout I understand that disease of disordered metabolism whose clinical manifestations appear chiefly in the joints, the arteries and the kidneys. Beyond this it does not seem expedient to venture, though I must not be understood to suggest that the disease does not manifest itself in other organs or systems. I am quite aware that by adopting this attitude I am evading a difficult question, but as it is no part of my present purpose to attack that question, and as the majority of us agree as to what is meant by the term gout or goutiness, I am content to leave the matter thus. By common salt-containing waters I mean natural mineral waters which contain common salt to the extent of one per mille or upwards. Many of these waters are, I am aware, often classed under other designations, such, for example, as sulphur waters, but for my present purpose the fact that a water contains chloride of sodium to the amount indicated, suffices to bring it into my category, whether or not the therapeutic value of the water is usually attributed to the presence of some other ingredient.

Having thus cleared the ground of any misunderstandings which might arise from the title, I would like to premise what I have to say by reminding you how little we really know of the action of natural mineral waters. That they are active beyond anything which an analysis of their mineral constituents would lead one to expect, we all know. That they are active in directions which are often surprising, we also know. These activities and their nature still present attractive problems to those who are interested in this matter. Comparatively recently radio-activity has been added to the number of positive factors which may aid in the solution of the problems to which I refer. I say *one* of the factors advisedly, because it is quite evident that the comprehensive claims which have been put forward in favour of radio-activity in explanation of the efficacy of chemically indifferent waters will scarcely bear examination. For it is obvious that if this was the only weapon, or, indeed, the most potent weapon, employed in Nature's laboratory for endowing waters with therapeutic properties of obscure origin, then it would be quite easy for us to imitate Nature's methods by adding small quantities of salts of uranium to our laboratory preparations. We must admit then that in spite of radio-activity, the real nature of the subterranean processes are, so far as our present knowledge goes quite inexplicable. The matter, shortly put, seems still to stand thus: Judged by ordinary pharmacological standards, chemical salts which appear in natural mineral waters are endowed with a degree of therapeutic activity very much superior to that of the same salts as dispensed by the chemist. I do not think that there is any instance of the converse of this proposition being true. I do not think, for example, that there is any instance of a chemical salt which is known to be active when administered internally, losing or abating any portion of that activity by the fact of its presence in a natural mineral water. Instances of hyper-activity are familiar to all. The waters of La Bourboule, for instance, though they contain a very small quantity of arsenic (.028 per mille), have proved themselves beyond all doubt to be specially efficacious in conditions in which arsenic is indicated. Similar instances, drawn from sulphur waters, and more especially perhaps, from iron waters, would be easy to adduce. But perhaps the best examples, because they are most easily appreciated, are those afforded by the natural waters which contain purgative salts, such as Carlsbad, Marienbad, Chatel-Guyon and Brides-les-Bains. Of these, that which shows the greatest quantity of analysable purgative salts is Marienbad, which contains 350 grains, *i.e.*, considerably less than one ounce of sulphate of sodium per gallon, a quantity which is, of course, quite insufficient to account for its carthartic properties. It would be easy to multiply such instances of what, when regarded from the laboratory standpoint, must be called the hyper-activity of salts as found in natural mineral waters; and in the absence of any single instance of sub-activity, we are justified in assuming that a natural mineral water which contains a chemical salt is at least as active in respect of that salt as a solution of the same strength artificially prepared.

So much being granted, let us briefly consider the position which chloride of sodium occupies in the physiological processes. Inasmuch as it is a constant constituent of the tissues, common salt is obviously necessary to life. But it is so in a very much smaller degree than is usually supposed. The organism requires a certain quantity (estimated at 30 to 40 grains a day), but anything over and above this quantity is quickly excreted. The surplus, so far from being advantageous as many of us have been taught to believe, though it may act to some slight extent as a diuretic, is, in health, practically inert; while in certain cases it is very deleterious. The salt when present in normal quantities assists in the osmotic processes which are continually taking place, and it is believed to act, if not as an antiseptic, then certainly in diminishing the toxicity of certain poisons. In illustration of this antiseptic influence we are reminded that during acute illnesses all the chlorides are retained in the system, to be discharged *en masse* when convalescence sets in; and it is now believed that they act, as opsonins act, by rendering the infective agent better suited to the attentions of the phagocytes. If, therefore, the chlorides can ever be regarded as curative agents, their proper sphere would seem to be the acute specific diseases, in which, so far as I am aware, they are seldom or never employed. It was at one time believed that serious consequences were liable to follow if an individual or a community could not obtain free access to common salt. M. Widal, (*b*) whose work in connection with the chlorides has deservedly obtained from him an even wider reputation than his work in connection with the reaction of the blood in typhoid, has shown that this is the very reverse of the truth. Not only have there always been vigorous communities who never salted their foods, but experimental researches conducted on

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(*a*) Paper read at a meeting of the British Balneological and Climatological Society.

(*b*) "La Cure de Déchloruration" (Baillière, Paris).

himself, his patients, and his friends, have conclusively proved that virtual deprivation of common salt may continue for some months and even years, without causing any difficulty whatever. Under these conditions the amount necessary for the proper performance of the physiological processes is retained by the tissues and the organism refuses to part with any, until more is supplied. Nature does not throw away her dirty water until she has clean.

The chlorides are normally excreted by the kidneys Where there is great intestinal activity some portion passes with the fæces, and, under the influence of sudorifics, the skin aids in their elimination. The part played by the two last-named emunctories is, however, accessory only, and it has been conclusively shown by Widal and others that a very slight degree of renal inadequacy will give rise to a retention of chlorides. Of all the urinary constituents the one which seems to find the greatest difficulty in passing the portal of the kidneys is the chloride constituent. We have already seen that in actute specific fevers the retention of the chlorides may be regarded as a defensive measure, deliberately adopted, but there can be no doubt that in other morbid states such retention is not only not helpful, but is, on the contrary, in the highest degree harmful. When from any cause a renal inadequacy is present, according to Widal (whose observations have been confirmed by a great many observers) what happens is this. The chlorides, unable to force the renal exit, are retained in the blood. It is impossible for this fluid to tolerate them in more than a certain proportion. The surplus is therefore passed into the tissues. Being deliquescent, the salts, as soon as they reach the tissues, attract water, and œdema becomes established. This œdema is at first slight, and is to be recognised clinically only by very careful comparison of the patient's weight. It is deep-seated, affecting by preference the solid organs, and among these organs the kidneys are the most likely to be involved. A kidney which is œdematous, even though it be so to a very slight extent, is obviously a very much less efficient excretory instrument than one which is intact. Thus, to the retention of chlorides, and directly consequent upon such retention, we have superadded the retention of other substances, many of which are grossly and notoriously toxic. If now, the ingestion of chlorides be continued in what may be called the ordinary quantities, it is evident that they must accumulate in the system, with the result that the œdema which at first was slight and difficult of recognition, soon becomes general and obstrusive. Widal has shown that in cases of œdema depending upon renal disease, it is quite possible to cause the disappearance of the fluid by the simple expedient of withholding common salt, and to cause its reappearance by reinstating chlorides in the dietary.

So much, then, for some of the possible consequences of taking common salt in any but the smallest quantities where there is any reason to believe that renal elimination is defective. The subject is large and very attractive, and I have been sorely tempted still further to dwell upon it. I must, however, refer the curious to Widal's book, and return to my thesis by enquiring what are the conditions in which renal inadequacy is most liable to show itself. A broad view of this question compels the answer that a large, a very large proportion of the morbid conditions in which we fear anything like a sustained dereliction of duty on the part of the kidneys, are those which are usually associated with the gouty diathesis. So much is this the case that chronic interstitial nephritis is often called "gouty" kidney, and we know that a truly chronic gouty manifestation, whether it be articular, vascular, cutaneous, or what not, will in many cases pass into a nephritis of the chronic interstitial variety before the curtain finally falls.

If the ingestion of natural mineral waters has a place in rational therapeutics (and this Society exists largely for the purpose of vindicating the affirmative) that place is surely occupied by the treatment of chronic diseases; and, among chronic diseases, the manifestations of gout to which I have referred certainly occupy the most prominent place. Almost all natural mineral waters are eulogised (not always, it must be admitted, from quarters which are wholly disinterested) for their powers in curing gout, and it behoves us, from time to time, to review these claims in the light of advances in knowledge both physiological and pathological. With this end in view I have prepared a table showing the amount per mille of common salt contained in many of the best known natural mineral waters which are used for drinking in the treatment of gout, in order that we see how far their anti-gouty claims are in consonance with the facts with which Widal's work has familiarised us.

With very few exceptions the quantities in these tables are taken from Dr. Huggard's book, (c) and they may therefore be regarded as representing in each case a fairly recent analysis.

GREAT BRITAIN.	*Per mille.*
Woodhall	19
Leamington	9·7
Harrogate	9·5
Cheltenham	7.0
Llandrindod	4·7
Llangammarch	2·6
Bath	0·2
Buxton	0·0
Strathpeffer	0·0

GERMANY.	*Per mille.*
Kissingen	11·7
Homburg	9·8
Wiesbaden	6·8
Baden-Baden	2
Ems	1
Wildungen	1
Neuenahr	0·1

FRANCE.	
Brides-les-Bains	1·8
Chatel-Guyon	1·8
Royat	1·7
Vichy	0·5
Mont Dore	0·36
Contrexéville	0·0
Evian	0·0
Pougues	0·0
Plombieres	0·0
Vittel	0·0

AUSTRIA.	
Marienbad	2·0
Carlsbad	1·0
Taplitz	0·4

SWITZERLAND.	
Tarasp	3·6
Schinznach	0·0

EXPORTED PURGATIVE WATERS.	
Friedrichshall	7·9 per mille
Aesculap	2·9 ,,
Apenta	1·8 ,,
Hunyadi	1·7 ,,
Arabella	0·2 ,,

Parts per mille = grammes (15 grs.) per litre (35 fluid ounces).

To render parts per mille into grains per imperial gallon (8 pints), multiply by 70.

A glance at this table shows that the "anti-gouty" stations in England and Germany contain, as a rule, waters which are very much richer in chloride of sodium than the stations in France and Austria. It is, I think, reasonable to suppose that in the case of those waters which contain purgative salts to any appreciable extent, the excess of chloride of sodium is readily carried off by the bowels. This refers more especially to Carlsbad, Marienbad, Brides-les-Bains, Chatel-Guyon and, to some extent, it may also be held to apply to Cheltenham. In the case of sulphur waters, with the exception, of course, of those which happen to be strongly purgative, it is difficult to see in what way the extra amount of common salt is to be got rid of. Sulphuretted hydrogen exercises little or no influence upon the activities either of the skin or the bowels; so that we must suppose that if the chloride of sodium does not find an exit by the renal route, its ingestion in such waters may give rise to retention in the system, with consequences which have already been considered.

There are three stations in Germany, namely, Kissingen, Homburg and Wiesbaden, which have with some physicians, and not a few of the laity, in this country, a great reputation in the treatment of gout, So far as the ingestion of their waters is concerned their claims in this direction would seem to be very difficult to sustain Kissengen contains no less than 11.7 per mille; that is, roughly, two ounces per imperial gallon; Homburg, 9.8 per mille, or roughly 1¼ ounces per gallon; Wiesbaden, 6.8 per mille, or roughly one ounce per gallon. As estimated by the standard of what is harmless in conditions of ordinary health, these qualities are not perhaps very large. What we have to consider, however, is the effect of these quantities on a person who, from the very fact that he visits one of these places, is proclaiming that he is not in ordinary health; that he is, on the contrary, suffering from some manifestation of gout, and that, consequently, his kidneys may be regarded as potentially inadequate to the full discharge of their duties. Assuming that such a person drinks but a single litre a day of the natural mineral water, he thereby adds to the amount of ingested NaCl, at Kissengen by 11.7 grammes, or nearly double the amount (6.5 grammes) which Widal estimates as the ordinary quantity taken by a man in good health. At Homburg the increment would be 9.8 grammes; at Wiesbaden 6.8. The cure at these places lasts from a month to six weeks, so that the amount of additional common salt which is taken during that time must be very large, especially when we consider that no restriction is placed upon the ordinary dietetic consumption of the condiment. It is unnecessary to dwell upon the deleterious effects of this in the case of a person the permeability of whose kidneys is in any degree impaired by his gouty tendency. It should not, of course, be forgotten that the cure at these places is by no means confined to the drinking of the waters. Climate, baths, dietetic and general hygiene are all powerful and skilfully employed factors; but then all of these advantages can be obtained, in at least an equal degree, at stations whose waters are free from the drawbacks to which I have just called attention.

(c) "Handbook of Climatic Treatment" (Macmillan).

Of the stations in this country, Buxton and Bath contain the smallest quantity of the salt, the amount in both cases being insignificant. Both are therefore quite free from reproach in this respect. Among the sulphur water spas, Strathpeffer is the least, and Harrogate the most, open to objection from this point of view. The Strong Well at Strathpeffer contains no chloride of sodium at all, and the other wells contain rather less than about 4½ grains per gallon. At Harrogate the old Sulphur Well is that which is chiefly used for drinking purposes. It contains no less than 893.5 grains, or roughly two ounces per gallon. But then this well is, locally at any rate, credited with strongly purgative properties, and we are told that a large proportion of the surplus common salt is discharged by the bowels. In France those stations which include the drinking of the waters in their treatment of the various manifestations of the gouty diathesis are conspicuously poor in common salt. These stations have, moreover, much to offer in the matter of those climatic, balneary, and dietetic adjuncts to which I have already referred as constituting in the case of such places as Homburg, Kissengen and Wiesbaden, elements of "cure" which may be regarded as counterbalancing to some extent the evils of common salt in the waters.

It is unnecessary further to examine the details of this table in order to bring out the point that there are certain waters, notably in England and Germany, for which it is claimed that their ingestion is helpful to the goutily disposed, which, nevertheless, contain very considerable quantities of chloride of sodium. In view of the work which has been done by Widal, of which I have given a brief, and, I fear, a very inadequate *resume*, we are obliged to conclude that, other things being equal, chloride of sodium, so far from being advantageous to the gouty, is liable, even in small quantities, to be very much the reverse. I am aware that common salt is theoretically credited with diuretic properties, and although I am not concerned to deny to it such virtues in this direction as it may really possess, it is necessary to remember that the condition precedent to the exhibition of such virtues is the complete permeability of the kidneys, a condition which, in the case of the majority of the truly gouty, there is every reason to believe does not exist.

The main objects of the spa treatment of gout are the encouragement of metabolism and the promotion of excretion, and if there is any element in the treatment at a particular spa, such as the presence of chloride of sodium in the waters administered by the mouth, which is, in any degree, calculated to check the excretion of the nitrogenous matters by the renal route, then I say that he is a wise physician who directs his patients to avoid that spa and to seek in preference one whose waters can be relied upon under all circumstances to increase, and not to diminish the renal output.

One further observation seems pertinent in this connection. The reputation of some spas dates from the days when gout, and indeed most other maladies, were regarded as due to inactivity of the liver; when consequently, therapeutic skill was measured by the nicety displayed in graduating the amount of purgation, to the degree of hepatic obstinacy on the one hand and to the patient's powers of endurance on the other. I suggest that, having since those days revised our views of pathology, we should do well to bring our treatment, as far as possible into harmony with the teaching of to-day. This teaching may be briefly summarised by saying that gout is due to a fault of metabolism which leads to the retention, or perversion, or both, of nitrogenous waste matters, normally discharged by the urine. Whether or not the liver be responsible for the perversion, there can at least be no doubt that it is the kidneys which are responsible for the excretion. We cannot too often remind ourselves that the part played by the bowels in this matter, of the disposal of nitrogenous waste, is merely accessory. The real metabolic waste passes with the urine; it is only the ballast, the constituents of the food which are by their nature incapable of assimilation, which constitutes the fæces. In view of these facts it is surely to the spas such as Contrexéville, Vittel, Martigny, and more especially perhaps Evian, which increase the activities of the normal excretory channels, that we should advise our gouty patients, rather than to those which, like Carlsbad and Marienbad, occupy themselves mainly with stimulating an accessory emunctory. Still less should we continue to regard as suitable to such patients those spas whose waters, while acting perhaps as laxatives, nevertheless contain a considerable proportion of a salt which is potentially inimical to complete renal efficiency.

THE OUT-PATIENTS' ROOM.

CHILDREN'S HOSPITAL, PADDINGTON GREEN.

Coxa Vara.

By Arthur Edmunds, M.S., F.R.C.S.

Among the out-patients was a boy, æt. 3, suffering from coxa vara. The child learnt to walk in the usual way, but about six months before he came to the hospital he had an attack of measles, which had left him unable to stand. On examination it was apparent that this was not now due to muscular weakness, but to the fact that he was unable to bring his feet into the normal position. One foot could be internally rotated until the patella looked nearly forwards, being only about ten degrees out. On the other side, however, the patella could not be made to look directly forwards by about forty-five degrees. Mr. Edmunds pointed out that this was the extreme position of internal rotation, the feet being usually almost in a line with the heels touching. It was obvious that it was this diminution in the basis of support which was responsible for the child's inability to stand. This deficiency in internal rotation is, Mr Edmunds said, the cardinal symptom of curvature of the neck of the femur or coxa vara. This deformity usually consists of a double curve in the neck of the femur; one curve is in the coronal plane, the convexity of the curve being upwards, with the result that the angle between the neck and the shaft of the femur is increased, and the great trochanter is found above Nélaton's line. As the deformity is bilateral, shortening of the limb is not commonly apparent. The second curve is in the sagittal plane, with the convexity forwards, and it is this curve which produces the deficiency of internal rotation. Rotation at the hip joint is not actually limited, but the arc through which the trochanter rotates is translated backwards, so that the patella, although it can be made to look directly forwards, may be made to look almost directly backwards. The case in question exhibited the usual signs of the disease, the legs could be put behind the shoulders, and the child was distinctly rickety; there was a slight degree of knock knee. Slight degrees of curvatures of the neck of the femur, Mr. Edmunds remarked, are extremely common, and it is not difficult to see the cause. If a child with knock-knees be placed on its back with the patellæ looking directly forwards, the internal malleoli will be found separated by a considerable distance. If the child be now made to stand erect it will be seen that this separation of the malleoli is very much diminished, and if the child be made to sit on the edge of a table with its legs hanging over the edge, the separation will disappear entirely. It can readily be seen that this deformity is corrected by an external rotation at the hip joint. External rotation of the hip joint, therefore, is a deformity which compensates knock-knee, and the slight curvatures of the neck of the femur which accompany knock-knee are probably directly dependent on it. In a feeble rickety child also the tendency of the legs to fall into the everted position when the child lies on its back is also a factor in the production of the deformity. Given the curvature of a bone the relationship between opposing muscles is disturbed, and the deformity becomes exaggerated. The treatment of these cases, like other rickety deformities, falls into two heads—first, constitutional, and secondly, an attempt to remove the deformity. In children of this age there is no question of any bone operation, although plastic operations on the neck of the femur, subtrochanteric osteotomy and other measures may be necessary in cases where ossification is more complete. The method adopted in this case was simply to apply a splint on the outer side of the leg reaching from the upper border of the crest of the ilium to a point about four inches below the heel; opposite the hip joint a piece of wood is screwed to the splint projecting forwards at right angles for about four inches; the projecting portions are connected by a light elastic band, so that when the legs are firmly bound to the splint there is a slight but constant passive internal rotation at the hip joint, the long splint serves to keep the leg at rest, and also to afford a very wide surface for getting a grip upon the femur. It is always difficult, Mr. Edmunds said, to avoid exerting undue pressure on any one spot, especially when dealing with the delicate tissues of children, but by utilizing the whole limb as a *point d'appui* this difficulty is overcome. In a previous case which Mr. Edmunds demonstrated, the measures he had just explained had met with unqualified success.

Northumberland Sanatorium.

The sanatorium which has been erected at Barrasford under the auspices of the Newcastle and Northumberland Branch of the National Association for the Prevention of Consumption and other Forms of Tuberculosis, was formally opened a few days since by Lord Armstrong. For the occasion there was a large gathering, many who are interested in the movement travelling from the city by a special train. The Sanatorium is magnificently situated, some two or three miles to the north-east of Barrasford railway station; and the inspection of the buildings and the view which was obtained from them of miles and miles of moorland and woodland scenery, backed by the Hexhamshire hills, proved a source of pleasure to the visitors.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

Pancreatic Cyst Possessing Undue Mobility.—Mr. Battle operated on a married woman, æt. 27, who had been admitted for a tumour in the upper part of the abdomen. She stated that she had felt soreness in the pit of the stomach after straining three weeks before admission, and that she had noticed a lump in that part of the body for a fortnight. On examination, a rounded cystic tumour could be felt over the region of the stomach; it was about the size of the egg of a goose, painless, and not tender; it could be moved freely into the splenic region, across to the gall bladder, and downwards to the umbilicus. Its exact mode of origin was uncertain, and it gave no symptoms of pressure on other contents of the abdomen, nor was the function of any abdominal organ in any way deranged. The patient's general health was good. The tumour was removed through a median incision in the epigastric region. It was a single cyst situated in the gastro-hepatic omentum, and was adherent to the tail of the pancreas, some of which had to be peeled off it. Some of the attachments were rather vascular. The cyst, which was removed intact, was full of clear watery fluid which contained no reducing substance and no ferments. It was lined with columnar-celled epithelium. The layers of the gastro-hepatic omentum were united after the bed from which the cyst had been taken away was thoroughly dry, and the abdominal wall sutured in the usual manner. The chief interest in the case, Mr. Battle said, arose from the fact that the tumour was so extremely movable. Its situation before it was exposed by operation appeared to be between the stomach and the transverse colon, and it was somewhat of a surprise to find it situated above instead of below the stomach. The diagnosis before operation was necessarily uncertain; it resembled a hydatid cyst more than anything, whilst its excessive mobility rendered unlikely any suspicion that it had any connection with the pancreas. Some years ago, Mr. Battle remarked, he showed a large dermoid cyst to the Pathological Society, which had been removed by Mr. Sydney Jones from the wall of the small intestine, and in some ways the present tumour resembled that cyst, but the one he had just removed was situated higher up, and was more elastic.

Radical Cure of Umbilical Hernia.—The same surgeon operated on a very stout married woman, æt. 50, suffering from a reducible umbilical hernia. She had had nine children. She had used a truss for part of the time, but had had attacks of constipation, pain in the hernia, and vomiting; accompanying these attacks, for a time, also, the rupture, which was about the size of a duck's egg, had been irreducible. A transverse incision was made. The hernia was found to contain small gut. The sac was removed with some overlying skin. A first row of silk sutures was put in, uniting the divided peritoneum and edge of the opening in the linea alba, from below upwards; after this, an incision was made a third of an inch below the sutured line, and another at an equal distance above the same line. These incisions extended through the aponeurotic layer lying over the subperitoneal tissue; both lines extended beyond the end of the united opening, and were somewhat concave towards it; sutures were then passed through the uppermost divided edge and the lowest divided edges, and these were drawn together as the sutures were tied, thus forming a reinforcing layer for the first row. The skin wound was then closed with fish-gut sutures without drainage. The contents of the hernia were unusual, insomuch as they consisted entirely of small intestine, there being no omentum or large intestine present in the sac. Mr. Battle explained that the opening was closed after its edge had been trimmed with a knife from below upwards, making a mere transverse line, because the pull of the abdominal muscles was mainly lateral, and there was no drag on the sutures when put in in this manner. Before making the additional incisions it was, he thought, advisable to clear the surface of the fibrous tissue of fat so that material of the same character may be brought together and united. It was seldom that the two lines of suturings accurately corresponded, which he thought was a great advantage, and should be effected if possible, as it was a great thing to get either line of sutures strongly reinforced by an unweakened strip of the linea alba. In cases where it had been possible to do this operation, the results, he said, had been uniformly satisfactory.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

Annual Meeting held Friday, May 24th, 1907.

The President, Mr. H. H. **Clutton**, in the Chair.

The reports of the Council and Treasurer were presented and adopted. With the conclusion of the present session the Clinical Society becomes merged in the new Royal Society of Medicine.

TWO CASES OF PROLONGED PYREXIA.

Dr. F. **de Havilland Hall** read the notes of two cases of prolonged pyrexia of hectic type. The first was that of a man, æt. 44, with pulmonary tuberculosis and enlarged glands; the second was that of a man, æt. 21, with ulcerative endocarditis. Dr. Hall pointed out that in practice cases of prolonged pyrexia were more commonly due to tuberculosis and malignant endocarditis than to any other two conditions. In arriving at a diagnosis family history might be of a certain assistance, as the occurrence of several cases of tuberculosis among the immediate relations of the patient should awaken suspicion. On the other hand a rheumatic family history should suggest the possibility of a rheumatic endocarditis. The past history of the patient would often yield valuable information, as for instance attacks of hæmoptysis, pleurisy, fistula in ano, enlarged glands, etc., might lead one to suspect tuberculosis. The history of pneumonia was of equivocal value. Pulmonary tuberculosis might supervene upon lobar pneumonia, especially of the apex, but against this was to be placed the fact that pneumonia was one of the most common antecedent conditions of ulcerative endocarditis. The history of acute rheumatism followed by cardiac trouble should incline the scale strongly in favour of ulcerative endocarditis. The comparative rarity of the association of valvular disease and especially mitral stenosis with pulmonary tuberculosis was insisted on. Stress was laid upon the importance of several examinations of the sputum, one or two negative results not being sufficient to exclude tuberculosis.

Dr. **Sidney Phillips** suggested the addition of ulcerative aortitis and ulcerative colitis to the list of causes given by Dr. Hall. He did not think that the absence of bacilli from the sputum excluded tuberculosis. He objected to the term hectic pyrexia, as in hectic fever any form of temperature chart might be present.

Dr. T. **Walter Carr** commented on the difficulty of diagnosing infective endocarditis, particularly in the absence of any evidence of valve lesions. He related the case of a man, aged 67, who had nothing but chronic pyrexia with rigors till a sudden attack of hemiplegia supervened and caused death in a few days. At the autopsy was found a large mass on one flap of the mitral valve.

Dr. C. R. **Box** referred to the pyrexial crises that might arise in chronic posterior basic meningitis.

Dr. **Glover** said that chronic pyrexia was sometimes of rheumatic origin.

Dr. **de Havilland Hall**, in reply, said that he used the term hectic pyrexia to included both intermittent and remittent pyrexia.

Dr. A. M. **Gossage** read a paper on

HEART BLOCK.

After pointing out that conductivity might be affected separately from the other functions of cardiac muscle, he explained that depression of conductivity showed itself chiefly in the muscle fibres that connect auricles and ventricles. Depression of conductivity was illustrated by tracings showing a lengthening of the normal interval between the contractions of the auricles and the ventricles; the dropping out of ventricular beats was shown when conductivity was further depressed, *e.g.* by digitalis or the action of the vagus. Tracings were exhibited where there were three auricular beats to every two ventricular, two auricular to one ventricular, and three auricular to one ventricular. In the last two cases the patients exhibited the Stokes-Adams Syndrome. The nervous attacks of this Syndrome were shown to be preceded and accompanied by a cessation of ventricular contractions over a considerable period. Wenckebach had suggested the possibility of a block occurring between the veins and the auricles, and a tracing was shown where two successive ventricular beats had apparently been dropped, a circumstance which could be explained by a block between auricle and ventricle for the first beat and between vein and auricle for the second.

A paper by Dr. F. W. Price on

FOREIGN BODIES IN THE BRONCHI

was taken as read.

Votes of thanks to the officers of the society terminated the proceedings.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Clinical Meeting held in the Royal Hospital for Sick Children on May 15th, 1907.

Dr. **Craig** in the Chair.

Dr. **Melville Dunlop** showed: (1) a case of infantile paralysis in which the abdominal muscles of one side were affected. Whenever the child cries or strains, the right half of the abdomen balloons out in a remarkable manner. The muscles do not re-act to faradism. Paralysis of the abdominal muscles is an extremely rare event in anterior poliomyelitis. (2) A baby with a rickety head, in which craniotabes was unusually well marked, the whole of the occipital and posterior parietal regions being soft and membranous. (3) A child with a peculiar bilateral scarred condition of the skin over the sacrum, the result of an attack of herpes. (4) A case of cretinism after fourteen years' treatment.

Mr. H. J. **Stiles** showed (1) a baby after operation for a large hydronephrotic cyst. (2) A boy after nephrotomy for advanced tubercular pyonephrosis. (3) A child after resection of the ilio-cæcal junction and part of the ascending colon for fæcal fistula following suppurative appendicitis. (4) Two cases of removal of the diaphyses of the tibia for tuberculous disease. In subperiosteal removal of the diaphyses the epiphysial line remained intact, and in the two children shown the tibia had been completely renewed. X-ray photographs showing the condition before operation, and at the present time, were also exhibited. (5) A baby with a large encephalo-cystocele (partial exencephalus). The whole brain, practically, was extended from the deficient cranium, and covered only with skin. In cases of encephalocele, meningocele, and spina-bifida, the dura mater was usually absent. The dura plays a more important part in the formation of bone than the pericranium, and the absence of the dura apparently has to do with the bony defect which is the ultimate cause of these malformations.

Dr. J. S. **Fowler** showed (1) a child who at the tenth month had suffered from unilateral convulsions, beginning in the face and passing down to the arm and leg. There was a distinct syphilitic family history. Under iodide the convulsions were speedily checked, but as there was reason to suppose that in such cases some syphilitic cortical lesion was present, the ultimate prognosis was not good; probably some mental defect would result. (2) A typical case of posterior basic meningitis, to contrast the appearances with those of the epidemic cerebro-spinal form of the disease.

Dr. W. B. **Drummond** showed a Jewish child suffering from amaurotic family idiocy. It was the third member of the family who had been so affected. From being a healthy, normally bright infant at eight months, the child was now, at fourteen months, apathetic, almost blind, and displayed the characteristic fundal changes.

Dr. J. W. **Simpson** showed (1) a case of rickets with large posterior beads of the ribs. Posterior beads differed from the common anterior form in being due to calcus from periostic fracture. (2) A child, æt. 2¼, with leukæmia. The points to be noted were, first, the enormous spleen, which filled almost the whole abdomen, and secondly, the fact that the disease was of the spleno-medullary type, which was at this age excessively uncommon.

Mr. E. **Scott Carmichael** showed a case of streptococcus peritonitis which had recovered after laparotomy. The patient was a Mongolian imbecile.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting held at Leeds, Friday, May 10th, 1907.

Dr. E. O. **Croft** (Leeds), President, in the Chair.

The President showed a microscopical specimen from a case of "Primary Carcinoma of the Urethra," removed from a married woman, æt. 37, who had complained of painful micturition with soreness and irritation for several months. The growth occupied the posterior lip of the meatus urinarius, and extended three-quarters of an inch down the urethra, destroying the urethra-vaginal septum. Enlarged glands were present in both groins. Complete removal was impossible.

Dr. **Hellier** (Leeds) exhibited a specimen of "Tubal Mole" removed from a multiparous woman, æt. 30, who had been married four years. Menstruation ceased on February 12th, and on April 7th she was seized with severe abdominal pain, accompanied by a red discharge. The uterus was somewhat enlarged, and there was a swelling in the left posterior quadrant of the pelvis. Abdominal section was performed on April 11th, and free dark blood was found in the peritoneal cavity. The left Fallopian tube measured 4 in. by 2 in., and was occupied by blood clot, in which chorionic villi were found.

The **President** (Dr. Croft) introduced a discussion on

THE TREATMENT OF ALBUMINURIA AND ECLAMPSIA OF PREGNANCY,

an abstract of which will be found on page 589.

Dr. J. B. **Hellier** (Leeds) advocated all measures directed toward the elimination of the toxine. He used saline injection and transfusion. He was in favour of the interruption of pregnancy as removing the exciting cause of the toxæmia, but did not believe in too rapid dilatation of the cervix and evacuation of the uterus.

Dr. **Lloyd Roberts** (Manchester) discussed the treatment of albuminuria of pregnancy, and laid stress on rest in bed, warmth, and dietetic measures, especially milk. He advocated intestinal antiseptics—*e.g.*, calomel, or grey powder, and saline purgatives, with the object of preventing auto-intoxication from the alimentary canal.

He would encourage the onset of labour when in spite of prolonged treatment the albuminuria increased or profound symptoms supervened. Coma and intermittent cardiac action he regarded as indications for the employment of more prompt measures.

Dr. **Stookes** (Liverpool) thought there was no distinct advance in the treatment of eclampsia. He referred to Ramsbotham's obstetric table from 1828 to 1850, including 48,776 cases with 220 deaths, a mortality of 4.5 per 1,000, which is rather less than that of England and Wales at present. In this table are 43 cases of convulsions before and after delivery (1.1 per 1,000), with only three deaths.

Now at the Liverpool Lying-in Hospital, between the years of 1886 and 1905, out of 3,818 admissions there had been 52 cases of uræmia and eclampsia, and out of these 22 have died, or 42 per cent. The incidence was the more interesting as 39 of the 52 cases have occurred during the last ten years.

Dr. **Stookes** regarded the prevention of eclampsia as far more important than its cure, and attributed the increase in this disease to increase in intestinal affections. He thought food played a very important *rôle* in the causation of the latter. For the pregnant woman he advocated routine and careful attention to the cleansing of the alimentary canal.

He believed in the free use of gastric and rectal lavage and saline injections into the subcutaneous tissues. He objected to the introduction of labour in the pre-eclamptic condition. He had not found thyroid to be of much value. In the eclamptic stage he preferred to treat symptoms, and allow labour to come on, if possible, spontaneously.

Dr. **Walter** (Manchester), having discussed the treatment of albuminuria of pregnancy, said that in the treatment of eclampsia he had found morphia useful. In one case, in which 10 fits had occurred during the night, the patient was admitted into hospital, morphia gr. ⅙ was administered. The patient slept 12 hours, no more fits occurred. Aperients, salines, and diaphoretics were also given. On the tenth day all albumen had disappeared, and the patient returned home. Two days later she was re-admitted in labour, and delivered by forceps of a living child, without any recurrence of albumen or fits.

In most cases of eclampsia he advocated emptying the uterus without delay, commencing, if necessary, with Hegar's dilators, then Champetier de Ribes' bag, and, when possible, using forceps rather than version. If Morphia gr. ¼ was given first, he believed less chloroform was needed. Saline injections, purgatives, and diaphoretics were essential. He had seen but very temporary benefit from venesection, and had not tried incision of the cervix or vaginal Cæsarian section.

Dr. **Croft** replied.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, May 2nd, 1907.

The President, Mr. **Frank T. Paul**, F.R.C.S., in the Chair.

NUCLEO-ALBUMINURIA.

Dr. T. R. **Bradshaw** related the case of a lad, æt. 17, in which nucleo-albumin in large amount was mistaken for myelopathic albumose. The patient when seen was greatly emaciated and exhausted, and died in about a week. The urine contained about one per mille of a proteid body which gave a turbidity when the urine was gently warmed with acetic acid, and which coagulated with hydrochloric acid. There was a remarkable deformity of the sacrum and tenderness over the upper ribs. The *post-mortem* showed extensive matting of the intestines from tubercular peritonitis, marked lordosis and inflamed glands under the pectorals. The bone substance was normal. After removing the urinary salts by dialysis the proteid was found to be precipitated by a trace of acetic acid, and gave the other reactions of nucleo-albumin. The significance of nucleo-albuminuria was not understood.

Dr. **Hubert Armstrong** remarked that nucleo-albumin occurred in the urine of children with some frequency. Precipitating with acetic acid in either hot or cold solutions, nucleo-albumin was occasionally mistaken for serum-albumin when the acid was not added to the urine until after boiling. In none of the cases he had seen could he attach any clinical significance to the presence of nucleo-albuminuria.

INTRA-TRACHEAL INJECTIONS OF IZAL.

Mr. **Colin Campbell** and Dr. **Masson** described a case of bronchiectasis, or rather of bronchiolectasis, and exhibited the patient, a male, æt. 38. When two years of age he had had a severe attack of German measles with pneumonia, and when twelve years old another attack of pneumonia. From the first attack he had never been free from cough. He came under Dr. Masson's care in 1901, and was then expectorating about a pint of glairy mucus twice in the twenty-four hours. The physical signs were practically confined to the lower lobe of the left lung. There was marked clubbing of the fingers, typical odour and much emaciation. For four years his condition grew worse in spite of all treatment, and the patient spent his winters in bed.

At the suggestion of Dr. Dreschfeld, who saw the patient in consultation with Dr. Masson, the patient was placed in Mr. Campbell's charge for intra-tracheal treatment. This treatment was commenced in May, 1906, and continued until December. About 2½ oz. of a 9 per cent. solution of Izal in glycerine was administered daily, and by means of Mr. Campbell's revolving chair the medicament was sent directly into the diseased part. According to the patient's calculation 40 lbs. by weight of Izal were used. While not liking the word "cure," Mr. Campbell claimed that it looked as if the patient had been cured. He had spent the last winter at work on his farm instead of in bed, had gained 16 lbs. in weight without any attempt at fattening, the clubbing of the fingers had disappeared, there was no cough and no expectoration.

At the request of the President, Sir James Barr examined the patient and reported that he agreed with Mr. Campbell's estimate of the effect of the treatment.

NOTES OF A CASE OF CEREBRO-SPINAL MENINGITIS—ISOLATION OF THE ORGANISM FROM THE CEREBRO-SPINAL FLUID-PREPARATION AND ADMINISTRATION OF A VACCINE—RECOVERY OF PATIENT.

Dr. **Claude Rundle** and Dr. **W. Stenhouse Williams** gave a full account of this case. The opsonic index was first determined on the 23rd day of the disease, and the vaccine first administered on the 27th day, and for the fifth and last on the 31st day. The coccus was obtained in pure culture from the cerebro-spinal dyes on Loffler's blood serum. It stained with the usual aniline dyes: Gram negative. Morphology: Cocci, diplococci, tetrads, adjacent surfaces of diplococci flattened, great in variety and size; no tendency to chain formation in liquid media. Anærobic cultures at 37 C. negative and ærobic cultures at 20 C. negative. The behaviour of the organism was compared with that of three strains from Glasgow and one from Belfast in ascitic fluid, carbohydrates cultures at 37 C.

The agglutination reactions were fully described. The authors did not, of course, claim that the recovery of a single case was to be regarded as proof of the efficacy of the vaccine, but recovery after the patient had been almost *in extremis*, and dating from the first administration of the vaccine was at least encouraging.

CALCULUS OF THE KIDNEY AND URETER AND SOME KIDNEY TUMOURS.

RENAL AND URETERAL CALCULI AND SOME KIDNEY TUMOURS.

Mr. **W. Thelwall Thomas** read a paper on the above subject. The stone cases formed a series of 28 operated on since 1904, a large proportion since 1903, when the X-rays proved of great service in locating even tiny calculi. All the radiographs had been taken by Mr. Thurston Holland.

The most common symptom had been pain in the back of a dull aching character. This occurred in 17 cases, typical renal colic only occurring in 9; colic was associated with hæmaturia and pyuria in 3, and with hæmaturia alone and pyuria alone in 1 case each. In 7 cases pain in the back was associated with pyuria, in 3 with hæmaturia and pyuria, and in 2 with hæmaturia. Hæmaturia was the only sign in 3 cases, and pyuria in 13. The cystiscope was of service in some cases by enabling ureteritis to be diagnosed; but the important confirmatory evidence was supplied by the radiographs.

The prone position was adopted during operation in all cases, and Edebohl's cushion rendered great assistance. Evisceration of the kidney was resorted to when possible and the pedicle clamped before incising the kidney substance. The kidney had to be removed in three cases on account of hæmorrhage. Death occurred in 1 case of nephrectomy for tubercle and stone, and in another from pneumonia after the wound had healed. Four cases of ureteral calculi were discussed, and a combined ilio-perineal or ilio-vaginal operation described. Seven cases of renal tumour were related, six of hypernephroma hæmaturia being the chief symptoms in all. All the tumours were removed by the lumbar incision. In one case prolonged anteriorly, the tumour weighing 3 lbs. Four of the hypernephroma patients were still quite well.

In cases in which the kidney could not be made out by palpation, cystoscopic examination enabled the affected side to be decided upon.

A full epitome of the calculus cases had been compiled by Dr. R. E. Kelly; this was circulated amongst the members and the calculi and radiographs exhibited.

Mr. **G. G. Hamilton** pointed out that after all a calculus of nephritic origin was a "symptom" just as was a gall-stone, and depended on the state of the lining membrane and the presence of micro-organisms. A prone position similar to that advocated by Edebohl had been found the best for many years at the Royal Infirmary. The difficulty in the interpretation of X-ray shadows arose from the occurrence of calcareous plates on arteries and of calcareous glands. In one of his cases the passage of a ureteral catheter, which threw a shadow, cleared up the diagnosis.

Mr. **C. Thurstan Holland** drew attention to the difficulties in the X-ray diagnosis of kidney stones, with especial reference to the shadows caused by calcareous glands, pointing out that such shadows might occur in any part of the stone area. At the present time, however, the X-ray appearances are so valuable that it was unjustifiable, given any symptom which raised the question of stone, to continue medical or surgical treatment without having a complete and satisfactory X-ray examination of the whole urinary tract, further treatment being based upon that examination.

Dr. **J. Hill Abram** said that success could be obtained in some cases by the free drinking of certain waters, although he agreed with Mr. Thomas that the solvent action was practically nil, at any rate, in the body. He had also seen expulsion of the calculus under the belladonna treatment recommended by Dr. Murray (senior), of Newcastle. He was struck with the large proportion of Mr. Thomas' cases in which pain in the back was the only symptom; he could add two similar cases from his own experience, one of exceptional interest, inasmuch as jaundice, had been present on one occasion. These cases strongly emphasised the value and importance of X-ray examination in all cases of persistent lumbar pain.

The following gentlemen also discussed the paper:—The President, Mr. Rushton Parker, Mr. R. W. Murray, Mr. K. W. Monsarratt, Mr. R. A. Bickersteth, Sir James Barr (who remarked that stones ought not to be allowed to form at all or to recur after removal), and Dr. E. T. Davies.

North Dublin Medical Supplies.

Mr. Denis Lynch explained at a recent meeting of North Dublin Guardians that the Local Government Board had received in a sympathetic manner the points made by the deputation of Guardians which recently waited on the Board in connection with the question of medical and surgical appliances for last year. The Local Government Board accepted the contract for last year, and committed themselves to the expression that they were ready in future to make concessions to local firms, even to the extent of 5 per cent. In connection with the contract of last year, they were allowed the full amount of the recoupment—£2,500. Mr. Lynch concluded by moving a resolution—which was seconded by Mr. M'Gough and passed—that the Guardian's reason for accepting the contract for surgical appliances from Messrs. Smith and Sheppard this year at 36½ per cent. off, as against 37½ tendered by a Liverpool firm, was the great convenience of the first-named contractors residing in Dublin.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, May 26th, 1907.

Treatment of Phthisis.

For a long time back, a comparison has been made between the waste of phosphoric acid at the outset of tuberculosis, and the final calcification of tubercles that get well. Just as the farmer supplies in an artificial manner the loss that a crop causes to the ground, an attempt has been made to cover, by phosphates given in abundance, the losses of phosphorus in tuberculous patients.

M. Ferrier, who read an interesting paper on this subject at a recent Congress, said that the patient not only lost phosphoric acid, but also lime.

Frequently, phosphate of lime and more especially glycero-phosphate of lime, has been given in phthisis, but the question is, not to take lime, but to assimilate it; and all the lime salts are not equally good. Sulphate of lime, acidified phosphates such as lacto-phosphate, monocalcic phosphate which is acid, increase the elimination of lime. On the other hand, the insoluble salts, as carbonate, phosphate (tricalcic), are easily assimilated and retained.

In all cases it is necessary to prescribe a rather severe regimen as in patients taking carbonate of lime; decalcification may be produced by accidental causes (absorption of acids entering into the food, and particularly of citric acid, of oranges and lemons, and, above all, gastric fermentation provoked by ill-feeding).

The patient should be forbidden the use of wine, beer, cider, liqueurs, or, in a word, any drink containing alcohol; salad, vinegar, oranges, lemons, lemonade, or butter, which is liable to produce acid fermentation in the stomach.

The patient should be allowed bread (not more than 10 ozs. a day), potatoes, carrots, split peas, macaroni, milk. The only drink should be St. Galmier water, or some other spring containing lime. If the waters contain gas, the bottle should be left uncorked, so that the carbonic acid gas escapes.

The *menu* might be as follows for each meal: At 6 o'clock in the morning, a glass of mineral water to insure the evacuation of the stomach in case there remained undigested food from the evening before.

At 7 o'clock, two eggs with 2 ozs. of bread, followed by a wafer, the composition of which is given below.

At 11 o'clock, a glass of mineral water.

At 12, dinner composed of lean meat, eggs, fish, except mackerel, herring, or salmon, sweetbread, kidneys, ham (unsmoked), a little vegetable, and 3 ozs. of bread. A wafer.

At 6 o'clock, a glass of mineral water.

At 7, potage, meat, eggs, a little vegetable, and, for dessert, cooked fruit, a little bread and a wafer.

The wafers prescribed by M. Ferrier are:—

Carbonate of lime, gr. 10.
Tribasic phosphate of lime, gr. 4.
Chloride of sodium, gr. 3.
Calcined magnesium, gr. 3.

In children, the dose of salts of lime is 6 gr. daily for the first year, and increased by 1 gr. for each year above that age.

Patients who possess a normal digestion, says M. Ferrier, improve rapidly under the above treatment. But, besides these wafers, small doses of chloride of calcium might be given twice a day in solution (10 grs. twice a day).

This treatment will be associated with other hygienic prescriptions such as ventilation, cutaneous frictions, &c. But it is quite sufficient in the initial stage of the malady. Later, it can be concurrently employed with other treatment necessitated by the condition of the patient.

M. Ferrier has published in favour of his method several interesting cases, and his statements have been confirmed by Sergent and Renon.

For the last eighteen months, says M. Sergent, I have submitted to the treatment of recalcification a large number of phthisical patients, and I affirm that the scepticism with which I received, at the beginning, the method proposed by M. Ferrier, vanished rapidly before the facts. From the very first days of the treatment, the digestive functions, disturbed previously by the classical and frequently ill-tolerated over-feeding, were restored, the appetite returned, and the patients gained strength; progressively the general condition improved, while the local sign of congestion disappeared. Naturally this method does not guarantee a cure by itself, but it certainly contributes to the cure of phthisical patients on the condition that it is carried out to the letter.

GERMANY.

Berlin, May 26th, 1907.

At the Medizinische Gesellschaft, Hr. Lohenstein reported a case of

Paraffin Calculus of the Bladder.

The patient was a young workman, æt. 23, who had suffered severe bladder pain for eighteen weeks, and had been treated unsuccessfully so far. On cystoscopic examination, in addition to signs of subacute inflammation of the bladder there was an ovoid yellow foreign body with a smooth surface; it was not attached to the bladder, but on account of its low specific gravity it lay close to the bladder wall. It could not be expressed by pressure from without. It could only therefore be a waxy mass, and the patient, on being pressed stated that on account of itching along the urethra he had passed in a pencil made from paraffin. It was remarkable that although the mass had been in the bladder five months, there was not the least incrustation on it. By repeatedly injecting benzine that could be retained in the bladder for forty minutes at a time, the foreign body was dissolved and discharged in the course of a couple of days. The paraffin was again obtained from the solution by distillation.

Hr. F. Krause showed (1) a patient who had paralysis of all four extremities, the result of an inconsiderable fall on to his back. There was no sign of injury along the spinal column. There must have been extravasation of blood into the spinal cavity. The paralysis did not improve until after the lapse of three months. Now, nine months after, the patient could walk with two sticks; the gait was spastic. (2) A boy who had as early as 1900 been treated for tuberculous spondylitis with a plaster jacket, there being no sign of paralysis. In 1901 in connection with an attack of varicella the condition became much worse, so that within a short period there was complete paraplegia of the lower half of the body. As treatment by extension was useless an operation was performed. Several spinous processes were resected, a granulation mass was found and several vertebral bodies completely destroyed. From here an abscess proceeded into the posterior mediastinum, which was opened from behind and drained. There was absence, therefore, of several of the bodies, and spinous processes, and the parts were retained in position only by the lateral processes. They were sufficient, however, for support. With very careful after-treatment, the wounds healed perfectly, and five months afterwards the first sign of returning movement in the paralysed parts was observed and the boy gradually learned to walk with sticks.

Hr. Westenhœffer made a communication on the

Nature of Tumours with Special Reference to Cancer.

He said there was no prospect of solving the question by histological and morphological investigations; that any further advance could only be expected from experimental and biological inquiries.

Tumours were on the one hand independent formations, on the other they lived in symbiosis with the organism. That was parasitism, a relation common to all tumours.

For the scientist and in the general consideration of the essential nature of tumours, the histological structure was not of much importance. For the sake of simplicity the speaker had turned to the consideration of carcinoma that showed its parasitic character by unlimited growth as well as by its tendency to develope metastases.

How it was possible that cells of the organism suddenly took on a parasitic character was hitherto an unsolved problem. The cells had not by this lost their character, as was shown by their limitless growth, but their specific character, for instance, their capacity for secreting, etc. A cell had not thereby become an embryonic cell, it had indeed the enormous power of development of that cell, but it lay in the nature of the embryonic cell to develope in harmony with the needs of the organism. The characteristic of the tumour cell lay in the ontogenetic development much further back, it corresponded rather to the type of the primal cell (Urzelle).

To prove the truth of this theory he had made various biological experiments; on the one hand he had proved that the juice of cancer digested both animal and vegetable albumen., and on the other the serum of animals that had been treated with carcinoma showed changes in the sense of complementary aversion, in the sense of averting.

It was true that liver cells could digest albumen, but only that of foreign bodies. Carcinoma cells, on the contrary, could digest their own body albumen.

Further investigations would follow. The immediate cause for a cell of the organism to lose its own specific character and take on one of growth he considered to lie in the action of a chronic irritation, and as an illustration he adduced the development of cadaveric tubercle.

AUSTRIA.

Vienna, May 26th, 1907.

Pulmonary Gangrene.

At the Gesellschaft Lotheissen demonstrated two patients on whom he had operated for gangrene of the lung. These were the last two of nineteen within the last four years with a mortality of 40 per cent., which is lower than the late Lenhartz, who had a mortality of 60 per cent. None of the deaths were due to the operation.

Ozone in Surgery.

Gleich gave an account of his practice with ozone in surgical operations. The idea is not new, but the application of the gas to the wound has always been the difficulty. His first experiments were conducted with oxygen and ozone mixed, which he blew into the wound from a condensing cylinder. He is still hopeful with a high tension current to regulate the quantity and make the treatment practicable by means of electricity. He finds the gas a powerful antiseptic in the dressing of wounds.

Peritoneal Pseudo-Ligaments.

Lorenz demonstrated the fallacy of his opponents in the belief that pseudo-ligaments did not exist. The preparation which he exhibited was taken from a patient who some time previously had been operated on by a colleague for appendicitis. The false ligament passed over the ileocal valve, which was firmly attached to the mesentery, which made a circle of 180 degrees around the bowel, quite strangulating it. Within the last three years he has operated for three of these cases after appendicitis. In all three the appendix had been misplaced; that probably led to the operation being necessary. Where simple appendicitis exists without displacement he is of opinion that no pseudo-ligaments will arise, and that early appendictomy should be performed to avert this subsequent accident.

Therapy of Puerperal Diseases.

Latzko next read a long paper to the members on the latest treatment of puerperal inflammations, such as parametritis, metastatic abscesses, etc. The diseases usually leading to these morbid changes are bacterial and are comprehended under endometritis, metrophlebitis and peritonitis, which have common ætiology in being microgenic and to which the modern operation is applicable. The so-called radical operation or extirpation of the uterus may be excluded, although it is recognised as the most effectual, but it is usually considered unnecessary, or the case is received too late. The total number received into his own ward was 470 puerperal cases with 112 deaths, a little under a fourth of the total number. Among the total were 117 septic abortions, 42 of them with a temperature of 38.5 on reception = 101·5 Fahr. followed by parametritis, peritonitis and death. There is another class of high fever cases in the number with only 30 per cent. of deaths, which causes one to pause before pronouncing the "indicatio vitalis" which decides the operation according to Sippel's dictum. In his own ward the rule is, if a patient maintains a temperature two days at 39° or 40° centigrade or over this for 48 hours without improvement, the case is operated on without any further formality. Operate early in these cases as in appendicitis. The aim of the surgeon is to limit or destroy the source of the puerperal pyæmia by tying the veins and cutting off the septic supply. The danger from medial laparotomy in extra peritoneal operations is very small if ordinary care be exercised. The tying of the veins is best accomplished by Bumm's method. The separation of the artery and vein is not always an easy matter when phlebitis is present, particularly in the hypogastric and spermatic. The tying of the artery should be carefully avoided as the pus of the ligature cannot be prevented from entering the circulation. Where thrombo-phlebitis of the vaginal plexus is present the hypogastric veins should be tied and as many removed as possible, as the purulent matter can be easily cleared by the vagina. The arteries and uterus should be carefully observed, while the veins should be carefully emptied and the spongy parts tamponned. Never delay operating with high temperature rigors with general disturbance, as many lives are lost by waiting. In peritonitis, laparotomy with washing the cavity with salt and water is better than colpotomy as formerly practised.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Lunacy and the Law.—A case which was tried at the High Court of Justiciary on May 20th illustrates the curious relationship of insanity in criminal procedures. In what was referred to some weeks ago as the New Cumnock poisoning case, the prisoner, though desirous of standing his trial for murder, and anxious to rebuke the theory of the prosecution that he was insane, was found to be of unsound mind and therefore incapable of giving instructions for his defence, and was accordingly ordered to be detained during His Majesty's pleasure, though the actual question of his guilt was never settled by the jury. This present case is in some respects the exact converse of the preceding. Thomas M., in 1899, was arrested on the charge of having shot his aunt, and at the time he was found to be incapable of instructing his defence, being of unsound mind. As a matter of fact, Dr. Clouston and other experts who examined him at the time found that he was suffering from insane delusions which were of a nature to lead him to commit the crime in question. He was accordingly confined in an asylum, and under proper treatment he has now recovered his reason and was discharged a sane man a month ago. According to practice he was rearrested and the crime inquired into again. Evidence was led on Monday as to the circumstances under which the murder was committed, and medical testimony was given that the prisoner was insane at the time, and was now recovered and perfectly sane. The Solicitor-General, in addressing the jury, said this was a very peculiar and unusual case. After the evidence led it was obviously impossible for him to ask them to find the prisoner guilty. It had become the duty of the Crown authorities not to let the accused lie down under the charge of murder but to place the facts before a jury so that they might pronounce a verdict absolving him from that charge. He said absolving, because if a jury called upon to investigate a charge of murder thought that the prisoner was insane when the act was committed their first duty was to find him insane, and their second to find him not guilty on account of his insanity. The Lord Justice Clerk directed the jury to deal first with the act which the accused had committed, and then with the question of insanity. The jury found the prisoner not guilty on the ground that he was insane at the time he committed the offence. The Judge then made the usual order, that the prisoner be kept in confinement "until His Majesty's pleasure be known." The next step will be to apply to the Secretary for Scotland for his release on the ground that he has recovered from his insanity.

The two cases are on all-fours in this respect, that the Crown, not the defence, pressed the question of insanity, and to this extent defended the prisoner against a verdict of murder. In the New Cumnock case we had, as the result, the verdict that the patient was insane, and no decision as to whether he had committed the crime alleged; and the sentence of detention in an asylum. In this case the same thing occurred, and after a lapse of eight years, on the recovery of the prisoner, his guilt is again inquired into, and he, admittedly now sane, is sentenced to be detained because he was insane when he committed the act. Presumably his second detention is merely a formality, and will be of short duration, but the curious topsy-turvy state of matters the case reveals suggests that criminal procedure, in cases of insanity, requires some revision.

Cerebro-spinal Meningitis.—In Edinburgh and Leith the epidemic of this disease is showing no signs of increase, though a few cases occur every week. For the week ending May 18th two cases were notified in Edinburgh; five of the cases in the city hospital died, and sixteen remained under observation. In Leith during the same period four cases were notified. Although the outbreak had not been serious numerically, the mortality had been very high. Probably the death-rate is not much under 90 per cent. of those affected.

Galashiels Consumption Sanatorium.—This sanatorium was opened for the reception of patients on May 20th. It accommodates six patients, and has been erected by the efforts of the local branch of the National Association for the Prevention of Consumption, as the outcome of a lecture delivered in the town by Dr. R. W. Philip, Edinburgh. It is stated that phthisis is unusually prevalent in Galashiels, and this fact has enabled the committee to obtain funds enough to have erected the sanatorium within a comparatively short space of time.

BELFAST.

Cerebro-Spinal Meningitis.—Last week the number of cases of this disease reported was rather less than in recent weeks, being 24 as compared with 29 the week before. The number of deaths was 21, but the more recent cases show a tendency to be milder than the earlier ones. The total number of cases in Belfast is now 445, and the total deaths registered 316. A child died in Lurgan Union Fever Hospital last week from cerebro-spinal meningitis, making the third death in this institution.

County Antrim Infirmary, Lisburn.—The annual report of this hospital has just been issued, and shows an increasing amount of work. Dr. St. George reports having had under his care 376 intern and 454 extern patients. A charge of one shilling is now made in the extern department for all except workers in public works which make an annual collection for the hospital funds. The daily average of patients in the hospital was 36, and 85 accident cases were admitted to the wards. The operations numbered 149. A complete X-ray of apparatus had been presented to the hospital by the Barbour family of Lisburn, to whose generosity much is already owed.

The Health Commission.—The Commission has adjourned till July 15th, when it is hoped that a final series of sittings will conclude the hearing of evidence. Before adjourning they heard evidence from Dr. John McCaw, senior physician to the Belfast Hospital for Sick Children. He dealt with the infantile death rate, which he said was 144 per 1,000 in 1906, and was much too high, though probably 80 per 1,000 was inevitable in a manufacturing city like Belfast. The diarrhœa diseases and rickets were accountable for 50 per cent. of the infantile mortality. The mothers went to work and left their infants to the care of old women, who undertook the duty for a small payment, out of which they bought the food, probably skim milk at a penny a pint. This milk was exposed for sale in small shops in a most objectionable way, and he thought the Corporation should have control over it. Deaths from overlying were common, specially on Saturday nights, and the witness thought that where the mother was proved to have been drunk she should be prosecuted. He joined with previous medical witnesses in advocating a crusade of cleanliness.

LETTERS TO THE EDITOR.

THE ALCOHOL MANIFESTO.

To the Editor of the Medical Press and Circular.

Sir,—May I call attention to a statement made by your correspondent, Dr. Churchill, relating to the consumption of alcohol at Guy's Hospital in 1905? The sentence in his letter of the 15th inst.: "Of this amount the resident staff no doubt help to consume a fair amount of alcoholic drinks in each hospital," might lead the reader to suppose that in the figures quoted are included the "alcoholic drinks" of the resident staff. As a matter of fact, the figures relate to alcohol supplied to patients only, the alcohol for the resident staff being included in the separate items, "Board of Resident Medical Officers" and "Board of Nursing Staff."—I am, Sir, yours truly,

E. C. Perry, Superintendent.

Guy's Hospital, London, May 23rd, 1907.

THE EDALJI CASE.

To the Editor of the Medical Press and Circular.

Sir,—All friends of Mr. Edalji must be grateful to the Medical Press and Circular for the part it has played in the case. I observe, however, that you now think finality has been reached. I trust that the exhibition of the actual documents in the *Daily Telegraph* and their analysis will convince you that there is as little truth in the accusation that Edalji wrote the letters as that he did the outrages. In this respect a fresh injustice has been done. The man who did the deeds wrote the letters, and that man was neither directly nor indirectly connected with George Edalji.—I am, Sir, yours truly,

Arthur Conan Doyle.

The Grand Hotel, London, May 24th, 1907.

[We are much obliged to Sir Arthur Conan Doyle for giving us this further information, and we shall be very glad to see the actual documents. In the absence of any fresh light, we are of course bound to accept tentatively the interesting opinion of Sir Arthur Wilson and his colleagues.—Ed. M. P. and C.]

LAW FOR LAWYERS AND LAW FOR DOCTORS.

To the Editor of The Medical Press and Circular.

Sir,—The grotesque inequality and absurdity of the law, which, be it remembered, represents the attitude of the State towards the professions of law and medicine respectively, are illustrated daily in one direction or another in the newspaper press. The bare record of these illustrations would occupy fully a page of the medical press weekly. I trust you will continue to keep the matter before the profession by publication at least of samples of the worst anomalies. One of such examples appears in the *Times* of May 22nd, a qualified solicitor was summoned at Bow Street on May 21st charged with "wilfully and falsely pretending to be a solicitor." It turned out that the defendant was a fully qualified man, and had been on the rolls for many years, but his certificate had been refused last year in consequence of his being an undischarged bankrupt. The defendant pointed out that there was nothing dishonourable about his bankruptcy and no allegation against his professional integrity. There had been no false representation on his part, he was acting for an old unfortunate client. He was, nevertheless, fined £5 and costs, or imprisonment in default of distress. Contrast this case with what is going on under medical law, or, rather, in the absence of medical law. An abortion-monger who had been previously convicted and struck off the medical register was recently sentenced to penal servitude, having re-commenced his old trade soon after release from prison. He employed the title of "Dr.," and was not interfered with for this, nor need he have been interfered with if he had refrained from commission of crime bringing him within the reach of ordinary law. Many convicted offenders expelled from the profession are practising under similar false pretences, mostly engaged in nefarious forms of quackery, advertising cures for hopeless cases of cancer and consumption, which ought to bring them within the clutches of the law if the State showed proper concern in the protection of the classes—the helpless victims of disease, who have most claims upon its guardianship. It cannot be believed that the present state of things would be allowed to go on for long if the profession would unite, force attention to their case, and demand the needed reforms. If the profession cannot prove their entire unselfishness, they can at any rate demonstrate conclusively that what they ask for is required a thousand times more for the protection of the people than for their own advantage.

I am, Sir, yours truly,
Henry Sewill.

Hotel Bernascon,
Aix-les-Bains,
May 22nd, 1907.

LONDON HOSPITALS AND GENERAL PRACTITIONERS.

To the Editor of The Medical Press and Circular.

Sir,—Your correspondent, "General Practitioner," seems to have missed the point of "R. L.'s" letter, which I take to be that if hospitals were State-supported, and therefore State-managed, the present members of their staffs would cease to serve in an honorary capacity; but that this would be no great loss as a whole. Perhaps not, but would they so cease? However irksome and troublesome a hospital may be, it is sure that the man with scientific ardour will always seek it because of the opportunity afforded him for the observation of disease. Ordinary private practice is notoriously of little use for purposes of study and self-improvement, because we have not the means of continuous and careful observation. However far from ideal hospitals may be, they form the nearest approach to furnishing "laboratory conditions" that is possible in this fallacious world. For this reason, State hospitals could always rely on securing a highly-qualified staff of honorary physicians. It is possible, too, that if they paid their staff adequately for their work, they would secure the cream of the men who now leave hospital and go into practice, because of the necessity of making a living for themselves as soon as possible. At present, of course, "the highest skill in the medical world" is obtained by paying for it. Hospital posts are not bought and sold with West Ham candour, but they are a question of means, primarily, secondarily, and (almost) entirely.

I am, Sir, yours truly,
Another G. P.

London, S.E., May, 20, 1907.

OBITUARY.

SIR JOSEPH FAYRER, Bart., K.C.S.I., M.D., F.R.S.

We regret to announce the death of Sir Joseph Fayrer, Bart., K.C.S.I., Physician Extraordinary to the King, at Falmouth, in his eighty-third year. Though Sir Joseph had been ailing for some time, his illness became dangerous only ten days before his death. Sir Joseph Fayrer, was born at Plymouth in 1824. Educated privately, he began medical study at the Royal Naval Hospital, Bermuda, and continued it at various medical centres. The year 1847 saw him a member of the Royal College of Surgeons of England, and subsequently he obtained the M.D. of Edinburgh and the Fellowships of the Royal Colleges of Surgeons of England and of Edinburgh and of the Royal College of Physicians of London. At the age of twenty-three he entered the Royal Navy as assistant-surgeon on His Majesty's ship *Victory*, two years later transferring to the Army Medical Service as an assistant-surgeon in the Royal Artillery, and again a year later to the Bengal establishment of the Indian Medical Service. His career in India, thus commenced in 1850; it continued till 1874, when he returned to England and became Surgeon-General, President of the Medical Board of the Indian Office and a consultant of wide repute, not giving up work finally until 1904. His work in India brought him the appointment to the Residency of Lucknow, and thus led to his presence as senior medical officer throughout its siege during the Mutiny in 1857. He was one of the Council of War summoned to decide the question of defence or retreat, and it was in his house, one of the principal points of attack, that the Brigadier-General, Sir Henry Lawrence, eventually succumbed. Subsequently Dr. Fayrer and the medical men associated with him during the siege received the thanks of the Governor-General in Council in a General Order, and he was promoted in rank. In 1867 he received the Companionship of the Star of India, and in the following year was made Government Trustee of the Indian Museum. Three years later he was selected to accompany the Duke of Edinburgh during his tour in Upper India, and in 1871, while still in India, was appointed Honorary Physician to Queen Victoria. After his return to England and his appointment to the India Office he again went out to India, this time in the suite of the King, then Prince of Wales, during his Indian tour in 1875-6. On its termination he was appointed honorary physician to his Royal Highness and made K.C.S.I., being raised to the position of Physician Extraordinary and created a baronet on the accession of King Edward to the throne. Fayrer's scientific attainments met with wide recognition both at home and abroad, and he received many corresponding honours. Thus, in addition to being elected a Fellow of the Royal Society of London, he was LL.D. of the University of Edinburgh and St. Andrews, and at one time President of the Epidemiological Society of Great Britain, of the Medical Society of London, and Consulting Physician to the Charing Cross Hospital. Similarly he was elected to the honorary membership of many foreign societies, such as the Academy of Medicine of France, the Royal Academy of Science of Lisbon, the Royal Academy of Medicine of Rome, and the College of Physicians of Philadelphia. He was also a Knight of Grace of the Order of St. John of Jerusalem.

JOSEPH GROVES, J.P., B.A., M.B.Lond.

We regret to record the death, on May 21st, of Dr. Joseph Groves, of Carisbrooke, Isle of Wight, in his sixty-eighth year. Dr. Groves was for a quarter of a century medical officer of health for the rural district of the Isle of Wight, in which position he worked courageously for the sanitary improvement of the island. He also took a leading part in helping forward movements for higher education; whilst as president of the Isle of Wight Horticultural Improvement Association and of the Isle of Wight Amateur Athletic Club he did much for horticulture and sport. He was formerly president of the southern district of the British Medical Association, and last year he presided over the preventive medicine section of the meetings of the British Medical Association in Canada as the English vice-president of that section. He was a member of the council of the British Medical Association and lately President of the Incorporated Society of Medical Officers of Health, and he was a Fellow of the Geological Society, the Royal Meteorological Society, and the Statistical Society.

DAVID MacMAHON BROWNE, L.R.C.P. and S. Edin.

We regret to record the sudden death of Dr. MacMahon Browne, of Tooting. Deceased had been in good health until the Saturday before his death, when he took to bed with what he described as a heart attack. On the Monday after a severe attack of angina, he paid a visit to a patient's house, where he said that if it had not been for the serious condition of her baby he would not have left the house. Soon afterwards he fell to the floor and died. Deceased was medically educated in Edinburgh, where he took the double qualification in 1882.

REVIEWS OF BOOKS.

A NURSES' VADE MECUM. (a)

This well-intentioned little manual has been compiled from "notes and jottings taken down during a course of twenty-seven years of nursing, and twenty years of instruction and training of nurses, in various countries," but in spite of this, seems fairly up-to-date. At all events the author should know something of what nurses need. So many admirable handbooks on nursing are now available that we should have thought that there would have been but little demand for such a necessarily restricted work as this. Like all books of this class it has the defects of its supposed virtues. As a ready source for suggestions and directions it should be of help to many nurses who in district or other work have often to do the best under difficult conditions and acting more or less on their own initiative; but it is to be hoped that it will not be relied upon to an extent which will displace more thorough and complete manuals.

FLEMING'S PRACTICE OF MEDICINE. (b)

This volume presents the student or practitioner with an excellent, if somewhat condensed, practice of medicine. The author has set out with the intention of writing a short book upon a large subject, and he has achieved that most difficult task in a fairly satisfactory manner. Here and there he is content to state principles and leave the student to work out their application. Speaking of the diet in typhoid fever, he remarks that there is much difference of opinion as to whether we should order milk, with egg flip and other easily digested and nourishing foods, or whether we should be content with a minimum of other nourishment." "*The principle governing the dietetic régime is to have as little waste matter reaching the inflamed portion of the intestine as possible, and probably a middle course is desirable.*" In a matter of such importance we should have preferred to have a clear statement of the writer's own experience and practice. In acute rheumatism we are told the "proper medicinal treatment is much disputed." That observation hardly seems to recognise the firm belief of most practitioners in some form or other of the salicyl compounds. The section of the book dealing with diseases of the nervous system is specially clear and helpful. In the space at our disposal it is impossible to enter into any detailed criticism. Broadly, however, it may be stated that Dr. Fleming has produced in this book a general outline of individual disease, the details of which must be filled in by the student himself. The author's experience as a lecturer on medicine to the Royal Colleges and as an assistant physician to the Royal Infirmary, Edinburgh, ensures the amount and the accuracy of his information. This unassuming book, indeed, is worthy of the best traditions of the Scotch school, and may be safely recommended to all who need an authoritative if rude map to the great field of modern medicine.

LABORATORY NOTES.

The demand for drugs in tablet form has led the Bayer Company, Ltd., to put up several of their well-known products in that shape, and we have samples of Aspirin, Helmitol, Tannigen, Trional-Bayer and Veronal, all in 5-grain doses, and Heroin Hydrochloride in 1-24th grain doses. These preparations will doubtless be welcomed by many who are in the habit of prescribing these useful drugs.

Messrs. Parke, Davis and Co. are introducing in Iodalbin, an ioda-proteid compound containing 21.5 per cent. of iodine, for which it is claimed that while producing the same therapeutical effects as the alkaline iodides, it does not give rise to gastric irritation and iodism. They also present some new compound tablets—Phenol Phthalein, intended for use as an habitual laxative. The aperient qualities of the main drugs are reinforced and modified by addition of Belladonna and Strychnine.

The same firm have also brought forward a nutritive Liquid Peptone, in which prime beef is reduced to peptone by means of Bromeline—the proteid-digesting ferment of pine-apple juice—and extract of malt. The same preparation is also made up with beech-wood creosote and guiacol under the name of Nutritive Liquid Peptone with Creosote. Their use is recommended especially in wasting diseases in which the digestion is impaired.

Several new and interesting preparations have lately been brought out by Messrs, Burroughs and Wellcome, among which we may note an Elixoid of Formates, Quinine Acetyl Salicylate, Iron Arsenate (soluble), and Bismuth Citrate (soluble), "Wellcome" brand. The Elixoid Formates Compound contains in each fluid ounce, Calcium Formate 12 grains, Sodium Formate 6 grains, and Magnesium Formate 6 grains. Two fluid drachms in water, thrice daily after food, is said to form a pleasant and useful nerve and general tonic.

Quinine Acetyl Salicylate is a drug which is said to combine the advantages of Quinine and the Salicylates without any free salicylic acid being given off to irritate the stomach, the acetyl-salicylic acid that is formed not being a gastric irritant. In all rheumatic and periodic conditions, especially in such as exhibit both features, the drug would commend itself for trial.

Iron-Arsenate (soluble), "Wellcome" brand, is intended to supersede the unsatisfactory Ferri-Arsenas of the British Pharmacopœia. This drug is insoluble in water and variable in composition as officially prepared, and Messrs. Burroughs and Wellcome are now able to supply in their substitue a preparation which is readily soluble in water, miscible with other drugs, and of staple composition. The Bismuth Citrate (soluble) "Wellcome" brand, is designed to replace the Bismuth Ammonium Citrate preparation of the United States Pharmacopœia, and should also be useful in Great Britain.

Cases of spotted fever have occurred sporadically at Constantinople during the last two months, and with increasing frequency in the past fortnight, when there have been one or two deaths daily, chiefly among infants and young people.

(a) "The Nurses' 'Enquire Within': A Pocket Encyclopædia of Diseases and their Symptoms, Nursing Treatment and much other Valuable Information. Alphabetically arranged." By C.O.M. Pp. 166. London: The Scientific Press, Limited. Price 2s. net.

(b) "A Short Practice of Medicine." By Robert A. Fleming, M.A. F.R.S.E., Lecturer on Medicine, Royal Colleges, Edinburgh, &c., &c. London: J. and A. Churchill. 1906.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT SURGICAL LITERATURE.

Acute Dilatation of Stomach.—Connor (*Amer. Jour. of Med. Science*, Philadelphia, March, 1907) bases his study on 82 recorded cases of acute dilatation of the stomach, two personal cases and 18 cases of mesenteric obstruction of the duodenum. He considers acute dilatation of the stomach a disease of considerable clinical importance, one which develops under a variety of conditions, but is especially frequent after operation done under general anæsthesia. In the majority of cases reported, there was found an associated dilatation of the duodenum; in fact, in a large proportion of cases—about one-half—the dilatation is associated with, and seems to result from, some form of obstruction of the duodenum. The most common cause of such obstruction is found to be constriction of the lower end of the duodenum, between the root of the mesentery and the vertebral column. The constriction occurs when the mesenteric root, with the superior mesenteric artery, which runs in it, is stretched tightly across the duodenum as the result of traction exerted by the small intestine hanging over the brim of the pelvis. Although great dilatation of the stomach would doubtless increase the liability to mesenteric obstruction by crowding the intestines into the pelvis, Connor is of the opinion that in some cases at least the duodenal obstruction is primary. The mortality among the reported cases was 72 per cent., but Conner says that there is much evidence to show that the disease can usually be controlled and cured, if the diagnosis is made and suitable treatment begun before complete collapse of the patient has occurred. D.

Retention of Urine in a New-born Female Child.—Rudaux (*Paris Med. Journ.*, April) describes the case of a normal female child born at term. After twenty-four hours she had not passed any urine, but suffered from spasmodic attacks, evidently of dysuria. There were œdema above the pubis and hypogastric distention, the vulva bulged outwards, the hymen forming a convex septum. On pressing the hymen almost solid mucous escaped. A stout loop of silkworm gut was bent and passed into the minute orifice of the hymen. This broke up the solid mucous, and a considerable quantity was emptied out of the dilated vagina. Another loop of gut was introduced into the urinary meatus, and at once a strong jet of urine escaped. There was no further trouble, the infant micturating normally within a few hours, and next morning the œdema and distention had disappeared. G.

Primary Suture of the Median Nerve.—Stirling (*Intercolonial Med. Journ.*, March, 1907) reports the case of a wood-carter whose arm had been caught in machinery. There was a large, foul gaping wound, just above the inner side of the right elbow, dividing the structure down to the joint, and among them the brachial artery and the median nerve. It was found that three inches of the nerve had been destroyed. The ends were united as well as possible with catgut and the wound partly closed; there was a considerable amount of sepsis; the wound re-opened and granulated up. A month later, the wound now having completely healed, the nerve was again exposed and found to be, as was expected, widely separated again, the severed ends being fully three inches apart. The sciatic nerve of a small dog was grafted on to the freshened ends of the median. This operation was aseptic. Twelve months later the patient reports, "My arm is very much improved. I am now able to bend and grip anything with the last three fingers of the hand. The first finger and thumb I can also bend very well, but cannot grip so well with these. The arm itself is much stronger, and I can move it very freely. The only drawback is the skin of the hand, which is very soft and tender. The least little knock breaks it, and it heals very slowly then." Evidently the motor-functions of the nerve have been almost completely established, while the sensory, as is so often the case in lesions of the musculo-spiral, have been only partially restored. G.

The Treatment of Hæmorrhoids by Injections of Carbolised Glycerine.—Vulliet describes a method (*Rev. Med. de la Suisse Romand*, December, 1907) which has been practised for several years by Prof. Roux with marked success. The advantages claimed for the method are freedom from hæmorrhage, the short duration the patient is confined to bed, and the simplicity of the instruments required for the operation, a stout hypodermic syringe and a 60 per cent. solution of carbolic acid in glycerine being all that is necessary. With the patient under an anæsthetic, the piles are made to protrude in the ordinary way; the needle is introduced into the base of each pile in turn, and one or two drops of the solution injected, care being taken that none of the solution gets on to the surface of the piles. It is better to keep the bowel continuously douched to prevent this occurring. Immediately after the operation the piles become swollen. They are left protruding from the bowel, well smeared with vaseline. For a few hours this swelling continues, the piles becoming dark purple and even showing small areas of sloughing tissues, but in three days shrinking begins, which may be aided by hot applications. There is little pain, and the patient need only be confined to bed for five days. It is quite unnecessary to constipate the patient. For some weeks fibrous nodules remain about the anus, but these gradually disappear and cause no trouble. While the immediate results are rapid, relapses have seldom been known to occur. G.

Pus Tubes in the Male.—Belfield (*Medical Record*, May 4th, 1907) considers that pus infection of the seminal tube, including the vesicle, in the male, appears to be quite as frequent as pus infection of the Fallopian tube in the female. It is not so often recognised, for its usual symptoms—pyuria, frequent and painful urination, and partial or complete retention of urine—are usually referred to the bladder and prostate, and the patient therefore treated for cystitis and prostatitis. In gonococcal infection when complete retention of urine is terminated by a sudden discharge of pus into the urethra, it is usually diagnosed as prostatis abscess, and often when caused by abscess formation in the seminal vesicles. The non-gonorrhœal infections of the seminal vesicle in men over 40 years of age the author considers are often labelled prostatic hypertrophy, as they cause the same symptoms. These are the cases of alleged prostatic enlargement, which were benefited by vasectomy, when that operation was popular. The author's treatment of the condition consists essentially in opening the vas, stitching the cut edges of the skin, and injecting through a curved hypodermic needle any chosen solution into the proximal vas. This liquid traverses the vas and ampulla, and enters the seminal vesicle. By digital massage from the rectum, the injected liquid can be expressed into the urethra if desired. Through the fistula daily injections of the vesicle can be made as long as seems necessary, after which the fistula is easily closed. Complete transverse section of the vas may safely be made, if preferred, since anastromosis of the cut ends, and restoration of the lumen can be easily accomplished. The first injection should not exceed thirty to sixty minims, lest spermatic colic and retention of urine be provoked. S.

Medical News in Brief.

Royal College of Surgeons in Ireland.

The following candidates having passed the necessary examination, have been admitted Fellows of the College:—F. J. Cahill, L.R.C.S.I., etc.; R. H. Dickson, L.R.C.S.I., etc.; T. W. A. Fullerton, B.Ch., etc., R.U.I., Major, I.M.S.; P. E. Hayden, L.R.C.S.I., etc.; H. Stokes, B.Ch., etc., Univ. Dub.; P. D. Sullivan, L.R.C.S.I., etc. The following candidates have passed the primary part of the Fellowship examination:—W. F. O'Connor, B.Ch., etc., R.U.I.; Miss E. R. Benjamin, R. Charles, F. J. Colgan, E. A. Gregg, P. M. J. Power, R. S. White.

Association of Physicians of Great Britain and Ireland.

The first general meeting of this Association was held on Thursday and Friday last, May 23rd and 24th, in the rooms of the Royal Medical and Chirurgical Society, Hanover Square, London. The chair was occupied by Sir R. Douglas Powell, Bart., President of the Royal College of Physicians, and there was a very large attendance of members. The opening portion of the meeting was devoted to business matters, and thereafter a large amount of good scientific work was submitted. The time of meeting was from 10 a.m. to 6.30 p.m. daily, with intervals for luncheon and tea. On Thursday evening the members dined together at the Trocadero Restaurant. The Association is to meet next year in Edinburgh.

Trinity College, Dublin.—Post Graduate Classes.

A reference to our advertising columns will show that the post-graduate classes, which have been so successfully carried on during the past three years, will commence on 17th June. Trinity College was the first medical school in Ireland to organise special classes for qualified men, and each year the numbers entering for the course have increased. This year the classes will be conducted on the same lines as in former years. The syllabus before us shows that instruction will be given in medicine, surgery, diseases of the eye, throat, nose, ear and skin in the forenoons, while the afternoons will be occupied with clinical pathology, operations, anatomy, X-ray work, physiology, and the like. An attractive and popular feature of the course is the possibility of obtaining rooms in College and dining at Commons. As the number of rooms is limited, early application by those intending to reside in college is desirable. Financial details are given in the advertisement, and any information not contained therein may be had from the Honorary Secretary.

Society of Apothecaries of London, May, 1907.

The following candidates, having passed the required examinations, have received the L.S.A. Diploma of the Society, entitling them to practise medicine, surgery and midwifery:—H. S. Burnell-Jones, S. A. Mahmood, E. Moir, C. C. Morrell, R. Spears, and E. W. Squire.

St. Bartholomew's Hospital.

The annual report of this Royal hospital shows that the past twelvemonth was a successful one. The gross rentals increased by £1,118, and the expenditure decreased by £1,846, the result being an advance of £2,964 in the sum carried to the general account for hospital purposes. The total income is stated at £72,919, and the expenditure at £75,557, a deficit of £2,638 appearing therefore at the close of the year. The principal items of outgo were salaries and wages, £25,701; provisions, £13,183; domestic, £12,171; establishment charges, £6,656; surgery and dispensary, £7,513; administration, £2,199; extraordinary expenditure, £4,030; convalescent and home, £3,252. The legacies received during the year were £2,295, and of this £1,427 has been applied to the rebuilding fund. With regard to that fund the treasurer states that the receipts for the twelvemonth only amounted to £13,838, raising to £118,371 the total sum given or promised, exclusive of £3,208 for the pathological block, £2,459 for the nurses' home, and £959 on account of Dr. Norman Moore's book on the hospital. As to the work done it is stated that the number of in-patients treated was 7,615, the daily average being 556, and the average period of residence 26.6 days. The casualty patients numbered 75,683 medical and 49,223 surgical. The total number of new cases was 126,021, and of attendances 287,231. Inquiry was made into the pecuniary condition of 8,673 patients, and as a result 103 could not be found at the address given, and 277 were considered to be unsuitable for gratuitous aid. The number of patients sent to the Convalescent Home was 1,070, and in addition 201 patients were received at other homes.

Proposed National Health Authority.

A meeting of representatives of the county councils of Northumberland and Durham and the urban sanitary authorities of Newcastle-upon-Tyne, and other Tyneside towns was held yesterday in Newcastle to consider measures to be taken to combat tuberculosis. The following resolution was carried: "That, in the opinion of this meeting, it is desirable that a permanent union of the sanitary authorities of England and Wales be established as a supreme national health authority with the object of safeguarding and promoting the public health interests of the people at large against tuberculosis and other dangers to the public health."

Society for Relief of Widows of Medical Men.

At the Annual General Meeting of the above Society, Dr. Blandford, president, in the Chair, a resumé of the work done by the Society during the past year was presented by the secretary. Ten new members were elected, nine died and one resigned. The Society consists at the present time of one honorary, 140 life, and 145 paying members, making a total of 286, which, considering the number of medical men who are eligible for membership, is but a very small proportion. The invested funds of the Society amount to £98,960, from which is derived in interest the sum of £3,114 4s. 11d.; £334 19s. was received in subscriptions and donations. The working expenses for 1906 were £217 10s. 5d. Amongst the annuitants of the charity, namely 54 widows and 21 orphans, the sum of £3,268 10s. was distributed, each widow receiving on an average £50 and £10 extra at Christmas, and each orphan £10 and £3 extra at Christmas.

The Copeland Fund is a special fund which enables the Society to grant to any widow or orphan already in receipt of the Society's ordinary relief, extraordinary relief in special circumstances of unusual distress, such as blindness, paralysis, insanity, severe disabling accident, or grave permanent disease, and to continue such extra relief in the case of orphans as the Court of Directors may think fit.

During the year six widows, in receipt of grants, died. One, whose husband had paid a life subscription fee of £21, received £900; another, whose husband had paid the maximum amount in annual subscriptions, namely, £52 10s., received £697, the remaining four widows had received on an average £600 each. Five widows were elected during the year, and on December 31st there were 47 widows and 20 orphans in receipt of grants. One of the widows has been on the books since 1854, and has already received over £2,000.

Relief is only granted to the widows and orphans of deceased members, who have paid their annual subscription for three years, or are life members.

The Directors strongly urge upon members of the medical profession, especially the younger ones, the desirability of joining the Society. Membership is open to any registered practitioner, who at the time of his election is resident within a 20-mile radius from Charing Cross. The annual subscription is two guineas; every member who shall have paid this sum for twenty-five years becomes a member for life. Further particulars may be obtained from the Secretary, 11 Chandos Street, Cavendish Square, W.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office: if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

ADVERTISEMENTS.

FOR ONE INSERTION:—Whole Page £5; Half Page, £2 10s.; Quarter Page, £1 5s.; One-eighth, 12s. 6d.

The following reductions are made for a series:—Whole Page, 13 insertions, at £3 10s.; 26 at £3 3s.; 52 insertions at £3, and pro rata for smaller spaces.

Small announcements of Practices, Assistancies. Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

MEDICUS.—The newspaper report which has reached us through the ordinary channels, is at variance with our correspondent's statement. We will, however, make inquiries into the matter, with a view to dealing with it.

CONTRACT.—The appointment you mention is one that should not be applied for without careful inquiry of the local members of the profession. There has been considerable dispute about the conditions attaching to it, and if you apply and are elected you may find yourself isolated from your fellow-practitioners in the town.

CASES WHICH PUZZLE THE DOCTORS.

THERE have been many parallels to the case of the young man in the Croydon warehouse, whose voice, lost through an accident seven years ago, has been restored through the shock produced by an exploding syphon of soda-water. Not long ago, John Moore, an ex-soldier, of Gosport, who had been dumb for four years, suddenly recovered his speech in an alarm caused by a trivial bicycle accident. More remarkable still was the case of Mathias Steingruber, who was thrown from his horse in a charge in the Mexican war, sixty years or so ago. For more than half a century his mind was an absolute blank—the machinery of the brain stood still, until mind and memory were restored by a severe blow on the head from a piece of wood thrown from a circular saw. A few years since a Bavarian cattle dealer, who had long been dumb, was restored to speech by a horse's kick; William Wilkinson was "stone-deaf" until an accident in a Leeds street gave him back his hearing; and a gentleman who had been blind for seventeen years recovered the use of his eyes after an operation which followed injury in a carriage accident near Exeter.—*Westminster Gazette.*

DUNS SCOTUS.—Several sanitary authorities have used their isolation hospitals as sanatoria for consumptives during slack times, and it might be a solution of your difficulty if you could get permission to use your small-pox hospital for the purpose. The Galashiels Sanatorium, which has just been opened, was originally built for a small-pox hospital.

DR. R. A.—If you want to place your patients with a colleague, you should apply to the Hon. Secretary, Association of Medical Men Receiving Resident Patients, 56 Outer Temple, Strand, W.C., A list of medical men willing to receive patients, together with information as to accommodation, fees, etc., is kept by the Secretary for the use of inquirers.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 29th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Cantile: Clinique.—(Surgical.) 5.15 p.m.: Lecture:—Dr. P. Stewart: The Diagnosis of Disseminated Sclerosis.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, MAY 30th.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5.30 p.m: General Meeting. Election of Officers for the ensuing year. 6 p.m.: Address:—Dr. N. Moore: Air, Water, and Situation. 7.30 p.m.: Annual Dinner at the Trocadero Restaurant, Piccadilly Circus, followed by an Entertainment.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. F. M. Sandwich: Cerebro-spinal Fever.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (D. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m.: Special Demonstration on Medical Cases (Dr. Whiting).

FRIDAY, MAY 31st.

EPIDEMIOLOGICAL SOCIETY (11, Chandos Street, Cavendish Square, W.).—8.30 p.m.: Papers:—Prof. A. Holst (Christiana University): Studies concerning Ship Beri-beri.—Prof. Holst and Dr. T. Frolich (Christiana University): Polyneuritis in Poultry (Polyneuritis Gallinarium Eijkman) and Scurvy in Guineas-pigs.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. J. Horne: Clinique. (Throat.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—9.30 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

Corporation of the City and County of Newcastle-upon-Tyne.—Assistant Medical Officer of Health. Salary £300 per annum, with board, lodging, etc. Applications to the Medical Officer of Health, Town Hall, Newcastle-upon-Tyne.

Egypt.—Sub-Inspector of Ophthalmic Hospitals. Salary £500 a year, with two months' salary in lieu of travelling expenses to and from England. Applications to the Director-General, Department Public Health, Cairo.

The Hospital for Sick Children, Great Ormond Street, London, W.C. Anæsthetist. An honorarium of 15 guineas. Applications to the Secretary. (See advt.)

Middlesbrough: North Ormesby Hospital.—House Surgeon. Salary £120 per annum, with apartments and board. Applications to R. T. Milner, Secretary, Royal Exchange.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—A House Surgeon. Salary £20 for six months, washing allowance £2 10s., with board and residence in the Hospital. Applications to the Secretary. (See advt.)

City of London Hospital for Diseases of the Chest, Victoria Park, E.—Resident Medical Officer. Salary £120 per annum, with board, etc. Applications to the Secretary.

Alnwick Infirmary.—House Surgeon. Salary £140 per annum, with furnished apartments, attendance, coals, and gas. Applications to Wm. T. Hindmarsh, Honorary Secretary, 26 Bondgate Without, Alnwick.

London Temperance Hospital, Hampstead Road, N.W.—Resident Medical Officer. Salary £120 per annum, with board, lodging, and washing. Applications to A. W. Bodger, Secretary.

Appointments.

CHARLES, HERBERT, M.R.C.S., L.R.C.P.Lond., Assistant Anæsthetist to the Middlesex Hospital.

CLEARY, M., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Newport District of the county of Mayo.

DOLAMORE, W. H., M.R.C.S., L.R.C.P., L.D.S.Eng., Lecturer on Operative Dental Surgery at the Royal Dental Hospital of London, Leicester Square, W.C.

FINDLAY, W. D., M.B., C.M.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Middleton District of the county of Lancaster.

GELLATLY, ANDREW, M.B., C.M.Edin., Medical Officer of Health of Droys'den, Manchester.

HIBBERT, J. COOTE, M.D.Lond., D.P.H., Medical Officer of Health of the Borough of Warrington.

LOGAN, W.A., F.R.S.C.Eng., L.R.C.P.Lond., Clinical Assistant to the Chelsea Hospital for Women.

Births.

CRAIG.—May 22nd, at 18 Merrion Square, Dublin, the wife of James Craig, M.D., of a daughter

MOONEY.—On May 21st, at 22 Lower Baggot Street, Dublin, the wife of Herbert Mooney, M.B., of a daughter.

MCNEIGHT.—On May 22nd, at Thaxted, Essex, the wife of W. R. P. McNeight, M.D., T.C.D., of a daughter.

REEVES.—On May 12th, at 6 Streatham Hill, London, S.W., the wife of Albert Reeves, M.R.C.S., L.R.C.P., of a daughter (still-born).

Marriages.

MARSHALL—DE BRUNO-AUSTIN.—On May 22nd, at St. James's, Piccadilly, London, Richard Wildridge, younger son of Dr. John Marshall, late of Coatbridge, N.B., to Gwendoline Lucy, elder daughter of F. J. de Bruno-Austin, of Hampton Wick.

RIVIERE—OSLER.—On May 22nd, at Rosslyn Hill Chapel, Hampstead, Clive Riviere, M.D., son of Briton Riviere, R.A., to Henrietta Maria, daughter of Thomas Osler, of Hampstead.

STANWELL—GILLING.—On May 23rd, at St. John's Parish Church, Chipping Barnet, F. Skey Stanwell, M.D., of Palmers Green, Middlesex, son of the late Dr. Stanwell, of Cambridge, to Edith Elizabeth, second daughter of Henry R. Gilling, J.P., of Barnet, Herts.

Deaths.

COGHILL.—On May 24th, at 16 Clareville Grove, London, S.W., Agnes, the wife of the late J. G. Sinclair Coghill, M.D., F.R.C.P (E.), of Ventnor, I.W., formerly of Edinburgh.

GROVES.—On May 21st, at Carisbrooke, Isle of Wight, Joseph Groves, B. A., M.B.Lond., in his 68th year.

MISKIN.—On May 22nd, at 160 York Road, Lambeth, Nicholas Miskin, M.R.C.S., L.S.A., in his 97th year

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, JUNE 5, 1907. No. 23

NOTES AND COMMENTS.

English and German Sanatoria.

WHATEVER mistakes of overstatement have, in the past, been made by anti-tuberculosis enthusiasts, it will be agreed on all hands that the sanatorium is the most suitable place for the tuberculous worker who cannot afford efficient treatment at home or abroad. The prospect of arrest which was so freely promised is, of course, far from assured in many cases, but on the other hand in a goodly proportion it takes place. In many such arrest is only temporary, but in some it is undoubtedly permanent. At all events, there is no sort of alternative to sanatorium treatment which holds out any reasonable prospect of relief, and certainly none whereby the patient can be properly separated from the healthy. The bulk of working-class consumptives live and sleep in the same room with several members of their families, and from the preventive point of view the sanatorium offers important attractions. But though in the last few years sanatoria have been springing up in all parts of the country, the number of beds available for workers who can afford to pay nothing for their treatment is pitiably small; it is said that there are less than a thousand, a number which contrasts ludicrously with the demand that an annual mortality of 70,000 persons from tuberculosis connotes. At the Congress of the League against Tuberculosis, held at the end of last month in Germany, it was stated that there are at present 87 sanatoria in Germany for the use of the masses, and that these provide no less than 8,422 beds. Besides these, there are 17 further sanatoria for children suffering from tuberculosis, and 35 private hospitals. The figures as they stand, throw our own into ignominious contrast, and it is proposed by the League still further to increase the accommodation for children and young people, so that this country has an enormous amount of lee-way to make up before it can hope to rival Germany in its care for the consumptive poor.

The Sphinx Club and Professional Advertising.

THE Sphinx Club, we learn from a press report, devoted its April banquet to a discussion on "Professional Men and Advertising," several representatives of the medical and legal professions being invited to give their views on the subject. The proceedings being somewhat of a convivial nature it was natural perhaps that the discussion should have been devoted rather to playful pleasantries than to the serious aspects of the question, but it was noticeable that most of the medical speakers, who for some reason were more fully reported than the lawyers, seems to have been imbued with ideas as vague as they are peculiar. One orator rested the extraordinary doctrine that no general practitioner could afford to advertise—even if permitted to do so—on the still more extraordinary statement that it cost £1,400 to take one page in the advertisement columns of a medical journal. The gentleman in question may rest assured that for a hundredth of that sum any medical journal would be glad to grant him a whole page on which to display his encomiums on himself. Another speaker gave vent to the equally absurd declaration that so long as the characteristics described in advertisements were limited to goods or animals, the public would give them a hearing, but when they were applied to persons they were regarded as ridiculous and vain-glorious puffs. If this were so, it would be difficult to account for the success of persons like the physical culturists, or the "beauty specialists," or the hernia or deafness curers, or the thousand other professors of their own powers in the treatment of disease. Perhaps the most sensible statement made by any of the guests was one to the effect that if the advertisements one sees were true, there would be no need for the medical profession at all.

Theodore Williams Scholarship.

THE opportunities for saving money presented by the pursuit of medicine are so poor that it is not a matter for wonder that few medical men indeed find themselves in the position to advance the science or study of medicine by the giving of scholarships. It is then all the more pleasing to be able to record the really handsome benefaction just founded at Pembroke College, Oxford, by Dr. Theodore Williams. This is to take the form of a scholarship of £100 a year, to be known as the "Theodore Williams Scholarship," and is to be held by an honours student of the natural sciences who has the *bona fide* intention of proceeding to the degrees of B.M. and B.Ch., and of eventually practising medicine. The scholarship under proper safeguards is tenable for four years at Oxford, and may be extended for one year more at the discretion of the Master and Fellows. Of course, £100 a year will not keep a student at Oxford, but it will go a long way towards it, and as English universities do not enjoy Carnegie endowments, the poor English student has hitherto had very little chance of getting through a course at the older foundations. We congratulate Dr. Theodore Williams on this wise and generous foundation, which should be all the more appreciated in that the founder has made the necessary pecuniary sacrifices during his life-time.

Expert Fees in India.

One of the disadvantages that medical men suffer under is that in any system they nearly always find themselves in a position of subordination to men of other callings, and often of no callings at all. This is particularly galling in a bureaucratic country like India, where all the services are jealous of the "doctor," and try in various ways to snub and offend him. A glaring instance of this policy occurred in the High Court of Calcutta, where an action involving an estate of several lakhs of rupees was recently tried, and on the express order of the Registrar, certain highly-placed medical officers in the service were called to give expert evidence as to the sanity of the petitioner. The highest fees named were Rs.500 (about 30 guineas) a day, some of the witnesses taking rather less; and these charges must be considered moderate indeed compared with the size of the estate and the responsibility involved in the decision. Yet when the costs came to be taxed, these fees were cut down to the beggarly sum of Rs.80, and, in the case of one Lieutenant-Colonel, only Rs. 16 were allowed. The judge when appealed to to interfere, refused, owing to a technicality, and the medical officers had to pocket the affront.

Outrageous Scandals in American Asylums.

The State Board of Charities in Illinois has just presented a report on the conditions of the county lunatic asylums under the jurisdiction of that State, which is calculated not only to recall the horrors of the Inquisition, but to make them pale into insignificance. Indeed, the Spanish experts must be regarded as blundering amateurs in the science of torture compared with the artists in charge of the insane of Illinois; that is, if the report is to be believed, and it is hardly possible to doubt an official document of deliberation and responsibility such as the report appears to be. In many counties a system of farming out the insane to the lowest bidder prevails, with consequences that beggar description. Boxes and cages are used for refractory patients, and in them the wretched lunatics are padlocked at night, small holes being cut for ventilation. Steel handcuffs and chains are part of the normal equipment of these ghastly institutions, and vermin and filth of every kind abound. Some of the patients are never washed, and those who are allowed water are given a single bath for use among a crowd of both sexes. Indeed, separation of males from females is considered a refinement of decency to which no countenance should be accorded, and women are consequently violated and outraged without compunction. So horrible and revolting are these disclosures that we can hardly bring ourselves to believe them, but if a tithe be true, we can only say that they constitute such a disgrace to humanity as to call for the combined intervention of every civilised country.

LEADING ARTICLES.

THE BILL TO INCORPORATE KING EDWARD'S FUND.

The Bill to incorporate the King Edward's Hospital Fund has been sent from the Lords to the Commons. In the latter House it passed its second reading, and has now reached its Committee stage. The possibility of amending it in various ways and to almost any degree still remains in the power of the Commons. From rumours that have lately been heard in various quarters, the proposed Bill is not likely to pass into law with the smoothness and celerity that marked its earlier stages. The attention of many members, it seems, has been directed to the principles involved in its proposals, and there is every likelihood that not a few pointed criticisms will be heard when the matter comes on for discussion. We believe that we may claim for the Medical Press and Circular priority in drawing public attention to the defects of the constitution of this important metropolitan fund, and of the undesirability of perpetuating them in the charter of the King Edward's Fund. We may perhaps, therefore, be excused in making some comments on the position. Without doubt the matter is one of some delicacy. No king has ever secured the whole-hearted confidence of our countrymen with anything remotely resembling the enthusiasm that is everywhere accorded to King Edward VII. That loyal feeling has to a large extent sprung from the recognition of the kindness of heart, genuine common-sense wisdom, and unfailing tact that mark the attitude of our great sovereign with regard to his subjects. However, as regards the proposed charter of the Fund which bears his name we cannot help feeling that His Majesty's advisers have not shown their usual soundness of judgment and grasp of modern opinions. The first great fact with regard to the Fund is that it is governed by a small autocratic and non-elective and non-representative board. From this it follows that there is no appeal from its decisions, whether just or unjust. Let us see how this method might work out in practise. The Fund, let us imagine, throws a slur upon a particular hospital by refusing a grant. The hospital can get absolutely no explanation as to why the grant has been refused, so that there is no way of getting at the root of the offence. It is a method comparable in a distant way to the irresponsible decrees of the Star Chamber of evil memory. There is no elective control of members of the Executive of the Fund, and whether it be the case or not it is always open to those who imagine they have a grievance against the Fund to say that a private grudge has been satisfied at their expense. It seems in any case possible that under certain circumstances an undue proportion of power in allotting the vast revenue of the Fund might fall under the control of one or two of its more active members. Sir Edmund Hay Currie to-day holds a dominant voice in the politics of the Fund, but the power that he wields with such absolute fairness and broad-minded wisdom to-day might to-morrow devolve upon a narrow-minded, imperious, and ill-balanced successor. There is, again, the danger that members who hold extreme views in the field of hospital politics may be able to influence the action of the Fund unduly. Take, for instance, the opportunity afforded to a member who maintains that hospital patients should contribute to the cost of their relief, or that a policy of amalgamation should be pressed at all costs upon certain institutions, or that the smaller hospitals should be exterminated. As the proceedings of the Fund are private, and their members are irresponsible, it is open to imagine that any of these extreme individuals may be running his peculiar hobby at the expense of this, that, or the other hospital which is refused a grant. Nay, in some instances certain persons have not been slow to assert that the exclusion of a particular hospital from participation in the King Edward's Fund grant has been due to individual animosity on the part of a member of the Executive. It is, of course, impossible to accept such a suggestion for a single moment; but here again the very irresponsibility of the Fund renders it equally impossible to refute rumours of the kind, however obviously idle, malicious or ill supported. The key to the dissatisfaction, as we have often urged, lies in the non-representative nature of the Fund. We maintain that the Executive should be partly if not wholly elected by the governors, by the hospital staffs, both lay and medical, by the medical profession generally, and by the public who participate in the benefits distributed by the Fund. In this way a wide and instructed guidance would be secured in the administration of the Fund. There is another aspect of the question which we placed before our readers in our issue of May 8th (page 497) in the following words:—"The powers sought are at variance with every principle valued by a free and democratic country, and the most unhappy part of all is that this authority is to be vested in the Prince of Wales, who will thereby incur the odium which the action of the Fund may excite at any time. The proposed constitution is the worst that could have been sought, and the Prince of Wales is the last person who should have been chosen to be the responsible person under such a constitution." These criticisms may perhaps seem somewhat more emphatic than are warranted by the circumstances of the case, but we can only say that they have been written in a spirit of the highest loyalty. In our opinion the Royal Family should be kept strictly out of all controversial matters, especially in a situation of the kind under discussion, where the possibility may arise at any time of the Fund being made the stalking-horse of individual interests. It is to be hoped that both the Metropolitan Hospital Sunday and the King Edward's Funds will revise their constitution upon lines of popular representation such as those adopted by the Hospital Saturday Fund.

THE GENERAL MEDICAL COUNCIL.

The eighty-fifth session of the General Medical Council was opened on the 28th instant by the usual address from the chair. On the present occasion the President, Dr. Donald MacAlister, had nothing of more than ordinary interest to communicate. As regards his own position on the Council, he was able to state that the University of Cambridge had requested him to complete the term of five years to which he had been elected as its representative. In this way Dr. MacAlister is enabled to retain his seat in the Council, in spite of the fact that he has been unexpectedly called by His Majesty to become the resident head of the University of Glasgow. The General Medical Council may be congratulated on retaining the services of so fair-minded and accomplished a president. The present session has been marked by the introduction of the four recently elected direct representatives, Dr. Langley Brown, Dr. L. S. McManus, and Dr. H. A. Latimer for England, and Dr. Norman Walker for Scotland. The last-mentioned succeeds Dr. Bruce, of Dingwall, who for twenty years has rendered valuable service to the Council. In his address the President referred to certain proposed changes in the course of study and examination for medical degrees in the University of Edinburgh, as to which the opinion of the Council had been asked for by the Lord President. The completion was announced of the negotiations for medical reciprocity with the Province of Nova Scotia, to which His Majesty in Council was pleased last year to apply Part II. of the Medical Act, 1896. The Executive Committee had felt justified in granting recognition to Nova Scotian degrees and diplomas on terms which, while they fulfilled the conditions of the Medical Act as regards efficiency, were at the same time satisfactory to the Provincial Medical Boards. An incidental consequence of this recognition was that Canadian medical graduates, who had fulfilled the conditions applicable to the Marine Province, are now eligible for commissions in the Royal Army Medical Corps. Graduates of provincial universities in Canada, other than Nova Scotia, however, are still ineligible for appointments in the medical services of the Crown, and it rests with the universities concerned to remove the disability. Dr. MacAlister reported progress in the Bill proposing amendment in the law relating to the practise of medicine and of dental surgery by joint stock companies. Approved by the Council, that measure had passed the second reading in the Lords without opposition, and had been referred to a Select Committee. The Bill to empower the Society of Apothecaries to confer upon those who had passed its qualifying examinations the title of "Licentiate in Medicine and Surgery" had passed through several of its stages in Parliament. Turning to penal administration, the President reported that the Secretary for Scotland had been pleased to give directions similar to those already given in England and Ireland, which would result in the notification to the Council of all cases in which registered practitioners were convicted in Scotland of offences punishable by fines. This step will undoubtedly strengthen the hands of the Council in the performance of its disciplinary functions in Scotland. It is significant that of late years there has been a considerable decrease of charges of "infamous conduct" brought before the Council. The majority of penal cases now claiming their attention refer to conviction before the ordinary tribunals for crimes or other offences of various kinds. It is satisfactory to note that notwithstanding the expenditure of £870 over the election of direct representatives, the financial year shows a balance of £40 to the good, instead of a deficit.

CURRENT TOPICS.

Science and the English Public.

A few days ago a debate was held in which Professor Halliburton had the courage to oppose the views of Miss Lind, of Hageby, and other prominent anti-vivisectors. In his address, Professor Halliburton had occasion to mention the name of Lord Lister, and he was interrupted with shouts of "He's a brute!" This expression of the mind of the man in the street toward the greatest benefactor of his age is a sad example of the attitude of a large section of the public towards science and men of science. There are few countries in which so little respect is paid to knowledge and learning as England. If he lived in Berlin, for instance, or in Paris, Lister's name would be a household word, and an insult of this kind in a public assembly would meet with its fitting revenge. The great bulk of Londoners, however, are careless of the names of such men as Lister, and the mere suggestion that he had to do with scientific research was enough to call forth the expression of opinion we have quoted. It is not as if the abuse came from a Hyde Park orator, or from one of an ignorant mob. Miss Hageby's meeting was, we understand, "select," and attended by well-dressed and —save the mark!—educated people. It is some time since Arnold preached against the "Philistinism" of the British public; it has been left to our day for it to merit the word "Hooliganism."

The General Medical Council as a Court.

The Medical Defence Union has done an important service to the profession—by no means its first—in commenting strongly, in its Annual Report, on the unsuitability of the General Medical Council as a tribunal. In many cases, the Council has to act both as prosecutor and as judge, contrary to accepted principles of justice. In all cases it suffers from the unwieldiness of its constitution and the exiguity of its powers. A bench of some thirty judges, with no power to compel witnesses or to administer oaths, is hardly a convenient machine for the fulfilment of justice. Moreover, with a magnificent irresponsibility, the Council refuses to be bound by precedents, and what is evidence at one time is not evidence at another. The present position is unsatisfactory to all concerned. It ought to be possible to devise some means by which a Court, both effective and trusted, could be established to deal with penal cases, and when the reform of the General Medical Council—long overdue—arrives, the point must not be forgotten.

A Suggested Army Male Nursing Co-Operation.

There are many features of interest in the suggestion of Miss Ethel McCaul to organise a male nursing co-operation for retired orderlies on leaving the service. A good training is now given to these men in the branch of the Army Medical Service concerned, and, be it noted, at a considerable cost to the country. In the present unorganised state of male-nursing in the United Kingdom there is a considerable risk that after discharge they will find no market for their skilled labour. From an economic point of view, however, it is abundantly clear that to allow such men to drift into the ranks of the unemployed after giving up their naval and military duties is nothing short of wanton extravagance. The general dearth of male nurses was evident at the time of the South African war, when the Army Medical Department scoured the country for recruits, but for the most part had to depend upon undisciplined and often untrained men at a high rate of remuneration. The present scheme for founding a co-operative nursing association is to be commended, inasmuch as it proposes to establish an agency, which should in the course of time be self-supporting, for the benefit of a deserving class of public servants.

Report of Experiments on Animals.

The Home Office Inspector under the Experiments on Animals Act (Dr. G. D. Thane) has just issued his report for last year, and it shows that the number of experiments on animals is rising steadily. Last year there were 46,073 experiments, an increase of no less than 8,138 on the 1905 figures, the bulk of which was due to the work of the Imperial Cancer Research Fund. For the fund no less than 21,082 experiments were performed in 1906, 20,795 of them being inoculations. Indeed, the experiments performed under Table IV. (B), which shows which were performed without anæsthetics, numbered no less than 43,287, all of them being inoculations or trivial operations; in no case was a cutting operation more severe than a superficial venesection allowed to be performed without anæsthetics. Of these 43,287 experiments, many, of course, were failures, that is to say, that the animal was not infected with the injected substance, and it therefore suffered no inconvenience beyond the prick of the needle. The number of experiments done under the regulation that the animal must be kept under an anæsthetic the whole time of the operation, and killed before it comes round, was 1,588, and the number in which such subsequent killing was dispensed with for one reason or another was 1,198. So that the amount of pain actually suffered as the result of a year's "vivisection" must really have been very small indeed.

It is noticeable that nearly 6,000 experiments were performed for public bodies; 2,114 experiments were for the Royal Commission on Tuberculosis; 4,732 for the preparation of serums, and 1,079 for testing of drugs. In a word, the utility of experimental work is becoming better known and more widely recognised as years go by, and there is consequently a greater measure of public confidence accorded to its results. The anti-vivisectionists have plenty of sound and fury, but they represent a very small section of the public.

Registrar-General's Annual Summary.

It is a curious reflection that whereas among Eastern nations it was held to be peculiarly unlucky to enumerate the population, at present vital statistics are of essential importance for the purpose of learning the tendencies, weaknesses, and faults of a nation. The present Annual Summary of the Registrar-General is the fifty-third issued, each number being a little fuller and more informing than its predecessor. It is a pity that the Registrar-General relies on the old and untrustworthy method of estimating the population during an intercensal period, namely, that of assuming a similar average annual increase as during the last completed period. Surely he has the exact figures of births, deaths, immigrations, and emigrations. However, assuming the old ratio, the population of England and Wales is reckoned to be 34,547,016, of which 16,689,707 are males, and 17,857,309 females. During 1906 there were 269,734 marriages, giving a rate of 15.6 persons per 1,000 of the population; this was 0.3 per 1,000 above the corresponding rate in 1905, but 0.2 below the rate for the preceding ten years. The birth-rate was 27.0 per 1,000, giving a rate 0.2 below 1905, 1.7 below that for the previous ten years, and, altogether, the lowest rate on record for any year. The deaths on the other hand numbered only 15.4 per 1,000 of the population, which, though 0.2 above the rate for 1905, was 1.4 below the rate for 1896-1905. The infantile mortality was 133 per 1,000 registered births, also a decrease of 5 per 1,000, as compared with 1905, and 14 below the preceding ten years' average. A similar story is told throughout the report, and these figures are the best proof that the sense of national responsibility is rising, and that the population is tending to regulate its life by intellectual rather than animal standards.

PERSONAL.

THEIR MAJESTIES THE KING AND QUEEN will receive the delegates to the International Red Cross Conference at Buckingham Palace on June 15th.

HIS MAJESTY THE KING received at a special Levee on Monday last, the following medical veterans, who were present at the Indian Mutiny campaign fifty years ago:—Surgeon-Generals Sir J. H. K. Innes; J. Corbyn, J. Fairweather, C. A. Innes, and C. Kilkelly.

SIR ARTHUR RUCKER, M.A., D.Sc., LL.D., F.R.S., Principal of the University of London, will distribute the prizes to the successful students at Guy's Hospital, on Thursday, July 4th next. The usual garden party will be given in the grounds.

THE Cavendish Lecture of the West London Medico-Chirurgical Society will be delivered on Friday, June 21st, in the Kensington Town Hall by Mr. C. B. Keetley, F.R.C.S., the subject being "The Question of Preserving or Sacrificing Parts and their Functions."

DR. N. H. CHOKSEY, whose name is known in connection with plague-research in Bombay, at the fourth annual meeting of the American Society of Tropical Medicine, was elected an honorary member of the Society.

WE learn with great regret that John R. Kissinger, one of the two United States Hospital orderlies who submitted himself for experiment with yellow fever mosquitoes, is very ill with myelitis, the result of the infection. He is still under thirty years of age.

MAJOR H. HERBERT, I.M.S., whose name is well-known in connection with cataract extraction, is leaving India for England.

WE regret to announce that Dr. D. B. Lees is retiring from the active staff of St. Mary's Hospital, having been physician to that institution for twenty years. In accordance with precedent Dr. Lees will retain his connection with St. Mary's Hospital as a member of the consulting staff.

DR. H. A. CALEY has been elected to the vacancy caused by the retirement of Dr. Lees. He has served eleven years as assistant physician with charge of out-patients at St. Mary's Hospital.

SIR PATRICK MANSON, medical adviser to the Colonial Office, has been selected for the position of medical attendant to the King of Siam during the latter's forthcoming visit to this country.

THE Secretary of State for India has appointed Sir R. Havelock Charles to represent India at the Red Cross Conference.

AT a meeting of the Corporation of the City of London held at Guildhall last week, it was resolved to present the freedom of the City to Lord Lister in a gold box, in recognition of his eminence as a surgeon and the invaluable services he had rendered to humanity by the discovery of the antiseptic system.

SIR CHARLES LAMBERT ORMSBY, late President R.C.S. Ireland, and Mr. F. Conway Dwyer, Fellow and Examiner in Surgery, R.C.S. Ireland, have been appointed assistant examiners in surgery to the Apothecaries' Hall, Dublin, vice Sir Henry Howse and Mr. Alexis Thomson, retired.

THE annual dinner of the Indian Medical Service will be held at the New Gaiety Restaurant, London, on Thursday, June 13th, at 7.45 p.m., when Surgeon-General Sir Benjamin Franklin, K.C.I.E., will preside. Officers intending to be present should communicate with the honorary secretary, Lieutenant-Colonel P. J. Freyer, 27 Harley-street, London, W.

THE degree of Doctor of Medicine has been conferred upon Dr. Wilfred T. Grenfell, C.M.G., by the University of Oxford, in recognition of the work he has achieved in improving the social condition of the Labrador fisherfolk. This is the first honorary M.D. degree conferred at Oxford. Dr. Grenfell was educated at Queen's College, Oxford, and obtained his "Blue" for Rugby football. Afterwards he studied at the London Hospital and was house surgeon to Sir Frederick Treves. During the fifteen years he has been in Labrador he has established four hospitals.

A Clinical Lecture
ON
DEVELOPMENTS AND DANGERS OF EXTRA-UTERINE PREGNANCY (*a*).

By ARTHUR E. GILES, M.D., B.Sc. Lond., F.R.C.S. Ed.,

Surgeon to the Chelsea Hospital for Women; Gynæcologist to the Prince of Wales's General Hospital, Tottenham.

The history of our knowledge of the subject of extra-uterine pregnancy is one of the most striking in the whole range of gynæcology. From some of the trees of knowledge science would seem to be content to pluck a fruit now and then, perhaps even at long intervals; but here, one might think that in a frenzy of ardour, perhaps impelled by a prophetic intuition that the time was fully ripe, she had seized and shaken the trunk and lost no time in gathering and tasting the abundant fruit.

Twenty-five years ago the subject of extra-uterine pregnancy was hardly touched upon in gynæcological text-books, except unconsciously, when the condition known as "hæmatocele" was described. I say unconsciously, because, though extra-uterine pregnancy was mentioned as a possible cause of hæmatocele, it was mentioned without much conviction, apparently in the same spirit as that displayed by a candidate at an examination who is determined to leave out nothing that has even a remote bearing on the subject. Knowing, as we do now, that a hæmatocele arising independently of extra-uterine pregnancy is very rare, the progress made in these twenty-five years is strikingly brought home to us when we find that in the text-books of that period extra-uterine pregnancy is mentioned, along with ovarian tumours, pelvic cellulitis, etc., as one of the conditions to be differentiated from a hæmatocele. The explanation is, of course, simple; the significance of the mole, and the value of the microscopical demonstration of chorionic villi as evidences of pregnancy were unknown; and an extra-uterine pregnancy was recognised as such only when a fœtus was found. Up to twenty-five years ago, an operation for intraperitoneal hæmorrhage occasioned by rupture of a gravid tube had never been undertaken, although it had been recommended. Taylor (*b*) quotes a striking passage from Parry's work, written in 1876:—"From the middle of the eleventh century, when Albucasis described the first known case of extra-uterine pregnancy, men have doubtless watched the life ebb rapidly from the pale victim of this accident as the torrent of blood is poured into the abdominal cavity, but have never raised a hand to help her. Surely this is an anomaly, and it has no parallel in the whole history of human injuries. The fact seems incredible, for if one life is saved by active interference it may be triumphantly pointed to as the first and only instance of the kind on record. In the whole domain of surgery —for we cannot look to other than surgical measures under the circumstances—there is now left no field like this. . . . The only remedy that can be proposed to rescue a woman under these unfortunate circumstances is gastrotomy—to open the abdomen, tie the bleeding vessels, or to remove the sac entire."

When surgery at length responded to the urgent appeal of the dying woman, the results were far-reaching, for not only were many women brought back to life whose feet were already cold with the waters of the river of death, but pathology hastened to follow where surgery had led the way; and most—we might almost say the whole—of our knowledge of early extra-uterine pregnancy was gained by this means. I cannot stay now to trace the evolution of that knowledge; let it suffice that I recall two names that stand out prominently on the roll of honour. It was Lawson Tait who had the courage to take up the challenge of Parry, and performed in 1883 the first operation deliberately undertaken for tubal rupture; to his initiative thousands of women owe the saving of their lives; whilst to Bland-Sutton our profession is chiefly indebted for the advancement of our knowledge of these conditions, by his work on the Tubal Mole and Tubal Abortion, and by his demonstration that the chorionic villi afford us a certain test of the presence of extra-uterine pregnancy.

I must now pass on to the consideration of my more immediate subject—the Developments and Dangers of Extra-Uterine Pregnancy. There are two forms of extra-uterine pregnancy, ovarian and tubal. There are two other interesting varieties found, namely, *interstitial* or *tubo-uterine*, where the pregnancy is neither frankly in the uterus nor frankly outside it, and runs a course whose striking characteristic is a particularly dangerous form of rupture; and *pregnancy in the undeveloped horn of a uterus unicornis*, where the pregnancy is properly speaking intra-uterine, but runs a course similar to that of a tubal pregnancy.

Ovarian pregnancy is a very rare condition, the very existence of which has been established beyond dispute only within the last ten years. I shall therefore restrict my observations to the subject of *tubal pregnancy*, which I propose to deal with on the same lines as those followed in an earlier communication (*c*); that is, I shall take a tubal pregnancy from its beginning and trace its possible developments with special reference to their clinical aspects. The following table, taken from my previous paper, will serve as the text of my remarks.

Table to Illustrate Developments and Dangers of Extra-Uterine Pregnancy.

Course of Extra-Uterine Pregnancy.

1. Early tubal rupture (third to sixth week). Fœtus perishes.
2. Tubal abortion (sixth to eighth week). Fœtus perishes.
3. Later tubal rupture (sixth to twelfth week).
    - (I.) Primary intra-peritoneal rupture.
        - (*a*) Fœtus perishes.
        - (*b*) Fœtus survives and goes on as abdominal pregnancy to term.
    - (II.) Intra-ligamentary rupture.
        - (*a*) Fœtus perishes.
        - (*b*) Fœtus survives.
            - (*a*) Mesometric pregnancy goes on to term.
            - (*b*) Secondary intra-peritoneal rupture.
                - (i.) Fœtus perishes.
                - (ii.) Secondary abdominal pregnancy goes on to term.

We suppose, then, that a fertilised ovum (oösperm) is arrested on its way to the uterus and becomes engrafted in the Fallopian tube. Making the most of the slender resources at its disposal, it proceeds to form a placenta; for this purpose the rather indifferent decidua supplied by the tube is utilised. So poor is this decidua at first, that Clarence Webster's discovery of its presence was for a long time questioned by other competent observers; but it is now generally

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(*a*) A Clinical Lecture delivered at the London Post-Graduate College, January 23rd, 1907.

(*b*) "Extra-Uterine Pregnancy," by J. W. Taylor, London, 1899, p. 2.

(*c*) Clinical Journal, December 28th, 1904.

conceded that Webster's theory is correct. The symptoms that are so characteristic of intra-uterine pregnancy are not always present with tubal gestation; morning sickness is usually absent and menstruation is not always arrested. In the minority of cases, however, an extra-uterine pregnancy may proceed to full term without any suspicion being raised in the mind either of the patient or her doctor that it is not a normal pregnancy. Some authorities believe that it is possible for a tube to carry a fœtus to term without rupturing at all; but I believe that a case in which this occurrence is incontrovertibly proved has yet to be described. It is certain that this course is at least very rare; as a general rule the career of an extra-uterine ovum is marked by greater vicissitudes than are even found in the proverbial course of true love. We shall now consider these accidents in the order of their occurrence.

(1) *Early Tubal Rupture.*—By this is meant a rupture taking place between the third and sixth week of pregnancy. The cause of the accident is almost invariably the occurrence of hæmorrhage in the ovum, between the chorion and the amnion. The blood is of fœtal origin, as is proved by the presence of nucleated red corpuscles. As the result of this hæmorrhage the ovum rapidly increases in size, and if it be situated in a part of the tube that is not adapted to rapid expansion, the inevitable result is rupture of the tube, associated with free hæmorrhage (this time maternal blood) into the peritoneal cavity. We shall see presently that later rupture frequently takes place into the broad ligament; but in the early days the broad ligament has not been sufficiently expanded to allow of this (Fig. 1), and so the rupture is invariably intraperitoneal. By the end of the second month the broad ligament has expanded (Fig. 2.), so that an intraligamentary rupture becomes possible, as we shall see later. Another important characteristic of early rupture is that the bleeding is always profuse, and consequently does not become limited in the form of hæmatocele, as may occur with the later rupture.

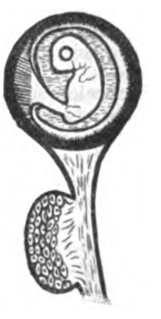

FIG. 1. — Diagrammatic transverse section of a gravid tube at the end of the first month.

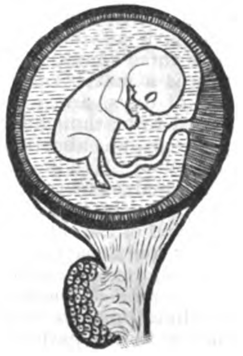

FIG. 2.—Diagrammatic transverse section of a gravid tube at the end of the second month.

The clinical picture of such a case is therefore that a patient who has perhaps gone beyond the usual time for menstruation by only a week or two, and may in fact not even be overdue, is suddenly seized with marked collapse and faintness, perhaps associated with some pain on one side. She rallies very little if at all, and very soon presents all the signs of internal hæmorrhage—deathly pallor, a weak, thready, rapid pulse, subnormal temperature, coldness of the extremities, sighing respiration and a sense of impending death. Untreated, these cases represent the most appallingly sudden disaster that may happen to an apparently healthy woman; but when treated by prompt surgical intervention, they represent the most signal triumphs of surgery, for the patient is obviously brought back to life from the very verge of death.

These cases make us realise the burden of responsibility which, like some "old man of the sea," sits for ever on our shoulders, though we may at times forget its presence. For the life or death of the patient is determined within twenty-four hours of the rupture; and which of the two it will be depends on whether or not a prompt diagnosis is arrived at. Fortunately diagnosis is here relatively simple; the sledge-hammer blow that brings a healthy woman down to the lowest ebb can be brought about by nothing else that presents at all similar characteristics to a ruptured gravid tube; perhaps the nearest approach to it is a perforated gastric ulcer, and that has many distinguishing features. But even if the diagnosis between these two were difficult, it would matter the less since the treatment is the same in either case, namely, the opening of the abdomen at the earliest possible moment.

The cause of early rupture is not well understood. Taylor states that it is often associated with pregnancy in the uterine end of an atrophic or ill-developed tube. We will now suppose that this early danger is escaped, and that the pregnancy goes on developing until the eighth or tenth week. Is a diagnosis possible at this stage, before further troubles arise? It is possible in certain cases. For example, if a patient has gone eight or ten weeks without menstruating, and presents symptoms of pregnancy, but complains of one-sided pain, and an examination is made, and the uterus is hardly larger than a normal unimpregnated uterus, whilst the tube on the side to which the pain is referred is felt considerably enlarged, then a diagnosis of unruptured tubal pregnancy would be justified. We may note in passing that the swelling produced by an unruptured gravid tube is nearly always mobile and free; whilst the swelling that results from tubal rupture or abortion is nearly always fixed. Perhaps the chief reason why a diagnosis is not usually made at this stage is that no abnormal symptoms may be present, and consequently an examination is not made. A difficulty in diagnosis might arise if an early intra-uterine pregnancy were associated with a small ovarian cyst or a swelling of the tube such as a hydrosalpinx or a new growth. But I am certain that when symptoms of pregnancy co-exist with a swelling on one side of the uterus, a diagnosis of extra-uterine pregnancy is praiseworthy, even if it should turn out to be incorrect.

Pursuing our study of the destinies of the tubal embryo, we find that at some stage from six to ten weeks the ovum may be converted into what Mr. Bland-Sutton has called a "tubal mole," by hæmorrhage taking place between the chorion and amnion, as previously described. This paves the way for an accident known as "tubal abortion."

(2) *Tubal Abortion.*—It is well known that a cause of uterine miscarriage is the conversion of the ovum into a "mole;" hæmorrhage occurs, and continues until the mole has been expelled. A parallel course of events may take place in the gravid tube; and if the fimbriated end of the tube has remained open, the mole may be expelled into the peritoneal cavity; the bleeding may then cease, the tube returns to its normal calibre, and after a few days' disturbance the patient gets all right again. This, however, is not the usual history. More often the mole remains partly attached, and so bleeding goes on until the patient succumbs or is relieved by operation. Bleeding from an unruptured tube is seldom profuse and cataclysmic, as it is when the tube ruptures; it is usually gradual, and may amount to little more than what Taylor calls a "blood-drip." In that case, as the blood collects round the open end of the tube, it tends to become encapsuled, probably owing to the setting up of a mild localised peritonitis. Such an encapsuled collection of blood round the open end of a tube is called a *peritubal hæmatocele* (Fig. 7). The hæmatocele becomes gradually larger, owing to the outpouring of fresh blood into its centre; in a case that goes on for days or weeks, the peripheral part of the blood becomes coagulated in layers, producing an appearance similar to that found in a sacculated aneurysm. Sometimes a curious phenomenon is observed: if the ovum be situated near the

tubal isthmus, blood may collect in the outer half of the tube and become partly coagulated; this is expelled into the peritoneal cavity, and a second collection of blood forms and is expelled. This process may continue for some time. On opening the abdomen one of these clots may easily be mistaken for the mole; the presence of several will reveal their true character, and the mole itself will be found within the tube. When tubal abortion occurs or threatens, hæmorrhage from the uterus takes place; this is due in some cases to reflux of blood from the tube into the uterus, and in such a case the bleeding may be fairly free; but it may be due to disintegration and gradual expulsion of the uterine decidua, and then the bleeding takes the form of a rather scanty brownish discharge.

The clinical picture presented by such a case is therefore as follows:—A patient who has gone two or three weeks over the time for menstruation has a little hæmorrhage, which she may regard as a delayed period. But the bleeding continues, perhaps for weeks, seldom profuse, but scanty, dark, or perhaps as a mere brownish discharge, intermixed with decidual fragments.

There may be no pain at all, or there may be pain of varying severity, referred to one side. On examination the uterus is little if at all enlarged; on one side and behind it is a rather soft, doughy, or boggy swelling. Neither the symptoms alone nor the physical signs alone are sufficient for a diagnosis; but when they are present together, the diagnosis can hardly be missed.

It is a noteworthy fact that in many of the stages of extra-uterine pregnancy a diagnosis cannot be made on physical signs alone, because there are other pelvic conditions which cause very similar signs; and so the diagnosis comes to depend largely on the history and symptoms, the value of the physical signs being that they confirm, or at least are not inconsistent with, the deductions drawn from the history of the case.

The fœtus invariably perishes when either early rupture or abortion occurs; we might almost describe it as suicide, because the accident in these early days is almost invariably of fœtal origin, that is to say, it is brought about by hæmorrhage into the ovum and the formation of a mole; and the disturbance in the tube, whether it takes the form of rupture or abortion, is brought about by the sudden increase in the size of the ovum.

(3) *Later Tubal Rupture.*—If a tubal ovum survives the obstacles to its development which have just been enumerated, it reaches another and even more critical period, that of the tenth to the twelfth week. I say "more critical" because, while the earlier dangers may be avoided, this one must be faced, for no tube can go longer than three months without rupture.

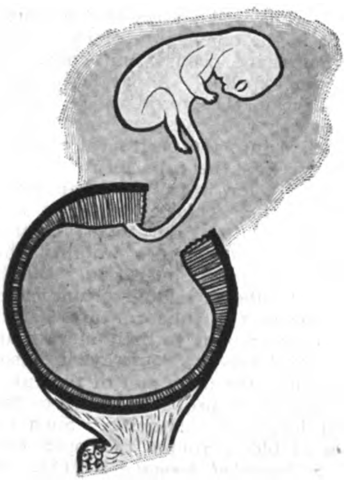

FIG 3.—Intra-peritoneal rupture; placenta uppermost; hæmorrhage; the fœtus perishes.

To this general statement there are only two exceptions: First, those very rare and even doubtful cases in which the pregnancy goes to term in an unruptured tube; and, secondly, those rare instances in which a late abortion occurs. Of this there is only one case that I know of on record, described by Cullingworth and Fairbairn.

When the ovum has reached the age of three months, the broad ligament has become sufficiently stretched to allow of two possibilities in the direction of the rupture, namely, intra-peritoneal and intra-ligamentary. Into each of these divisions the position of the placenta introduces two sub-divisions, in one of which the fœtus necessarily perishes, whilst in the other it may survive (see Figs. 3–6).

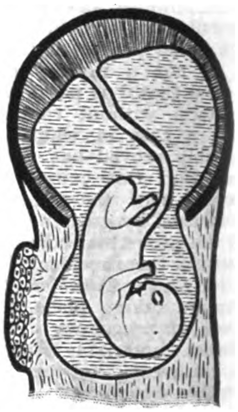

FIG. 6.—Intra-ligamentary rupture; placenta uppermost; the fœtus survives.

I.—*Primary Intra-peritoneal Rupture.*—(*a*) If the placenta lies in such a position that it is involved in the rupture of the tube, or the amnion is broken, the fœtus perishes, and severe intra-peritoneal bleeding takes place (Fig. 3). This bleeding is seldom quite so desperate as it is in early rupture; for while in early rupture the mother seldom survives unless operated on within twenty-four hours, in the later rupture the bleeding may be sufficiently gradual to give two or three days' grace. But I should advise no one to rely on these extra days if an intra-peritoneal rupture is diagnosed. On the other hand, the bleeding is more rapid than it is in cases of tubal abortion, and the shock and collapse are proportionately greater. Later intra-peritoneal rupture thus occupies a somewhat intermediate position between early rupture and abortion. Without pretending to precise accuracy, but to give an impression of the relative severity of these three conditions we may say that while early rupture is a matter of hours, later rupture may be a matter of days, and abortion of weeks.

It used to be thought that a hæmatocele could only result from an abortion; but it has been shown, especially by Handley, that a rupture may cause such gradual hæmorrhage that there is time for encapsulation. In this case the clot does not surround the free end of the tube as it does in peritubal hæmatocele, but only partially surrounds the tube in its course, and Handley therefore gave it the appropriate name of *paratubal hæmatocele* (compare Figs. 7 and 8).

The clinical picture of a case of later intra-peritoneal rupture is that a patient who thinks herself between two and three months pregnant is suddenly seized with faintness, frequently accompanied by pain, as if something had given way inside her. She may be doing something involving some exertion; one patient I saw was stooping down to do something in the garden, but the rupture may occur when the patient is lying quietly in bed. By degrees she gets weaker and fainter, presenting, sometimes sooner, sometimes later, all the signs of severe internal hæmorrhage. On examination there may be a sense of fulness and resistance in the pelvis and lower abdomen, if the bleeding has been going on for some time; vaginal examination generally shows a definite swelling on one side of the uterus, due to the enlarged tube; and the pouch of Douglas gives the sensation of obscure resistance produced by an accumulation of thick fluid. It is hardly possible to mistake the nature of the condition, if only its possibility be borne in mind.

(*b*) If the placenta occupies such a position that it is not involved in the rupture of the tube, and the amnion remains unbroken, the fœtus, enveloped in the amnion may pass into the peritoneal cavity, and continue its development without interruption (Fig. 4). This is a *primary abdominal pregnancy*. It is a noteworthy fact that a primary abdominal pregnancy cannot occur as the result of the dropping of a fertilised ovum into the peritoneal cavity in the first instance; if the placenta cannot have the uterine decidua in which to develop it must have a tubal decidua; so that an abdominal pregnancy must pass through the stage of a tubal pregnancy.

II.—*Intra-ligamentary Rupture.*—We have seen that this accident cannot occur very early, because the broad ligament is not sufficiently expanded to permit of its taking place. It is specially prone to occur about the tenth to the twelfth week. It is a noteworthy fact that nearly all the difficulties that lead to a wrong diagnosis in tubal pregnancy centre round this form of rupture. The position of the placenta in relation to the rent in the tube gives us two possibilities in the sequence of events.

(*a*) When the placenta lies over the broad ligament it is involved in the rent; hæmorrhage takes place, and the fœtus perishes (Fig. 5). The bleeding is usually less severe than in any other form of rupture, because the layers of the broad ligament provide a ready-made capsule by means of which the amount of bleeding is restricted. The resulting blood-tumour in the broad ligament is properly a "hæmatocele" (Fig. 9), although this term is usually restricted to an encysted collection of blood in the peritoneal cavity. Broad ligament hæmatocele is usually called a "hæmatoma." Owing to the anatomical restriction of the bleeding in these cases, the symptoms are seldom very pronounced. There is usually an attack of faintness, which may be so slight that the patient lies down for a few hours and then gets up feeling comparatively well. Very soon there is a slight "show" from the vagina, due to the commencing disintegration of the uterine decidua. This may go on for weeks or even months, in the form of a brownish discharge. The patient and her medical attendant may both think that she is in for a miscarriage. There are three important things that should put the medical attendant on his guard and lead him at least to suspect the true state of things. The first is the slight syncopal attack, which may be repeated; the second is the complaint of pain on one side, which is nearly always present; the third is the complaint of a scanty brownish discharge; and when an examination is made, as should invariably be done in the presence of these symptoms, a swelling other than the uterus is felt in the pelvis, showing at any rate that we have not to do with a case of ordinary miscarriage.

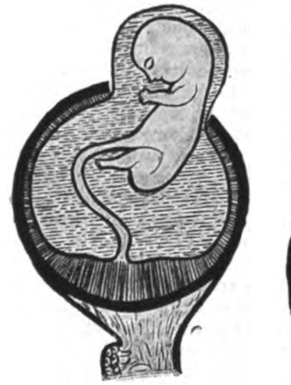

FIG. 4—Intra-peritoneal rupture; placenta below; the fœtus may survive.

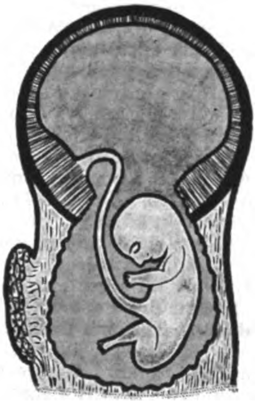

FIG.* 5.—Intra-ligamentary rupture; placenta below; hæmorrhage; the fœtus perishes.

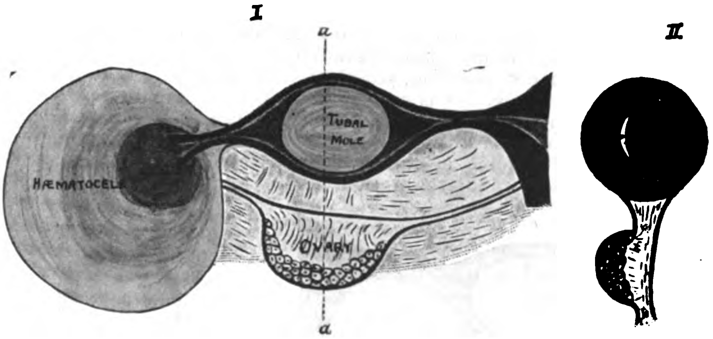

FIG. 7.—A peri-tubal hæmotocele. In this and the two following figures, 1 is a longitudinal section, and 2 is a transverse section through a.a.

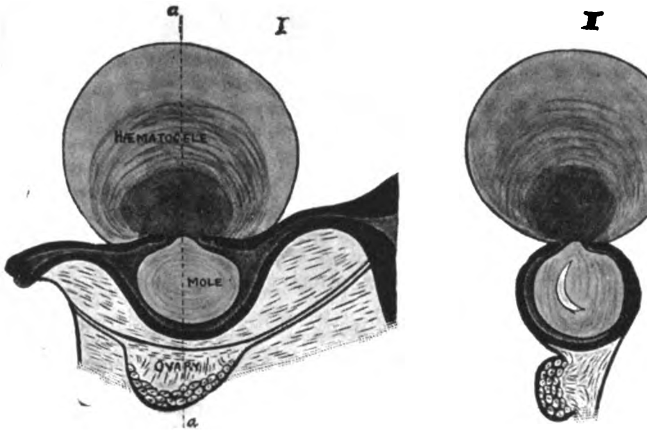

FIG. 8.—A paratubal hæmatocele.

When the bulk of the swelling is situated behind the uterus, as sometimes happens, the uterus is pushed up and the cervix is pressed against the pubes; and as it may be difficult to differentiate the body of the uterus from the rest of the swelling the condition may closely simulate retroversion of the gravid uterus, particularly because in both cases there is retention of urine. A useful distinguishing feature is the doughy feeling imparted to the examining finger by the sac and effused clots in the pouch of Douglas, contrasting with the tense elastic feeling of the retroverted gravid uterus.

Chronic inflammatory disease of the appendages often presents such a striking resemblance to the form of tubal pregnancy we are now considering, that it is impossible to distinguish between them. This is more particularly the case when inflammatory disease affects one side. With both conditions there is lateral pain, with or without rise of temperature; and a fixed tender swelling is found by the side of the uterus. We have then nothing but the history of amenorrhœa to clearly distinguish tubal pregnancy; and as menstruation may be uninterrupted in this condition, and may be irregular or profuse with tubal disease, mistakes may easily arise.

(*b*) When the placenta is situated in the upper part of the circumference of the tube, and the rent takes place on the broad ligament side, as in Fig. 6, the pregnancy may continue uninterrupted as a mesometric pregnancy. But even now the possibility of other vicissitudes is not yet over. After a mesometric pregnancy has gone on for a month or two, a secondary intra-peritoneal rupture may take place with two final possibilities: (i.) The fœtus perishes, probably because the rent involves the placenta or its blood-supply, in much the same way as with primary intra-peritoneal rupture; but it would appear that this is a very rare accident, because it is a very exceptional thing for a patient to be seized with severe intra-peritoneal hæmorrhage later than the fourth or fifth month of extra-uterine pregnancy. Probably the more common occurrence, when secondary intra-peritoneal rupture takes place, is for the fœtus to continue developing, this being a secondary abdominal pregnancy. It is easy to surmise a reason for this. As the broad ligament expands, it becomes thinned out; and if rupture takes place the rent is more likely to involve a non-vascular part of the thinned-out membrane than the fleshy placenta.

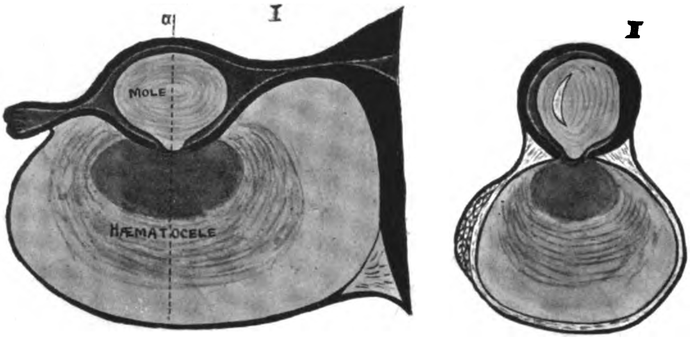

FIG. 9.—A broad ligament hæmatocele (hæmatoma).

It will be seen that an extra-uterine pregnancy may go on to full term in one of four distinct ways:—

(1) By the development of the pregnancy in an unruptured tube.

(2) By the development of a primary abdominal pregnancy.

(3) By the development of a primary intra-ligamentary pregnancy.

(4) By the development of a secondary abdominal pregnancy.

In the last case the fœtus must survive two ruptures, the first of the tube into the broad ligament, and the second of the broad ligament into the peritoneal cavity.

The phenomena of extra-uterine pregnancy at full term forms too large a subject, however, to be dealt with here.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Samuel West, M.D. Oxon., F.R. C.P. Lond., Physician to and Lecturer on the Principles and Practice of Medicine at St. Bartholomew's Hospital. Subject: "Foods and Feeding in Certain Conditions."*

ORIGINAL PAPERS.

ON THE EXAMINATION OF THE URETHRA AND BLADDER BY THE ELECTRIC LIGHT. (*a*)

By ANDREW FULLERTON, M.D., F.R.C.S.,

Hon. Assistant-Surgeon to the Royal Victoria Hospital and to the Belfast Hospital for Sick Children.

PART II.—(*Conclusion.*)

To use the cystoscope, pass the instrument like a bladder sound, and, turning down the beak, examine the most important area, namely, the trigone. Its base is formed by the interureteric bar, at the extremities of which, the openings of the ureters can be seen as small slits acting rhythmically. Having examined carefully this triangular area, every portion of the bladder-wall must be systematically inspected. A bubble of air is usually seen at the apex or highest point of the bladder when the beak of the instrument points upward. It serves as a landmark for localising abnormal appearances.

The neck of the bladder is not easily seen with the ordinary cystoscope. Newman, of Glasgow, has suggested a modified prism for this purpose. The rays of light are reflected at an acute angle, so that objects situated in front of the prism are more readily seen. On applying for this instrument to the makers I was informed that some improvements in it were being effected, so that I am unable to speak personally as to its advantages.

Returning to the ureteral openings, it is necessary to carefully note the following points: Their position, size, shape, colour, movements, efflux, and surroundings. For instance, instead of being slit-like, they may be slipper-shaped, oval, round, patulous, elongated, or contracted. They may be retracted, protruded, or prolapsed. They may be closely surrounded by blood-vessels, or they may open in an area comparatively scantily supplied therewith. Let me illustrate my meaning by referring to a few cases. In No. 46, examined seven weeks after suprapubic prostatectomy, the left ureteric orifice was seen to be oval and dilated, the result of back pressure from the enlarged prostate. In Case 28, a boy, æt. 5, they were slipper shaped—that is to say, the inner margin was depressed so as to form an orifice like the fenestra ovalis of the heart. This appearance denotes the first stage in dilatation, due, in the case of this boy, to a stone which blocked the internal orifice of the urethra during micturition, causing more or less back pressure. In Case 44, the left orifice was round and contracted, possibly due to a previous attack of pyelitis on that side. In Case 102, to which I shall again refer, the right orifice was dilated and surrounded by numerous minute vessels. Urine containing pus and tubercle bacilli was obtained from this ureter. The orifice of the opposite ureter was slit-like and normal. In Case 2, sent by Dr. Mackenzie, a male, æt. 53, who had just had an attack of right-sided renal colic, the lips of the right ureteric orifice were swollen and red, and a small stone lay free on the posterior bladder-wall. In Case 79, a man, æt. 36, suffering from symptomless hæmaturia, well-marked vascular twigs were seen radiating from the left ureteric orifice, and, as might be expected, the blood issued from that side. Increased vascularity round the ureteric orifice denotes a similar condition of the pelvis of the corresponding kidney. In Case 88, a man, æt. 29, suffering from pyuria, the right ureteric orifice was surrounded for a considerable area by clusters of closely set, cystic-looking bodies resembling minute red currants. These were due to the irritating effects of pus-containing urine from the kidney of that side. The urine from the opposite side was clear. These few examples will serve to emphasize the importance of carefully noting the appearance of the openings. At the same time, the diastole and systole of the ureteric orifice should be watched for a few seconds, and any departure from the normal noted. Just before the efflux, one can see a wave of peristalsis pass from without inwards in the line of the ureter. When the wave reaches the orifice, the latter opens and a jet of fluid issues. The opening then contracts till it is almost, if not quite, invisible, and then gradually resumes the position of rest. The character of the efflux must be carefully examined. In this way blood and pus may be seen to be ejected from one or both ureters, thus determining the organ affected, as I hope to show in my subsequent remarks. In Case 110, seen with Dr. Hicks, there was a swelling in the right kidney region. *No* urine could be obtained from the right orifice, and the catheter was arrested 7 ins. up, indicating, possibly, a block in the form, probably, of a kink or a stone.

Let me draw attention here to a very rare source of fallacy. Through the kindness of Professor Symington and Dr. Lowry, of the Anatomical Department of Queen's College, I was allowed during the present session to examine a case of single kidney in a dissecting-room subject. The body was that of a female, æt. 18. The left kidney was absent. On the right side, a large conglomerate mass represented both

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(*a*) Being a Paper Read before the Ulster Medical Society on February 28th, 1907.

kidneys. There were two fairly marked lobes with an intervening portion, the whole mass being provided with three arteries, three veins, and two ureters. The dimensions were 5¾ ins. by 3¾ ins. by 1½ ins. The organ was saddle-shaped and was situated as follows: The upper portion lay for the most part in the right iliac fossa at the inner margin of which the lower pole was curved on the upper to almost a right angle, the inferior extremity of the organ dipping down into the pelvis. The deep surface of the organ was closely applied to the posterior abdominal wall, and the outer wall of the true pelvis. There were two ureters, both arising from the anterior surface, the longer and thicker from near the upper pole, the shorter and narrower from near the lower pole. Both ran directly downwards, the larger to the right and the shorter to the left, to open at the usual situation of entry at the trigone of the bladder. I had the curiosity to cystoscope the bladder distended with water. The examination would have led me to suppose that there were two kidneys with the usual separate ureteral openings into the bladder. Both orifices were slit-like and normal in position. The right opening appeared to be about twice as long as the left, and longer than normal. The inter-ureteric bar was more pronounced on the right side. I need hardly point out what complications such an abnormality would give rise to in the matter of diagnosis, should it be found necessary to deal surgically with such a case. Fortunately the occurrence is rare—once in 10,000 bodies, according to MacDonald Brown (*Journal of Anatomy and Physiology*, Vol. XXVIII).

Having dealt generally with the examination of the bladder and ureteric orifices, I now propose to utilize the cases examined during the last year to illustrate some of the various abnormal changes which the cystoscope may be relied upon to disclose. In this way many of the uses of cystoscopy can be most clearly demonstrated. To do so, I have thought it well to take some of the main symptoms of urinary disease and select from my list examples to illustrate them. I will therefore discuss the cases under the following headings: (1) Those in which hæmaturia has been the chief symptom. (2) Those in which pyuria has been the chief symptom. (3) Those in which frequency of micturition has been the chief symptom; and (4) Those who have complained of a group of symptoms commonly found in cystitis, namely, pain, most commonly at the point of the penis, frequency of micturition, and the presence in the urine of pus or blood or both.

I. *Hæmaturia.*—In many cases of hæmaturia there is great difficulty in deciding the cause and site of the hæmorrhage as the following instances will show. Case 79, already briefly referred to, a male, æt. 36, had passed blood in his urine off and on for four years. The quantity was never very much, and the colour of the urine was sometimes red and sometimes darker in colour. He had been twice in the Royal Victoria Hospital. Professor Lindsay, under whose care he was on the last occasion, examined him carefully, but could find no clue as to the site of the bleeding. Radiography was tried with an unsuccessful result. Finally, the aid of the cystoscope was invoked. On December 3rd, 1906, I examined his bladder, when blood was seen to issue in vigorous jets, mixed with urine, from the orifice of the left ureter. On December 20th, I removed a small spicule of oxalate of lime calculus, which was found sticking in the parenchyma of the kidney of the left side. All bleeding ceased and he left the hospital in three weeks apparently cured. Case 83, a private patient, seen with Professor Lindsay and Dr. Sugars. A male, æt. 42, had had symptomless hæmaturia for about fifteen months. There was no indication whatever as to the site of the hæmorrhage, except perhaps the presence of crystals of oxalate of lime in his urine. I cystoscoped him on December 10th 1906, and thought that the efflux from the right orifice was slightly tinged. To make sure, both ureters were catheterized. The specimen from the right contained blood in small quantity. That from the left was normal. An exploratory operation on the right side was suggested. This has not yet been carried out. Case 96, seen with Mr. Mitchell at the Royal Victoria Hospital, was almost exactly similar. In this patient, a male, æt. 53, urine mixed with a considerable quantity of blood was seen to issue from left ureteric orifice. Clear urine issued from the right. The symptoms had lasted five weeks before his admission. He also awaits an exploratory operation. In these three cases the only symptom was hæmaturia, the urine contained no casts, and there was no pain anywhere.

Case 105, sent by Dr. Darling, is very interesting. A boy, æt. 19, had had hæmaturia, with no other sign except a slight puffiness of lower eyelids, for eight weeks. With the cystoscope, blood-stained urine could be seen issuing from both ureters. That from the left was darker in colour. In the specimens obtained by separately catheterizing both ureters, numerous casts, especially granular and epithelial, were seen by the microscope. Albumen was present in greater quantity than could be accounted for by the blood. The urine began to clear a few days after I saw him. He took an attack of influenza, however, and blood again appeared. The urine on February 16th was markedly blood-stained, specific gravity 1010, 66 ozs. in the twenty-four hours. Hæmaturia from both kidneys is rare, except of course in acute Bright's disease. There can be no doubt, I think, that this boy is suffering from a form of nephritis. Case 107, seen with Professor Lindsay and Dr. John Campbell, may be here cited. A young lady began three years ago to have attacks of hæmaturia, which was so free at one time as to threaten her life. At this time, Dr. Campbell found a large, easily palpable kidney on the right side. This attack, however, passed off, and the patient remained free for about two years, when she again began to bleed. It was now noticed that the right kidney had diminished in size, while the left had increased. In January of this year she had the last attack and in February 7th, I was asked to cystoscope her. Blood-stained urine was seen issuing from the right ureter, the orifice of which had running up to it a number of well-marked vascular twigs. The flow from the left side was normal in appearance. It was decided, however, to catheterize the ureters. Blood was obtained from the right and albuminous urine from the left. The opinion was expressed, therefore, that both kidneys were diseased. In view, however, of the risk of the patient bleeding to death it was decided to explore the side from which the hæmorrhage was coming. Accordingly on February 10th, 1907, Dr. Campbell cut down in the right side and found a kidney riddled with cysts. The kidney was removed in the forlorn hope of saving the patient, but the other being insufficient, the patient rapidly sank and died about ten days later from œdema of the glottis. Before death the left kidney began to bleed. While the result in this case is deplorable, it serves to illustrate the immense value of catheterization of the ureters even when apparently healthy urine is seen to issue from an orifice. Case 101, sent by Dr. Clokey, a male, æt. 24, an ex-soldier, was in good health until he went to South Africa in 1901. Nine months after he landed he began to pass blood at the end of micturition. He had no pain and no frequency, and, beyond the presence of blood in his urine, suffered no inconvenience. He was three years in South Africa. His symptoms have continued without change to the present date. He was cystoscoped on January 25th, 1907, when the following appearances were found: On the posterior wall, some distance behind the trigone, the mucous membrane was raised, rough, and of a dark red colour. Scattered over its surface were small, raised, whitish bodies, round in shape, varying in size from that of a small pin's head to that of a hemp seed. The red patches were irregular in shape and size, and extended principally towards the right. Small patches destitute of white bodies were seen in the vicinity. Between and beyond these patches, healthy pale mucous membrane was seen. The trigone and ureters were normal. The urine contained numerous ova of bilharzia hæmatobia.

I need only mention Case 72, seen with Dr. Colville. A lady, æt. about 50, had had three attacks of hæmaturia, the first thirteen years ago, the second a year and a half ago, and the third a day or two before I saw her. Unfortunately, she had just cleared up the day before she was cystoscoped. There was evidence, however, on the posterior wall of the bladder of a small vessel having recently been the seat of hæmorrhage. The urine from both ureters was free from albumin and casts.

In Case 43, the hæmorrhage also ceased the day before I had the opportunity of using the cystoscope. A young medical man had pain in the right kidney, and also sometimes in the left, with frequent attacks of hæmaturia. He was sent to me by Sir Wm. Whitla to decide definitely, if possible, which kidney was affected. Radiography had failed to give any definite information, and was blamed by the patient for producing an attack of hæmorrhage. Both ureters were catheterized and albumen was found in the specimen from the right, while normal urine was obtained from the left. On August 21st, 1906, I removed from the pelvis of the right kidney a rough oxalate of lime calculus. The patient has remained quite well ever since.

In Case 12, a male, æt. 30, who slipped while carrying a sack of coals on his back and strained his side: blood clot was seen distending the orifice and adjacent portion of the ureter of the right side. He had had hæmaturia, but this had ceased a few days before I saw him. I have referred very briefly to these cases of hæmaturia, but what I have stated will serve to show the use of the cystoscope in this condition.

II. *Pyuria.*—Under this heading let me very briefly direct your attention to one or two cases in which the cystoscope was of incalulable value. Case 102, a young lady, seen with Dr. McQuitty, complained of feeling out of sorts for about three months. She had lost weight and she stated that she had to make water more frequently than formerly. Dr. McQuitty found pus and tubercle bacilli in the urine. He leaned to the diagnosis of tuberculous bladder. On introducing the cystoscope, the ureteral orifice on the right side was seen to be dilated, and the surrounding area congested. Pus was obtained by the ureteral catheter from that side, and normal urine from the left. The bladder was normal. Neither kidney was palpable, and no pain was complained of on either side. There can be little doubt but that the right kidney is tuberculous. She is receiving tuberculin injections from Dr. Houston prior to operation. Case 106, seen with Professor Sinclair, a lady, æt. about 50, had two enlarged kidneys and pus in the urine. Professor Sinclair had designs on the right on account of a nodular feeling at the lower pole. The ureteral catheter, however, showed that the left was the offender, a urine of good specific gravity and free from albumen or pus being obtained from the right. In Case 1, under the care of Drs. Darling, McKisack, and Campbell, both kidneys were palpable, the right being the larger and more painful. Pus had been present in the urine for about two years. Tubercle bacilli were present. The patient wished to have the affected kidney removed, but before doing so it was deemed advisable to ascertain the efficiency of the presumably healthy one. The right ureter pumped urine containing pus into the bladder. The left ureter was catheterized and clear urine obtained. This, however, contained a trace of albumen and was deficient as regards its molecular concentration. Dr. Houston found that the co-efficient of excretion was 1.17 instead of 2. No operation was performed. I do not think I need take up any more of your time in dealing with this group. Let me refer you to the synopsis in your hands for further cases.

III. *Frequency of Micturition.*—Frequency may be the only symptom complained of, but, as a rule, others are added as the case proceeds. The following patients sought advice chiefly because of the inconvenience of having to pass water at short intervals. Case 3, female, æt. 27, was seen with Dr. John Campbell and Dr. Hicks at the Samaritan Hospital. Her chief complaint was frequency, but she also had some bladder pain. The symptoms had been present for four years. With the cystoscope, the following appearances were found: On the posterior wall of the bladder, behind the inter-ureteric bar, there were a score or more of round, smooth golden-yellow bodies, mostly about the size of a pin's head, and clustered rather closely together. Dr. Campbell had examined the patient some days previously by Kelly's method and had found these bodies, which he says were then white in colour. Possibly the yellowish tinge was given to them by the iodoform emulsion then injected. The little bodies in question were very like the tubercles one sees on the peritoneum. The occurrence of tubercle of the bladder in this form is rare, if, indeed, it was tubercle. Probably time will enable us to confirm or correct our diagnosis. She was examined on April 2nd, 1906. A note from Dr. Currie, of Ballymena, on February 13th, 1907, to Dr. Campbell, states that the patient is as bad as ever.

Case 62, a male, æt. 57, was referred to me by Dr. Calwell, of the Royal Victoria Hospital, to whom he was sent in the first instance. He had had stricture of the urethra which had been divided on two occasions. He had had hæmorrhage from his bladder on three occasions, but for the past two years he had been free from hæmaturia. He complained now of frequency of micturition without pain, being obliged to pass water every half-hour day and night. His urine was foul-smelling, alkaline, and contained albumen, pus, and a little blood. To wash him out I had to use a metal catheter, the usual rubber one being caught at the stricture. This caused considerable hæmorrhage, evidently from the bladder wall, which was with difficulty controlled by adrenalin. The cystoscope showed the following appearances. On the superior wall, a little to the left of the middle line, there was a star-shaped oblong patch which was darker than the surrounding area. The edges of this dark patch were thick-looking and its surface depressed. There was general cystitis, as well, and the bladder would only hold about 3 ozs. A few days later I performed a supra-pubic cystotomy, and found a large irregular patch in the superior wall, the surface of which was dark, rough, and raw, with, in some places, greyish shreds attached. The edges were irregular, raised, and a little hard. The wall of the bladder at the affected spot was thicker and firmer than the smooth, pliable, comparatively healthy portion elsewhere. The patch was scraped, and the bladder drained and washed out with weak solutions of nitrate of silver. This stricture, which had begun to contract, was dilated at the same time. When examined a month later, the surface previously described was dull and lustreless, but apparently healed. Both ureters, now seen clearly, were round and open like pits in the bladder wall. He could now hold his water for 2½ hours.

Frequency may be the principal or only symptom in cases of enlarged prostate. Examination *per rectum* is not always conclusive, as in Case 16, a man, æt. 65, from whose bladder I removed two stones by litholapaxy in May, 1906. He continued to form stones, and on examining his prostate closely a projection was found which evidently prevented him from properly emptying the bladder. I removed the prostate on February 13th, 1907, and found a polypoid projection growing from the left lobe. The gland itself weighed only 4 drachms, and had embedded in its substance one large and many small stones. He is now convalescent. On examining a bladder in a patient with enlarged prostate and bringing the beak towards the meatus, large mountainous masses may be seen of a dark colour, contrasting markedly with the pale mucous membrane of the bladder in the distance. The mucous membrane over these projections is frequently congested and ecchymosed. The prostate may project so much that it is impossible to see behind it, and stones may in this way escape notice.

In Case 104, a gentleman, æt. 68, sent by Dr. Wilson, of Castleblaney, and who had no residual urine but frequency of micturition and inability to hold it for an instant after the desire to urinate came on, I found a number of round projections encircling the neck of the bladder like a collar. These evidently prevented the sphincter from acting, and caused incontinence rather than retention. The bladder held with difficulty about 4 ozs. of fluid. I could multiply cases of typical enlarged prostate, but this would serve no useful purpose as the condition is recognised most frequently without the cystoscope. I might just briefly mention that the cystoscopic examination of a bladder some months after prostatectomy does not show, as might be expected, a huge pouch or scar. It would be exceedingly difficult to say from the cystoscopic appearances that anything abnormal was present in the disposition of the parts at the neck of the bladder. The ureters are frequently found dilated, and the muscular wall hypertrophied, but beyond a little pleating of the mucous membrane at the neck, nothing abnormal is seen. This accords with the actual state of affairs as found in Case 62, a patient of Dr. Huston, of Tynan, who developed a month after his discharge a small supra-pubic sinus. When scraping this sinus, I enlarged it, and explored with my finger the interior of the bladder, and found a well-formed internal urethral opening, and a scar, felt by the finger but possibly not visible, just at the anterior end of the trigone. It would have been difficult to say that any operation had been done. I have examined cystoscopically several cases at various intervals after prostatectomy, and have found in all the same condition of affairs.

IV.—I will now refer briefly to the cases illustrating the last division of my subject, namely, those who complain of pain and frequency of micturition with pus, and, perhaps, blood, in the urine. The pain is generally referred to the glans penis, but may be in the perineum or supra-pubic region. It is occasionally felt in more distant parts. Patients presenting these symptoms are often sent to be examined for stone. Let me describe the cystoscopic findings in a few. Case 66, a male, æt. 26, was sent by Dr. Reid, of Whiteabbey. He began to suffer from frequency a few weeks before. Micturition was obligatory every hour during the day and three or four times at night. He had pain at the point of the penis, most acute just after the act. There was a little blood at the end of micturition. The cystoscope showed well-marked general cystitis. The bladder-wall was thick and congested. Both ureteric orifices could be seen in their inflamed surroundings. No stone was present. The urine was alkaline, and contained phosphates, blood and pus. With urotropin, sandal oil, and irrigations of boric acid lotion, recovery was complete in a week. Case 24, a male, æt. 38, was sent to me by Dr. McQuitty to be examined for stone. He complained of severe pain at the point of the penis, frequency of micturition every half hour day and night, and hæmaturia on pressing to get rid of his urine. I asked him to allow me to cystoscope him, but he refused when he caught sight of the apparatus. I sounded him with a negative result. Some time later he returned requesting a cystoscopic examination, as his symptoms were such that life was unbearable. On June 1st, 1906, I passed a catheter, and obtained about a pint of residual urine. After washing out the cystoscope revealed a pinkish red tumour about the size of a hazel nut hanging from the anterior wall of the bladder, so as to lie almost exactly over the internal orifice of the urethra. The tumour was composed of a bunch of leaves shaped like those of a lettuce, almost transparent, waving in the fluid. Minute vessels ran along these to the end. The edges of some of these leaf-like structures were ecchymosed. There was also some cystitis present. I removed the little tumour, which had a long pedicle, with the portion of the mucous membrane to which it was attached, by a transverse suprapubic cystotomy early in July, 1906. The patient is now quite well, holds his water all night, passes it about every six hours during the day, and is a firm believer in cystoscopy.

Case 48, an old man, æt. 80, was sent to me by Dr. Morrow, with the following history: For the past two months he had complained of pain at the bottom of his stomach, that is to say, the suprapubic region, and had passed dark, blood-stained urine. During the last fortnight before examination, he had had pain at the point of the penis, which began with micturition and ceased when the act was completed. He had frequency, passing water every half-hour, day and night. On examination, the prostrate was found not to be enlarged, and there was no residual urine. On August 10th, 1906, I cystoscoped the bladder which would only hold, with great difficulty, 4 ozs. of fluid. Bleeding was profuse and was arrested by adrenalin. On the right side of his bladder, rather towards the superior wall, one could see a broadly pedunculated tumour. The basal portion was similar in colour to that of the wall of the bladder in the vicinity, but the free, rather bulbous part was sloughy, the sloughs being dark and grey or white in colour, and floating freely in the fluid. The whole swelling pulsated with the heart beats, and was apparently about the size of a marble. The growth was probably what Mr. Hurry Fenwick calls a bald epithelioma. The duration of life in these cases averages about 2½ years (Fenwick).

Case 20 is a typical case of stone in a male, æt. 28. He had been suffering for the past eleven months from frequency of micturition day and night, with some difficulty in passing water. He had blood and pus in his urine, and suffered pain before and after micturition, especially the latter. The pain was felt at the point of the penis and in the perineum. With the cystoscope a large round, roughish, grey stone was seen lying free at the base of the bladder. General cystitis was present with patches of ecchymosis in places. On May 18th, 1906, I removed by crushing a stone weighing 2 drs. and 10 grs. when dry, consisting of a central core of urates with a phosphatic crust. The cystoscope was used during the operation to ascertain that no particle of *debris* had been left behind. The use of adrenalin during the operation allows the bladder wall to be seen at any stage of the proceedings, and limits the damage caused by the lithotrite. His bladder was re-examined ten days later by the cystoscope, and found to be free from *debris*. He is now in excellent health. The following case is introduced here to show that stone may be present without any of the usual symptoms.

Case 56, a male, æt. 50, was sent to me by Dr. McQuitty with the following history: He had had three attacks of left-sided renal colic. Four years ago he began to have uneasiness in his perineum on walking, and after micturition. He had no frequency, no pain at the point of the penis, and his urine contained neither blood nor pus. The cystoscope, however, showed a round whitish stone about the size of a marble lying free in the bladder. This I removed by crushing on October 5th, 1906. It weighed 95 grains, and consisted mainly of oxalates with about a third part of phosphates. His bladder was re-examined by the cystoscope nine days later and found free from stone or *debris*. He also continues in excellent health.

Case 67, which I saw with Dr. Hicks and Dr. John Campbell, is worthy of more than a passing notice. A young lady, previously healthy, consulted Dr. Hicks a fortnight before, stating that she had experienced some bearing-down pains the day previous. She did not at that time complain of any symptoms referable to the bladder or kidneys. Dr. Hicks examined her *per rectum*, and found a nodule the size of a pigeon's egg in the right broad ligament close to the cervix uteri. She was admitted to hospital on the same day and examined under chloroform. The same tumour was felt *per vaginam*. Her urine was clear amber, acid, and contained neither albumen nor sugar. After four days in hospital she began to complain of excessive pain in the lower abdomen with great frequency of micturition and blood in the urine. No catheter had been used—nor had the bladder been interfered with in any way. The frequency and pain became so intolerable that three or four grains of opium were required to give relief. Day and night the patient passed water every ten minutes with the greatest agony. Dr. Hicks thought that the lump referred to might be a stone in the ureter. Under chloroform, on November 13th, 1906, the bladder was washed out with adrenalin and water for nearly a hour before we could obtain a medium sufficiently clear to see anything. Even under the anæsthetic, only 3 ozs. at the most could be injected into the bladder. The cystoscope showed the ureters and neighbouring parts to be somewhat injected but not ulcerated. A small ureteral catheter was introduced into the right ureter and passed well beyond the supposed stone, which was felt *per vaginam* to be well in front of the catheter. It is more likely that the nodule found was a small fibroid. On examining the bladder further, an extensive surface covered with what looked like a diphtheritic membrane was seen on the left posterior superior wall. This could be best seen with the beak of the instrument pointing up and to the left side, and appeared to me to extend over about a quarter of the bladder-wall. It could be indented with the ureteral catheter, and was not incrusted. The urethra was now dilated and the bladder examined by Kelly's method after drying out the interior. The area now looked dark, probably on account of the removal of a layer of mucus which covered it like a film of gauze. Scattered over the surface of this large patch were dark, smooth, round nodules almost like small sloes in appearance. From the cystoscopic appearance, I ventured on the diagnosis of acute phlegmonous cystitis with sloughing of a portion of the mucous membrane, but this conclusion was not accepted by my friends who favoured that of malignant disease. Her temperature ranged from 99° to 101°. The urine now contained pus and blood. The patient was treated by Dr. Hicks by washing out the bladder with weak chinosol solutions, and for some time by drainage with a Skene-Goodman's catheter, and at the end of a month I again cystoscoped her. This time no anæsthetic was necessary, either local or general. Three ounces of fluid were left in the bladder, but more could have been tolerated. The main portion of the wall had now almost recovered its normal colour. A few hæmorrhagic spots were still present in the more healthy parts. In the left posterior superior area there was a raw surface with a beautiful rich red streaked colour which began just to the left of the middle line. The margins of this ulcer were irregular, and extended almost to the inter-ureteric bar below, and on the left side. Far to the left healthy bladder wall was seen. The ulcer now appeared to occupy about one-sixth of the wall. Both ureters looked normal. The urine was neutral, specific gravity 1020, and contained a trace of albumen, a few pus cells, bladder epithelium, and phosphates. My reading of this interesting case is that an acute cystitis occurred, and that a portion of the mucous membrane sloughed, leaving the muscular layer bare. She subsequently had white leg on the left side. I hear from Dr. Hicks that she is now almost well, and that she can retain her urine for six hours at a time.

I had hoped to say a few words in this connection upon some cases of tuberculous bladder, an affection which is unfortunately fairly common in this part of the country, but I have already used up all the time I can reasonably expect to occupy, so that I must defer to a future occasion any remarks I may have to make on this subject. I had hoped also to give a short account of the comparatively large number of cases in which I have catheterized the ureters, male and female, but this must also be postponed. I now apologize for the length of this paper and for the fragmentary character of the notes of the cases which I have had the honour to bring before your notice. My object was to satisfy you of the utility of the urethroscope and cystoscope, especially in diagnosis and I leave it to you to say if I have succeeded in so doing.

IODISED CATGUT.

By PEYTON T. B. BEALE, F.R.C.S.,
Surgeon, Great Northern Central Hospital, and
J. CLARK,
Senior House Surgeon.

Some months ago my friend Professor Hewlett drew my attention to a report of a paper read before the Medical Society of the Missouri Valley on September 8, 1906, by H. H. Everett, M.D., dealing with iodised catgut, and published in the *Medical Herald.*

It seemed to me that this was an ideal method of preparation, as it was so extremely simple and so easily carried out. I determined to try it in order to see if it would stand the severe test of use in all kinds of surgical cases.

The following account has been written by the Senior House Surgeon, Mr. Clark, who has had charge of my beds for the last six months, and I can verify every word.

I think it is important that so easy and efficient a method of preparing catgut should be generally known, and as described below it is practically the same as that published by Dr. Everett.

The great drawback to the existing methods of preparing catgut for surgical work is that those processes which efficiently sterilise it at the same time impair very markedly its tensile strength. The following method leaves the catgut as strong as, or stronger than, it was before the preparation was commenced. It has also been proved to be perfectly efficient as regards rendering the catgut sterile. It can be used either for plain catgut, or for the chromicised variety.

The raw catgut, after its strength has been carefully tested, is rubbed over with a swab soaked in methylated ether to remove any fat or other impurity which may be adherent to its surface. It is then wound on a microscope slide, only one layer being put upon each slide, and immersed in a one per cent. solution of iodine in methyl alcohol. In this solution it should be left from one to three days, according to the thickness of the strands, after which it is quite sterile, as has been proved by repeated cultivation on ordinary media. Since the strength of the catgut is not impaired by a more prolonged immersion in the iodine solution, it is convenient to leave it for a week, and then, even if a variety of sizes have been prepared together, all will be quite sterile. The catgut is removed from the solution and each slide wrapped in two layers of sterilised filter paper, a process which can be carried out with forceps, so that the fingers need not touch the catgut. A final covering of thick parchment paper is wrapped round the filter paper, and the whole stored in a dry place. When required for use the paper wrappings are removed by forceps and the catgut dropped into lotion. If plain catgut is being used, it is better to place it in methylated spirit or some spirit lotion, as a watery lotion causes swelling of the strands and makes them weaker.

Catgut prepared in this way has now been used by Mr. Peyton T. B. Beale, F.R.C.S., in all operations for a period of six months, and the results have been perfect. During this time practically all the surgical operations in vogue at the present day have been performed, and this catgut used throughout, even the skin being sutured with it, and in no case has there been the slightest irritation around the stitches or any of those troubles which we associate with imperfectly sterilised ligatures or suture materials.

Chromicised gut prepared in this way will remain firm and unabsorbed for at least 18 days, the plain gut for at least 6 days.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

Carcinoma of Testis.—Mr. Edred Corner operated on a man, æt. 36, who was a whitesmith, suffering from swollen testicle, which he had first noticed ten months ago, his attention being attracted to it by its size and weight, but not by pain. Latterly he had had some pain, but not of a severe nature. He was rather uncertain as to whether he had injured the part or not. The pain came on in attacks lasting for a week at a time. The swelling had been mistaken for a hydrocele, as it fluctuated freely. Under this impression it had been tapped, when it bled freely. In this connection Mr. Corner said he would like to draw attention to the different results obtained in tapping a growth or a gumma of the testicle; the former usually bleeds freely, the latter does not. In this particular case the free hæmorrhage clinched the diagnosis of neoplasm of the testicle. At present there was a large cystic swelling on the left side of the scrotum; the skin over it was very tense, and the gland was indistinguishable. As the diagnosis was undoubted, the operation of castration, Mr. Corner said, would be done through an incision in the inguinal region rather than through an incision in the scrotum; the inguinal incision was to be preferred because it can be kept aseptic. The inguinal canal was opened, the spermatic cord separated and divided as high up as possible. Mr. Corner pointed out that he did not think it worth while to attempt to remove any of the constituent structures of the cord above the internal abdominal ring. The tumour was then drawn into the wound by invaginating the scrotum, it was then freed from the skin and removed. Mr. Corner drew attention to the fact that malignant neoplasms of the testicle possessed a bad prognosis because the infection proceeded straight from the gland to the intra-abdominal lymphatics; the glands in the inguinal region were only infected when the growth had involved the skin. In the latter case the infection travelled by the superficial lymphatics, and in the former it took place through the deep lymphatics which accompany the spermatic cord. In the history of cases of carcinoma of the testicle it was, he said, extremely common to obtain a history of an injury of the gland. This patient had no such accident. Further, it was stated that pain was a constant and early symptom of malignant disease of the testicle. In this case pain was a late symptom, and then only came on from time to time, the duration of each attack being about a week, whilst in the intervals the patient had no discomfort except for the weight of the gland. There was still one further point, Mr. Corner remarked. When the man was examined, he showed complete absence of testicular sensation, a sign which, he said, the text-books inform us, was restricted to gummatious disease of the testicle; but he thought it mattered not whether the disease which has affected the testicle was growth or syphilis; so long as the testicle has been destroyed testicular sensation will be absent.

SPECIAL REPORTS.

GENERAL MEDICAL COUNCIL.

Eighty-Fifth Session.

FIRST DAY.—Tuesday, May 28th, 1907.

Dr. MacALISTER, President, in the Chair.

The official notification of the election of the following members was read:—

(a) As direct representatives for England for five years:—From December 12th, 1906: Dr. Henry Langley Browne. From January 1st, 1907: Dr. Leonard Strong McManus, Dr. Henry Arthur Latimer.

Dr. Langley Browne was introduced by Dr. Saundby; Dr. McManus and Dr. Latimer were introduced by Sir John Williams.

(b) As direct representative for Scotland for five years, from January 1st, 1907: Dr. Norman Purvis Walker. Dr. Walker was introduced by Mr. Hodsdon.

The President delivered the following:—

PRESIDENTIAL ADDRESS.

"Gentlemen,—During the recess a general election has taken place in England and Scotland, with the result that four new members have been returned to the Council in the places of Sir Victor Horsley, Mr. George Brown, Mr. Jackson and Dr. Bruce. Sir Victor Horsley retired before the beginning of our last session, in order to spare the English constituency the trouble of a bye-election. . . . After a few graceful words concerning the retiring members, Dr. MacAlister said with reference to the new members that to them we look with confidence for that willing co-operation in the fulfilment of our responsible tasks which was rendered by their predecessors. We are well assured, by their past record, that they will in addition contribute to our deliberations something that is fresh and individual. . . . As you are probably aware, I have been unexpectedly called by His Majesty to be the resident head of the University of Glasgow. The authorities of the University of Cambridge, to whom I owe my seat in the Council, and accordingly in this chair, have kindly expressed a desire that I should complete the term of five years for which I was last re-elected by the Senate. As the Senate is not limited in its choice to persons in continuous residence at Cambridge, and as I shall maintain a close connection with that University, I have agreed to retain my membership of the Council as its representative. I have made such arrangements for the conduct of office business during the interval of our sessions as will ensure that the commonwealth shall take no detriment on account of my greater distance from London. It may even be that some advantage will accrue from the opportunity afforded to your President of studying at first hand the position of medical education and practice in Scotland as well as in England.

The Lord President of the Privy Council has just furnished us with an illustration. The University of Edinburgh has framed an Ordinance making certain changes in the course of study and examinations for medical degrees. On this Ordinance two of the three other Scottish Universities have offered to the Privy Council, as they are entitled by law to do, various criticisms, of which some refer to inter-university relations rather than to general principles, others perhaps to matters of substance. In regard to such general principles and matters of substance the Lord President invites an expression of opinion on the part of the Medical Council. The Executive Committee have resolved to refer the Ordinance to the Education Committee and the Examination Committee, with the request that they will respectively report to the Council whether the provisions of the Ordinance are in conformity with its existing *resolutions and recommendations* on the subjects of professional education and professional examination.

It is with special satisfaction that I record the completion of the negotiations for medical reciprocity with the Province of Nova Scotia, to which, as you will remember, His Majesty in Council was pleased last year to apply Part II. of the Medical Act, 1886. . . . The admission of Nova-Scotian qualifications to the British Register has already, as I understand, had the incidental consequence that Canadian medical graduates, who have fulfilled the conditions applicable to the Maritime Province, are now declared to be eligible for commissions in the Royal Army Medical Corps. The Australian States, which long ago entered into reciprocal relations with this country, are already in a position to offer similar advantages to their medical graduates. It is to be regretted that graduates of Provincial Universities in Canada, other than those of Nova Scotia, are still ineligible for appointment in the Medical Services of the Crown. It now rests with the Canadian Provinces themselves to remove the disability. The Council, which has always taken a broad view of its responsibilities to the Empire in general, will doubtless give the most favourable consideration to any overtures the Provincial Governments may make to this end.

His Majesty has not yet been pleased to apply the Act to the Province of Quebec, as it is first necessary that the Privy Council should be more fully informed of the actual provisions of the local law affecting the admission to the Provincial Register of practitioners registered in the United Kingdom. We are told that the requisite inquiries are being made through the proper channels. Until His Majesty in Council is satisfied regarding the provisions in question, the

Executive Committee is unable to take further steps towards the recognition of Quebec degrees.

The Foreign Office has forwarded to the Council copies of the International Agreement respecting the Unification of the Pharmacopœial Formulas for Potent Drugs, which was signed at Brussels on November 29th, 1906, by the diplomatic representatives of eighteen States on behalf of the respective Contracting Governments. This Agreement embodies, with slight amendments, the resolutions of the Brussels Conference of 1902. It includes the following reservation which, as Chairman of the Pharmacopœia Committee I venture to suggest should be made on behalf of this country: "The Government of His Britannic Majesty declares that it reserves the right of introducing into the stipulations of the present Agreement such modifications in detail as the progress of medical and pharmaceutical science may render necessary from time to time." In drawing up the next *Pharmacopœia* it will accordingly be incumbent on the Council, in the paramount interest of international uniformity and of public safety, to make certain changes in the formulas for a few poisonous drugs and preparations. . . .

Two Bills, proposing amendments in the law relating to the practise of medicine and of dental surgery by joint stock companies, which have already received the appproval of the Council, have been introduced in the Upper House by Lord Hylton, and have passed the second reading without opposition. They were supported in principle by Lord Halsbury, late Lord Chancellor, and by the Lord President of the Council on behalf of the Government. By consent they have been referred to a Select Committee, which will shortly sit to receive evidence from this Council, and from other bodies interested, respecting the abuses against which the Bills are directed, and the sufficiency of the proposals therein contained for the purpose contemplated. The Registrar and your Legal Advisers are actively engaged in preparing for submission to the Select Committee a statement of the evidence in the possession of your Companies-Bills Committee.

A Bill to empower the Society of Apothecaries of London to confer on those who have passed its qualifying examination the title of "Licentiate in Medicine and Surgery" has passed through several of its stages in Parliament. Certain amendments in its terms, suggested by the Executive Committee in the interest of the Council, have been readily adopted by the promoters.

A question seriously affecting the position of members of the Council as a judicial body has been raised by a communication from the Chairman of the Central Ethical Committee of the British Medical Association. The communication informs us that the Annual Representative Meeting has decided that the Association should act as complainant in cases which might require to be brought before the Medical Council; and that the Central Ethical Committee is the body whose duty it would be to consider whether a given case should be so brought, and to prepare the case for our consideration.

As many members of the Council (and of the Penal Cases Committee) are members of the British Medical Association, it appeared desirable that their position in regard to complaints made by the Association, if such were brought for inquiry before the Council (or the Committee), should be made clear. I accordingly consulted our Legal Advisers, who are familiar with the *dicta* of the Lords Justices in cases (such as Leeson's and Allinson's) where the suspicion of bias or prejudice on the part of members of the Council has been alleged as a ground of appeal against its decisions. The advice is that the proper course to be taken by a member of the Council, who belongs to the Association, is not merely to withdraw from the decision of a case in which the Association acts as complainant, but to withdraw from membership of the Association altogether.

The question of acting on this advice became urgent in my own case, when, at the beginning of this month, the Registrar reported that a formal complaint against a practitioner had been lodged at the office by a branch of the Association, and that the documents awaited my consideration in pursuance of the Standing Orders. As your President, I could not take even the first step towards a judicial inquiry so long as I remained a member of the British Medical Association. I therefore, without delay, sent in my resignation to the general secretary. So soon as my resignation takes effect I shall be able to look at the complaint; but I shall not be able to take the advice of the Penal Cases Committee upon the matter until the other members have also ceased to be connected with the Association. . . ,

The Secretary for Scotland has been pleased to give directions, similar to those already given in England and Ireland, which will result in the notification to the Council of all cases in which registered practitioners are convicted in Scotland of crimes or offences punishable by fines. The thanks of the Council are due to the Government authorities for this aid to the performance of its disciplinary function. . . .

Certain decisions given recently in the Chancery Division of the High Court, in connection with our judgment in an inquiry held by the Council last year, have raised legal questions of interest regarding the scope and meaning of the statutory phrase "infamous or disgraceful conduct in a professional respect." The Chancery decisions do not in form impugn the judgment of the Council, or call in question its jurisdiction; but some of the points involved concern us so closely that I have asked the Council's Solicitor to prepare a memorandum on the subject for our information. As we are advised that an appeal against the judgments is in progress, and as the cases are therefore *sub judice* I propose that the memorandum should be communicated to the Council *in camera*. . . .

In accordance with the resolution of November 30th, 1906, I communicated to Sir Henry Howse and Mr. Alexis Thomson your acknowledgements of the valuable services they had rendered to the Council during their long tenure of office as Assistant Examiners in Surgery at the Apothecaries' Hall, Dublin, and your desire to establish a system of rotation in the appointment of such Examiners in future. From both have come letters expressing appreciation of the Council's consideration, and concurring in the suggestion that rotation is desirable. Proposals will be made to you for the appointment of two Dublin Surgeons, one to act for two years and one for four, as Assistant Examiners (and on occasion Inspectors) for the Apothecaries' Hall. Their function is an important one, for through them the Council has to perform its statutory duty of maintaining the present standard of efficiency, and that not in surgery alone, at the examinations of this Licensing Body.

In conclusion, I have to congratulate the Council on finishing another financial year with a surplus instead of a deficit. But for the heavy expenses connected with the general election, expenses which are considerably increased by the introduction of the ballot system, the surplus would have amounted to £910, or a little more than last year. Of this sum, however, £870 was expended over the election, leaving a net balance of only £40. The actual expenditure on the enlargement of our chamber, and the improvement of our property, has for the time been met by means of the surplus in hand from last year. . . .

Moved by Dr. Norman Moore, seconded by Mr. Morris, and carried by acclamation:—

"That the President be thanked for his Address, and requested to let it be printed in the Minutes."

On motion from the Chair it was agreed:—"That the following constitute the Business Committee: Dr. Norman Moore, chairman, The President, Sir Christopher Nixon, Mr. Young."

Moved by Dr. McVail, seconded by Dr. Norman Moore, and agreed to:—"That nine yearly tables be received and entered in the Minutes: The tables showed results of Professional Medical Examinations during 1906; results of Professional Dental Examinations during 1906; and results of Competition for Commissions in the Medical Staff of the Royal Navy."

Moved by Dr. McVail, seconded by Mr. Young, and agreed to:—"That the thanks of the Council be conveyed to the Director-General of the Medical Department of the Royal Navy, the Director-General of the Army Medical Service, and the Under-Secretary of State for India, respectively, for the returns which they have again furnished to the Council, with the request that these returns may in the future continue to be furnished to the General Medical Council."

Moved by Sir John Moore, seconded by Dr. Little:—"That the Governor and Court of the Apothecaries' Hall, Dublin, be requested to furnish, for the information of the Council, a statement in reference to the Final or Qualifying Examination of that Body." The motion was lost—13 against, 10 for, 9 did not vote, 2 absent.

Moved by Dr. Adye-Curran, seconded by Sir Christopher Nixon, and agreed to:—"That Sir Lambert Ormsby, late President R.C.S. Ireland, and Mr. F. Conway Dwyer, Fellow and Examiner in Surgery, R.C.S. Ireland, be appointed Assistant Examiners in Surgery to the Apothecaries' Hall, Dublin, the former for a period of two years and the latter for a period of four years, *vice* Sir Henry Howse and Mr. Alexis Thomson, retired."

The President undertook to inform the Assistant Examiners as to their statutory duties under the Medical Act, 1886.

Moved by Sir Hugh Beevor, seconded by Mr. Morris and agreed to:—"That Mr. Henry Percy Dean, L.S.A., M.B., M.S. Univ. Lond., F.R.C.S. Eng., be appointed Assistant Examiner in Surgery to the Apothecaries' Society of London for a period of four years, *vice* Mr. Peyton Beale, who retires by rotation."

REGISTRATION OF COLONIAL DEGREES.

The following report by the Executive Committee was read:—The Executive Committee report that Part II. of the Medical Act (1886) having been extended by an Order in Council to Nova Scotia (see Minutes, Vol. XLIII., pp. 195–196), they have considered the conditions under which Medical Qualifications granted in the Province of Nova Scotia shall be recognised for registration in the *Colonial List* of the *Medical Register* of the United Kingdom, and on February 27th, 1907, adopted the following resolution:—

"That any person who holds—

(1) The Diploma or Licence in Medicine, Surgery, and Midwifery granted after examination by the Provincial Medical Board of Nova Scotia, together with the Licence to practise in that Province; or

(2) The Degrees of Doctor of Medicine and Master of Surgery of the Dalhousie University, together with the aforesaid Licence to practise or

(3) The Degrees of Doctor of Medicine and Master of Surgery of the Halifax Medical College, together with the aforesaid Licence to practise,

shall be entitled to be registered in the *Colonial List* of the *Medical Register*, provided he satisfies the Registrar of the General Medical Council regarding the other particulars set forth in Part II. of the Medical Act, 1886."

DONALD MACALISTER, *Chairman.*

February 27th, 1907.

On motion from the Chair, it was agreed unanimously:—"That this report of the Executive Committee be received and entered in the Minutes; that the Registrar be directed to give effect to the resolutions therein contained; and that the Council record its satisfaction at the establishment of reciprocal relations with the Province of Nova Scotia."

The Council then adjourned.

SECOND DAY.—WEDNESDAY, MAY 29TH, 1907.

The minutes of the last meeting were read, and, as amended, confirmed.

The Council proceeded to the consideration of the case of George Covey, registered as of 1, Heathcote Street, Mecklenburgh Square, London, W.C., M.R.C.S.Eng., 1864, L.S.A.Lond., 1865, who had been summoned to appear before the Council on the following charge:—

"That you were on April 23rd, 1907, convicted of the following misdemeanours at the North London Sessions: namely, of obtaining money by false pretences, and of obtaining money by fraud while being an undischarged bankrupt."

ERASURES FROM THE MEDICAL REGISTER.

Mr. Covey was called, but did not answer to his notice.

The Solicitor read the notice to attend, the Certificate of Conviction, and the answers by the accused practitioner, dated respectively April 30 and May 17th, 1907.

Strangers, by direction of the Chair, withdrew in order that the Council might deliberate on the case *in camera.*

Strangers having been re-admitted, the PRESIDENT announced the decision of the Council, as follows:—

"That George Covey having been proved to have been convicted of divers misdemeanours, the Registrar has neen directed to erase his name from the *Medical Register.*"

The Council considered the case of Andrew Dunn Turner, registered as of 71, Marina, St. Leonards-on-Sea, M.B., Mast. Surg., 1882, Univ. Glasg., who had been summoned to appear before the Council on the following charge:—

"That you were on November 21st, 1906, convicted of the following misdemeanour at Lewes Assizes: namely, of unlawfully, maliciously, and scandalously writing and publishing an obscene letter at Hastings, on June 25th, 1906."

Mr. Turner attended in answer to his notice. He was not accompanied by Solicitor or counsel.

The Solicitor read the notice to attend, the Certificate of Conviction, and a report of the trial from the *Sussex Daily News* of November 23rd and 24th, 1906.

Mr. Turner's letters in reply to the Registrar's request for an explanation and his letter in reply to the Solicitor's Notice of Inquiry were read.

Strangers then, by direction of the Chair, withdrew, in order that the Council might deliberate on the case *in camera.*

Mr. Turner and strangers having been re-admitted, the PRESIDENT announced the decision of the Council as follows:—

"Mr. Andrew Dunn Turner,—I have to inform you that, it having been proved that you have been convicted of a misdemeanour, the Council has directed the Registrar to erase your name from the *Medical Register.*"

The Council considered the case of Edward John Havens, registered as of East Donyland, Colchester, M.R.C.S.Eng., 1879, L.S.A.Lond., 1879, who had been summoned to appear before the Council on the following charge:—

"That you were on November 5th, 1906, convicted of the following misdemeanour at Thorpe Petty Sessions, Thorpe-le-Soken Essex: namely, of obstructing the highway; also that you were on December 17th, 1906, convicted at the like Session of disorderly behaviour whilst drunk; and also that you were on April 8th, 1907, convicted of the following misdemeanour, at Mistley Petty Session: namely, of common assault."

Mr. Havens attended in answer to his notice, but was not represented by counsel or solicitor.

The Solicitor read the notice, the Certificates of Conviction, and a report of the first trial from the *Essex County Standard* of November 10th, 1906, which, in answer to a question, Mr. Havens admitted to be a substantially accurate account of the proceedings.

The Solicitor then read a report from the *Essex Telegraph* of the proceedings at the second conviction on December 17th, 1906. Mr. Havens admitted this also to be a substantially accurate account of the proceedings.

The Solicitor also read a report from the *Evening Standard and St. James's Gazette*, of April 8th, 1907.

A letter from Mr. Haven's solicitors, Messrs. Birkett, Ridley and Francis, of Ipswich, in reply to the Registrar's request for an explanation, and a further letter from them in answer to the Solicitor's Notice of Inquiry were read.

Mr. Havens then addressed the Council on his own behalf, and answered a question put to him from the chair, and questions put to him by the Legal Assessor and by members of the Council through the chair.

Strangers then, by direction of the Council, withdrew, in order that the Council might deliberate on the case *in camera*.

Mr. Havens and strangers having been re-admitted, the PRESIDENT announced the decision of the Council as follows:—

"Mr. Edward John Havens,—The Council have deliberated carefully on the convictions which have been proved against you, but they have adjourned the further consideration of your case till the November Session, when you should be present to hear the result of their final deliberations.

The Council proceeded to the consideration of the report of the Dental Committee on the charge against James Marston, in regard to whom the Dental Committee had found that the following facts were established by evidence.

(*a*) The said James Marston is on the *Dentists' Register* as in practice before July 22nd, 1878, and of the address: The Shrubbery, East Howe, Kinson, Bournemouth.

(*b*) The said James Marston was convicted of bigamy on January 16th, 1906, at the Dorset Assizes, and was sentenced to twelve months' imprisonment with hard labour.

Strangers having, by direction of the chair, withdrawn, the Council deliberated on the case *in camera*.

Strangers having been re-admitted, the PRESIDENT announced the judgment of the Council as follows:—

That James Marston having been proved to have been convicted of a felony, the Registrar has been directed to erase his name from the *Dentists' Register*.

The Council proceeded to the consideration of the report of the Dental Committee on the charge against Thomas William Frederick Stewart, in regard to whom the Dental Committee had found that the following facts were established by the evidence:—

That Mr. Stewart was on November 21st, 1906, convicted at Lewes Assizes of feloniously embezzling the several sums of 10s. on July 15th, £1 8s. on September 23rd, and £5 5s. on October 7th, 1906, moneys of Frederick Charles Proctor, his master.

Mr. Stewart attended in answer to his notice.

The report of the Dental Committee having been read, leave was granted to Mr. Stewart to address the Council in regard to the report.

Mr. Stewart and strangers having, by direction of the Chair, withdrawn, the Council deliberated on the case *in camera*.

Mr. Stewart and strangers having been re-admitted, the PRESIDENT announced the decision of the Council as follows:—

"Thomas William Frederick Stewart,—It having been proved that you have been convicted of a felony, the Registrar has been directed to erase your name from the *Dentists' Register*."

The Council resumed the consideration, adjourned from November 29th, 1906, of the facts proved against William Henry Moseley and James Parkinson, whose names appear on the *Dentists' Register* as "in practice before July 22nd, 1878," and who were connected with the company of Foley's Limited.

At the conclusion of the proceedings on November 29th, 1906, the President announced *seriatim* that in the cases of William Henry Moseley and James Parkinson, the further consideration of the charge against them had been postponed until the next Session of the Council, of which due notice would be given them, and at which they would be expected to be present.

In regard to these cases the Dental Committee, at its meeting on May 27th, 1907, found that the following facts were established by the evidence:—

Both Mr. Moseley and Mr. Parkinson have since the hearing of the case by the Council in November last done their best to sever their connection with the Company, and they have both parted with their shares in the Company, and they have respectively practised at Ipswich and at Uxbridge Road independently of the Company, and there is no evidence that their professional conduct in the interval has been otherwise than satisfactory.

Mr. Parkinson attended in answer to his notice. Mr. Moseley was absent owing to illness, nor was he represented by solicitor or counsel.

The Registrar having read the supplementary report, the President announced that a letter had been received from Messrs. Kerr and Ramsden, Mr. Parkinson's solicitors, stating that they had inspected the register of shareholders in Foley's, Limited, and that Mr. Parkinson's shares had been transferred, as he had stated.

This closed the public proceedings, and the PRESIDENT announced that only those who had been members of the Council at the first hearing of the case in November could take part in the deliberations.

Strangers having, by direction of the Chair, withdrawn, the Council deliberated on the case *in camera*.

Strangers having been re-admitted, the PRESIDENT announced the decision of the Council as follows:—

"That the Council having further considered the charge proved against James Parkinson and William Henry Moseley, and the reports of the Dental Committee thereon, does not judge them guilty of infamous or disgraceful conduct in a professional respect.

Strangers having again, by direction of the Chair, withdrawn, the Council proceeded to the consideration *in camera* of a report by the Executive Committee on a communication received from the British Medical Association.

Strangers having been re-admitted it was moved by Dr. Norman Moore, seconded by Sir John Moore, and agreed to:—

"That the report by the Executive Committee on a communication from the British Medical Association be received and entered in the Minutes."

In the report it was resolved:—"That the Executive Committee, being advised that no Member of the British Medical Association should act as a member of the Penal Cases Committee, or take part in adjudicating as a Member of the Council in cases in which the British Medical Association or any branch of it acts as complainants are unanimously of opinion that it is under the circumstances undesirable that a member of the Council should during his tenure of office be a Member of the British Medical Association or any other body, which may submit complaints to the Council for inquiry."

Moved by Dr. Saundby, seconded by Sir T. McCall Anderson, and agreed to:—

"That a copy of the report of the Executive Committee on the communication from the British Medical Association be sent to the General Secretary of that Body for its information."

Moved by Dr. Saundby, seconded by Sir John Moore and agreed to:—

"That the report by the Executive Committee be approved by the Council."

Strangers then, by direction of the Chair, again withdrew, in order that the Council might receive *in camera* a communciation from the solicitor in regard to certain dental cases.

Strangers having been re-admitted, it was moved by Sir John Williams, seconded by Mr. Young, and agreed to:—"That the report by the Students' Practical Midwifery Committee as to further communications sent by the Licensing Bodies and Teaching Institutions be received and entered on the Minutes."

Moved by Sir JOHN WILLIAMS, seconded by Sir CHRISTOPHER NIXON, and agreed to:—"That the report by the Students' Practical Midwifery Committee as to the inclusion of Clinical and Practical work in the Qualifying Examinations in Midwifery and Gynæcology, as read by the Chairman, be received and entered in the Minutes."

Moved by Sir John Moore seconded by Dr. Lindsay Steven, and agreed to :—" That the following report from the Public Health Committee be received, entered on the Minutes and approved " :—

The Public Health Committee report that, in accordance with the Standing Orders, they met on May 28th, 1907, and that no business came before them for consideration and report.

As the Chairmanship of the Committee had become vacant owing to the fact that Dr. Bruce's membership of the Council had ceased, the Committee selected Mr. Power as Chairman.

The Council then adjourned.

THIRD DAY.—THURSDAY, MAY 30TH, 1907.

Dr. MacAlister, President in the Chair.

The minutes of the last meeting were read, and, as amended, confirmed.

STUDENTS AND THE PRACTICE OF MIDWIFERY.

Moved by Sir John Williams seconded by Mr. Young :—

" That the following be substituted for the existing recommendations of the Council, in regard to instruction in midwifery :—' Section 1.—Every student before commencing the study of practical midwifery shall be required to have held the offices of Clinical Medical Clerk, and Surgical Dresser, and to have attended a course of lectures on Surgery and Midwifery.' "

Amendment moved by Sir John Moore, seconded by Dr. Pye-Smith :—" That after the words ' course of lectures ' and before the words ' Surgery and Midwifery' the word ' Medicine ' be inserted."

After a discussion this amendment was lost.

Further amendment moved by Sir John Moore, seconded by Sir T. McCall Anderson :—" That the words ' Surgery and ' be omitted."

This amendment was lost.

Further amendment moved by Dr. Mackay, seconded by Dr. Finlay :—" That after the word ' required ' in the original motion the following words be substituted :—' To have attended a course of Clinical instruction in Medicine, and to have held the office of Surgical Dresser, and to have attended a course of lectures on Surgery and Midwifery.' "

The amendment was lost, and the original motion was then put and carried *nem con.*

Moved by Sir John Williams, seconded by Mr. Young :—" That Section (2) of the proposed recommendations be adopted, viz :—

> " ' Every student shall be required either—
>
> " ' (*a*) To have regularly attended the indoor practice of a Lying-in Hospital, or the lying-in wards of a General Hospital, for a period of three months ; and after having received therein practical instruction in the conduct of labour, under the personal supervision of a medical officer, to have conducted twenty cases of labour under official medical supervision ; or
>
> " ' (*b*) To have conducted not less than twenty cases of labour, subject to the following conditions :—
>
> > " ' That he has, during one month, given regular daily attendance upon the indoor practice of a Lying-in Hospital or the lying-in wards of a General Hospital ; and that he has therein conducted cases of labour under the personal supervision of a Medical Officer of the Hospital, who shall, when satisfied of the Student's competence, authorise him to conduct outdoor cases under official medical supervision.' "

Amendment moved by Dr. Saundby, seconded by Mr. Morris :—" That before ' every ' in the first line the following words be inserted :—' Where the necessary Hospital facilities exist it is desirable that,' and that in the same line the word ' should ' be substituted for the word ' shall.' "

After a discussion this amendment was lost.

Further amendment moved by Dr. Langley Browne, seconded by Dr. Lindsay Steven, and agreed to :—" That in Clause (*b*) after the words ' General Hospital,' the following words be inserted, ' or of a Poor Law Infirmary having a resident Medical Officer recognised for that purpose by the Licensing Bodies.' "

Further Amendments moved by Sir Charles Ball, seconded by Sir T. McCall Anderson :—" That in (2) (*a*) the word ' ten ' be substituted for the word ' twenty.' " and " That in (2) (*b*) the word ' fifteen ' be substituted for the word ' twenty.' "

Both amendments were lost.

The original motion as amended was then put as a substantive motion, and agreed to.

Moved by Sir John Williams, seconded by Dr. Latimer, and agreed to :—" Section 3.—No certificate that the Student has conducted the above-mentioned twenty cases of labour should be accepted unless it is given by a member of the staff of a Lying-in Hospital or of the Maternity Charity of a General Hospital, or of a Dispensary having an obstetric staff recognised for that purpose by the Licensing Bodies, or of a Poor Law Infirmary having a resident Medical Officer as recognised."

Moved by Sir John Williams, seconded by Dr. Latimer, and carried (16 for, 11 against, 4 did not vote ; 3 absent) :—" That the attention of the Licensing Bodies be called to the necessity, in the public interest, of instituting Clinical and Practical Examinations in Midwifery and Gynæcology in connection with each of the Qualifying Examinations."

Moved by Sir John Williams, seconded by Dr. Lindsay Steven, and agreed to after a discussion :—" That copies of these resolutions, and of the reports of the Students' Practical Midwifery Committee be sent to the Licensing Bodies and Teaching Institutions of the United Kingdom for their information."

Moved by Dr. Mackay, seconded by Dr. Norman Moore, and agreed to :—" That the Interim Report of the Education Committee on various matters submitted to it by the General Council be received and entered on the Minutes."

Dr. Mackay made a long and very interesting speech in which he gave statistics as to the ages of entrants, the length of curriculum, &c., in England, Scotland and Ireland ; he received congratulations for the work he had done.

Moved by Dr. Mackay, seconded by Dr. Norman Moore, and agreed to :—" That the President be authorised to apply to the Licensing Bodies for information regarding the dates at which the various professional examinations were entered for and completed in the cases of those of their Licentiates the statistics of whose educational career are included in the table upon which the foregoing report is founded."

Moved by Dr. Pye-Smith, seconded by Mr. Tomes, and agreed to :—" That the report by the Finance Committee on Income and Expenditure for the year 1906 be received and entered in the minutes and adopted."

The report may be considered satisfactory as it contained a surplus, in spite of the expenses attendant on the election of Direct Representatives.

Moved by Mr. Tomes, seconded by Dr. Lindsay Steven, and agreed to :—" That the report by the Dental Education and Examination Committee, be received and entered in the Minutes."

Moved by Mr. Tomes, seconded by Mr. Morris, and agreed to :—" That the application of the University of Sydney for the recognition of its degree of Bachelor of Dental Surgery be acceded to."

Moved by Mr. Tomes, seconded by Dr. Lindsay Steven, and agreed to :—" That it be represented to the Secretary of State for the Colonies that it is desirable that recognition of foreign Dental Diplomas shall only be granted in the case of those countries which give reciprocal recognition to British Diplomas in Dental Surgery."

Moved by Dr. McVail, seconded by Mr. Young, and agreed to :—" That the report by the Examination Committee on the returns as to Examinations for the Services received by the Council on Tuesday, May 28th, 1907, be received and entered in the Minutes."

Moved by Sir HUGH BEEVOR, seconded by Dr. NORMAN MOORE, and agreed to :—" That the report by the Students' Registration Committee be received, entered in the Minutes, and approved."

Moved by Dr. NORMAN MOORE, seconded by Mr. MORRIS, and agreed to :—" That the nominations of the Branch Councils for the Examination Committee, the Education Committee, and the Public Health Committee be adopted.

On the motion of Dr. NORMAN MOORE, seconded by Mr. MORRIS, the names proposed for the Pharmacopœia Committee, the Finance Committee, the Dental Committee, the Dental Education and Examination Committee, and the Students' Registration Committee were agreed to.

The PRESIDENT announced that the following had been elected members of the Executive Committee :—Sir Hugh Beevor, Dr. Pye-Smith, Mr. Young, Mr. Tomes, Sir John Tuke, Dr. McVail, Sir John Moore, Sir Charles Ball. And that the following had been elected Members of the Penal Cases Committee :—Dr. Saundby, Mr. Tomes, Dr. Finlay, Sir Christopher Nixon.

The Council then adjourned.

FOURTH DAY.—FRIDAY, MAY 31ST, 1907.

DR. MACALISTER, President, in the Chair.

THE minutes of the last meeting were read, and, as amended, confirmed.

Moved by Dr. NORMAN MOORE, seconded by Sir JOHN MOORE, and agreed to :—" That the report by the Pharmacopœia Committee be received, entered in the minutes, and approved."

The Council proceeded to the consideration of reports by the Education Committee and the Examination Committee on the proposed Ordinance by the University Court of the University of Edinburgh to alter Ordinance No. 15 of the Commissioners under the Universities (Scotland) Act, 1889, Edinburgh No. 1.

Moved by Dr. MACKAY, seconded by Dr. NORMAN MOORE, and agreed to :—" That the following report by the Education Committee be received and entered in the Minutes."

The Education Committee report that the changes embodied in the proposed new Ordinance of the University of Edinburgh are in accordance with the requirements of the Council in regard to professional education.

JOHN YULE MACKAY,
May 29th, 1907. Chairman.

Moved by Dr. MCVAIL, and seconded by Sir JOHN MOORE, that the report by the Examination Committee be received and entered in the minutes.

The PRESIDENT called attention to the fact that the recommendation contained in the report of the Examination Committee was based on a misconception as to the bearing of No. 13 of the Council's recommendations in regard to professional examination, namely :

" 13.—Seeing that the practice of different authorities varies on the question whether a student who fails to satisfy the examiners in either one or two of the several subjects of medicine, surgery, and midwifery should be referred on all of them or only on those in which he fails, the Council recommends that some general principle should be adopted with reference to this matter ; and suggests that a percentage of not less than 60—supposing that the pass requirement be 50 per cent.—should be exempt from re-examination in such subject."

Dr. MCVAIL, seconded by Sir JOHN MOORE, substituted the following motion, which was agreed to :—" That the report of the Examination Committee down to the end of the parallel columns be received and entered in the minutes as follows :—

(B) REPORT BY THE EXAMINATION COMMITTEE.

For the information of the Medical Council the Committee puts in parallel columns the Sections of the Ordinance as at present in force and the proposed altered Sections.

First column, Present Ordinance.
Second column, Proposed New Ordinance.

I. Section XI. of Ordinance No. 16 of the said Commissioners—Edinburgh, No. 1, Regulations for Degrees in Medicine—shall be altered to read as follows :—

Each candidate shall be examined both in writing and orally, and also clinically where the nature of the subject admits, in the following divisions—viz., *First*, in Botany, Zoology, Physics, and Chemistry ; *Second*, in Anatomy and Physiology ; *Third*, in Pathology and Materia Medica and Therapeutics ; and *Fourth*, in Surgery and Clinical Surgery, Medicine and Clinical Medicine, Midwifery, Forensic Medicine and Public Health.

In subjects which admit of practical instruction the examination shall be such as to test the practical requirements of the candidate.

Provided always that if a candidate have completed in a University of the United Kingdom, or in any other University specially recognised for the purpose by the University Court, a course of study, and have passed an examination in Botany, Zoology, Physics or Chemistry, qualifying for a degree in Science or in Arts he shall be held to have passed his examinations in the said subject or subjects ; provided that in the case of a university not in the United Kingdom the course of study and the standard of examination are satisfactory in the judgment of the Senatus Academicus.

II. Section XII. of the said Ordinance, No. 16, shall be altered so as to read as follows :—

Candidates who profess themselves ready to submit to an examination in any of the subjects comprised in the first division, viz., Botany, Zoology, Physics, and Chemistry, may be admitted to examination in one, or in any number, of these subjects, at any examination held after they have attended the necessary qualifying course or courses in each of the subjects professed.

III. Section XIII. of the said Ordinance, No. 16, shall be altered so as to read as follows :—

Candidates who have passed their examinations in the subjects comprised in the first division may be admitted to examination in each of the subjects of the second division, after they have attended the necessary qualifying course or courses in that subject—viz. : in Physiology at any time ; in Anatomy at any time after the end of the first half-session of their third winter session.

IV. Section XIV. of the said Ordinance, No. 16 shall be altered so as to read as follows :—

Candidates who have passed their examinations in the subjects comprised in the first and second divisions may be admitted to examination in each of the subjects of the third division after they have attended the necessary qualifying course or courses in that subject, viz. :—in Pathology at any time after the end of the third summer session in the case of those students who begin the Medical Curriculum in October, and at the end of the fourth summer session in the case of those students who begin their medical curriculum in May ; and in Materia Medica at any time after the end of the fourth winter session ; provided always that candidates may be admitted to examination in Practical Pharmacy, and also the physical, chemical, and botanical characters of medicinal substances, at any examination held after they have attended the necessary qualifying course of instruction in that subject.

V. Section XV. of the said Ordinance, No. 16, shall be altered so as to read as follows :—

Candidates who have passed their examinations in the subjects comprised in the first, second, and third divisions may be admitted to examination in each of the subjects of the fourth or final division after they have attended the necessary qualifying course or courses in that subject—viz., in Forensic Medicine and Public Health at any time ; in Midwifery at any time after the end of the first half-session of the fifth winter session ; in Practice of Medicine and Surgery at any time after the end of the fifth winter session ; and in Clinical Medicine (including the subject of the Diseases peculiar to women) and Clinical Surgery at the end of the fifth year of study.

Moved by Dr. MACKAY, seconded by Dr. NORMAN

MOORE, and agreed to :—" That the report of the Education Committee be adopted."

Moved by Dr. MCVAIL, seconded by Sir JOHN MOORE: —" That the Medical Council is of opinion that when subjects which are usually taken together are entered for singly, the pass standard should be at least 60 per cent."

After a discussion the motion was lost—17 against, 7 for, 5 did not vote, 5 absent.

Moved by Mr. THOMSON, seconded by Dr. MACKAY, and agreed to (15 for, 3 against, 9 did not vote, 7 absent) :—" That the reply of the Council to the Lord President of the Privy Council be as follows :—

" That the Council have considered the proposed Ordinance of the University of Edinburgh, and find nothing therein which is contrary to the Council's resolutions on professional education and examination."

The PRESIDENT announced that he had received letters from Sir Lambert Ormsby and Mr. F. Conway Dwyer, accepting the position of Assistant Examiners in Surgery to the Apothecaries' Hall, Dublin, and undertaking to carry out the duties assigned to them by the Medical Act, 1886.

Moved by Dr. NORMAN MOORE, seconded by Sir JOHN BATTY TUKE, and agreed to unanimously :—

" That Mr. Allen be appointed General Registrar of the Council till the end of the Summer Session, 1908."

Moved by Dr. NORMAN MOORE, seconded by Dr. LITTLE, and agreed to unanimously :—" That the best thanks of the Council be given to the President for his able services in the chair during the present Session."

The Council then rose.

CENTRAL MIDWIVES' BOARD.

MEETING HELD MAY 30TH, 1907.

The President, Dr. CHAMPNEYS, in the Chair.

IN the beginning a letter was read by the Secretary from the Clerk of the Council, transmitting an order in Council, approving the revised rules for the period ending September 30th, 1909, after which the REPORT OF THE MIDWIVES' ACT AMENDMENT COMMITTEE was submitted, it being recommended that :—" The Board should be enlarged by the addition of one member to be nominated by the Incorporated Society of Medical Officers of Health," which brought up the often-discussed subject of lay representation.

Dr. STANLEY ATKINSON moved that, as in his opinion, the Board was not large enough for the work, six members should be added, three from municipal boards, one each from the College of Physicians and College of Surgeons, and one from the Apothecaries' Society of London.

Sir WILLIAM SINCLAIR remarked that he wished to state his own opinion not only to the Board, but to the medical Press, that the C.M.B. should be entirely constitutional, and composed of medical men. Moreover, the London Colleges of Physicians and of Surgeons were already sufficiently represented and a slight had been put on younger universities. He did not wish in any way to disparage much useful service done by the lay members, nor did he expect his opinion to influence, but he felt bound to express it. He also proposed that as he had not come from Manchester to discuss the suggested nine alterations in the Midwives' Act, that the Board should proceed to the agenda.

After a somewhat heated discussion between the lay and medical members this was agreed to, and a letter was read from the Clerk of the Council, transmitting a copy of a letter from the Medical Officer of Health for Manchester, with regard to a proposed additional rule regulating the practice of midwives.

Sir WILLIAM SINCLAIR asked why a copy of the letter was not on the agenda, and asked that copies, or the gist of letters should be put there.

Dr. PARKER YOUNG said that the answer to Manchester as framed was hardly courteous—" On the next revision of the rules." How were they to know when the Board chose to revise the Rules ? It would be better to say that intimation of revision would be sent. This was agreed to.

A letter was read from Dr. Fram Gotla, enquiring whether instruction by correspondence only entitled a teacher to sign a certificate. Answer was returned that the words " lectures " and " attended " precluded such signing.

The following gentlemen were then appointed examiners for the London Centre : R. Drummond Maxwell, M.D., F. E. Taylor, M.D., J. Abernethy, Willett, M.D.

TRAINING SCHOOLS FOR MIDWIVES.

Applications for approval as Training Schools from Bradford Union Maternity Hospital, and the Queen Victoria Nursing Institute, Wolverhampton, were read, the first being granted, the latter refused, whereupon

Sir WILLIAM SINCLAIR said he thought it strange and unreasonable to encourage Unions where the least desirable were born, and to obstruct places where a better class of births took place. He was strongly against pauper births. More places of the second class were required, especially in London.

The PRESIDENT explained that the refusal was only *pro tem*, there being neither beds nor teachers as yet for the Maternity Ward, and the Board proceeded to the discussion of minor affairs.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 2nd, 1907.

TREATMENT OF VOMITING.

AMONG the substances that can be employed the most frequently cocaine takes the first place, given either in pills or mixture. It may be associated with either morphia or antipyrine.

Hydrochl. of morphia, gr. ¼
Hydrochl. of cocaine, gr. ¼.
Lime water, ozs. 4.

A tablespoonful every hour, or

Hydrochl. of cocaine, gr. 1.
Antipyrine, grs. 30.
Syrup of orange, oz. 1.
Water, ozs. 4.

A dessertspoonful every hour.

Tincture of iodine is given in 5-drop doses every half hour up to 10 or 15 drops. Dr. Huchard prescribes it in the vomiting of pregnancy associated with chloroform :—

Tincture of iodine, drachm 1.
Chloroform, drachm 1.

Ten drops three times a day.

The following is an excellent formula :—

Hydrate of chloral grs. 30.
Spirit of chloroform, drachm 1.
Peppermint water, ozs. 4.

A tablespoonful every quarter of an hour.

In cancer of the stomach or round ulcer vomiting is frequent and provoked by the pain produced by the contact of food on the ulcerated membrane.

In such cases absolute rest of the organ should be prescribed ; all solids should be suppressed for a time, only a tablespoonsful of iced milk allowed at prolonged intervals, and return to solid food should be made progressively and with great prudence. The pain is relieved by large doses of bicarbonate of soda, which act in modifying the gastric secretion.

Bicarb. of soda, grs. 8.
Chalk, grs. 5.
Calcined Magnesia, grs. 5.
Belladonna powder, gr. ¼.

For one wafer, two to four a day.

Periodical vomiting, or that coming on suddenly without any particular phenomenon between times should be treated by iced or effervescing drinks ; bromides, belladonna, opium, valerian, revulsion by mustard applied to the epigastrium, hot applications, or, on the contrary, the ice bag.

As regards prophylactic treatment, a severe regimen will be prescribed, nothing liable to irritate the gastric organ should be allowed; constipation should be treated and the patient advised to employ the cold douche and take exercise.

Plantar and Palmar Hyperhydrosis.

Sweating of the hands and feet is sufficiently annoying at all times, but it becomes a regular infirmity in the warm season.

The treatment differs according to authors, but one or other of the following formula will be found useful:—

Permanganate of potash, grs. 5.
Water, quart 1,
or
Formol, drachms 4.
Friar's balsam, drachms 3.
Water, quart 1.
As local baths (warm).

If, instead of being cold and cyanosed, the feet and hands are hot, the baths should be cold, and applications will be made of:—

Icthyol, oz. 1.
Water, drachms 4.
Lanoline, oz. 1,
or
Naphthol, drachm 1.
Glycerine, drachms 3.
Proof spirit ozs. 3.
Water. oz. 1.

As lotions twice a day:

Tannin, drachm 1.
Proof spirit, ozs. 6.
Water, ozs. 3,
or
Sulphate of quinine, drachm 1.
Proof spirit, ozs. 2.
Water, 4 ozs.

Besides baths and lotions, the following powder might be employed:—

Fuller's earth, ozs. 3,
Subnit. Bismuth, oz. 1.
Salicylic acid, drachm 1.
Tartaric acid, drachm 1.

While a piece of blotting paper steeped in the following mixture may be placed in the boots:—

Permanganate of potash, grs. 15.
Thymol, grs. 6.
Water, ozs. 4.

GERMANY.

Berlin, June 2nd, 1907.

At the Deutsche Gesellschaft für Chirurgie, Hr. Ehrhardt spoke on the

True and False Diverticula of the Gall-Bladder.

as a contribution to the ætiology of pseudo-recurrences after gall-stone operations. He discussed the significance of the false diverticula with circumscribed dilatation of the wall of the gall-bladder, arising like the tissue from preformed Luschka canals as regards retention of calculi, mucus, and pus. He laid stress on the fact that calculi lying in such diverticula, as well as the diverticula themselves, could easily be overlooked in cystotomy, and that from them a recurrence could easily arise that was no recurrence, but merely a result of the operation being only imperfectly performed. If extirpation of the gall-bladder was carried out to the opening of the cyst into the bile duct, such a thing could not occur. The speaker also showed interesting preparations from which it could be seen that gall-stones might occasionally be broken up and dissolved by pancreatic tissue growing into them

Hr. Sprengel, Brunswick, spoke on

Retroperitoneal Abscesses of the Bile Passages.

He had operated on a case of abscess that had descended from the bile passages to the back of the ascending colon. No such case had hitherto been recorded in literature. An examination of the case was made post-mortem, and it was shown that a perforation of the ductus choledochus just at the junction of the cystic duct originated this trouble. Anatomically it was difficult to understand how suppuration from the bile passages lying intraperitoneally should find its way to parts lying extraperitoneally. He had tried to make fluid take this course by experiments on the cadaver, but could never succeed. He concluded, therefore, that adhesions had formed posteriorly between the bile passages and the retroperitoneal space. He thought that lumbar counter incision should always be made in such cases.

Hr. Anschütz, Breslau, gave a contribution on

Resection of the Liver.

He said that resection of the liver was now carried out at the Mikulicz (now Garré) Klinik without any special technical appliances, but with careful ligature of the vessels. The tissue when it was thin was cut through with a sharp instrument under manual compression; where the tissue was thicker, after intrahepatic ligature causing pressure. This was applied by means of a Deschamp or similar needle. Then all the vessels on the cut surface were ligatured, and the wound surfaces united by suture, for which not much approximating force could be used. The liver wound was now placed intra-peritoneally by Garré, and the abdominal wound closed, whilst Mikulicz treated it extra-peritoneally. In order to open up the liver sufficiently, the suspensory and coronary ligaments were cut through if necessary. Resection of the ribs also was advisable from the cartilage of the sixth downwards. This method of procedure was better than a transpleural one. It was to be recommended also in searching for a subphrenic abscess, and also on the left side for operations on the fundus of the stomach and about the cardiac orifice.

Hr. Riedel pointed out the danger of resection of the costal cartilages; infection might follow, and this led generally to a total destruction of it by a long and dangerous process. With regard to subserous extirpation, he pointed out that this could only be done in the case of aseptic gall-bladders, not when they were inflamed and adherent. In the latter case the essential thing was to take care of the artery and to isolate the cystic duct as far as the hepatic branch.

Hr. Bockenheimer, Berlin, spoke on

The Treatment of Tetanus,

basing his remarks on his clinical and experimental studies. He would treat all wounds prophylactically as regarded tetanus. During the Japanese war, wounds were treated with Peruvian balsam and remarkably few cases of tetanus occurred. He had discovered that fatty substances acted antagonistically as regarded tetanus, and he recommended antitoxin ointment for local treatment. He had made his investigations in the Berlin Institute for Infective Diseases under the direction of Professor Wassermann.

The *Deutsch Med. Zeitung*, No. 36, has a reference to Further Experiences in Lumbar Anæsthesia with tropacocain, novocain, and, above all, stovaine. The author, Dr. Thorbecke, Heidelberg, would have no comparisons made at present between general anæsthesia and the lumbar form, for the reason that the one has nearly reached its limits as regards perfectibility, whilst the latter is still in its infancy. Lumbar anæsthesia is indicated in cases in which it would be unsafe to use general anæsthesia, particularly in old and decrepid individuals and in diabetes. The contra-indications are septic diseases, changes in the spinal column itself, diseases of the cord and brain, and certain groups of hysteria. Lumbar anæsthesia with semi-consciousness (Dämmerschlaf) is claimed as a humane procedure. Its advantages lie in complete relaxation of muscles; in operations under it having less effect on the system at large than general narcosis; in its being permissible to give nourishment, if required, immediately this operation is over, and in the elimination of post-operative bronchitis and pneumonia. Its disadvantages lie in the accessory and after-effects; these depend on dosage and the quality of the preparation made use of, in the technique and the degree of elevation of the pelvis. At present it appears to be suitable for use in hospital only.

AUSTRIA.

Vienna, June 2nd, 1907.

HÆMOLYSIS.

MULLER gave a history of his experiments in conjunction with Landsteiner and Poetyl to the members of the Gesellschaft in order to confirm or disprove Wassermann and Plant's discovery that cerebro-spinal fluid from a paralytic mixed with syphilitic material, prevented hæmolysis in progressive paralysis, a phenomenon which they have denominated "complemental union." Müller told the members that he and his co-adjutors had come to the conclusion after careful observation that dementia paralytica lends itself more to this action of inhibited hæmolysis than any other of that class, such as dementia præcox, delirium tremens, &c. The cerebro-spinal fluid of the paralytic when used in larger doses than Wassermann used, also acts as an anti-hæmolytic. Müller found that this inhibition property, without any antiseptic, except the addition of ½ per cent. of carbolic acid, was always present, but it was destroyed by 80° centigrade—*i.e.*, 176 Fahr. The anti-hæmolytic action of Wassermann will be found a valuable diagnostic in paralytics arising from syphilis.

This inhibitory reaction can be obtained with the same intensity in the mixing of paralytic serum and syphilitic material by mixing the spinal fluid with an extract taken from "condylomata acuminata," which if treated in the same manner as the foregoing loses its effect.

The question still remains unsolved whether Wasserman and Plant's phenomenon will prove a specific for the disease, as any anti-syphilitic property could not be discovered by the experiments, but they must admit that the complemental reaction does exist.

Kraus also recorded his investigations which he had made along with Volk and Dermatology. They found that serum from normal people and serum from a syphilitic in the eruption stage when mixed with an extract taken from a primary chancre inhibit the hæmolysis; the normal serum when mixed has a similar value of 0.1 to 0.05 of inhibition. Further experiments proved that normal serum with the same value as Wassermann's acted as a specific for syphilis, which has been confirmed by Ranzi in the institute. Many sera alone are able to inhibit the hæmolysis without any addition of extracts, while others require extracts from normal organs. We may conclude then if Wassermann, Neiser and Bruck's theory of the complemental deviation be a specific for syphilis many other normal sera are quite as efficient.

PERTUSSIS AND BACILLUS.

Albrecht reported the result of his investigations of 200 cases of pneumonia following pertussis which died after varying periods. The sputa of 70 had been examined from beginning to end, and in every one the Eppendorf bacillus was present and cultivated. This bacillus was first introduced by Jochmann and Krause, which they denominated a saprophyte, but affirmed that it was more numerous in cases dying from whooping cough. Albrecht does not admit the common presence of the bacillus as in metastatic abscesses, meningitis, pericarditis, and peritonitis, the same bacillus is found in the dead body. Hitherto the Eppindorf bacillus has been confounded with the influenza, measles and pneumonia bacilli, as no morphological or biological distinction has been noted. Albrecht has injected into guinea pigs this whooping-cough bacillus, and has found the agglutinating power of high value which is obtained in one hour or 62° cent. He found this value to vary between 1 in 1400 and 1 in 600, while in the blood taken from a child suffering from pertussis it was nil. He considers it a potent organism, but in several cases of intravenous injection with bouillon he found endocarditis in the mitral valves, which he exhibited to the members, and from this morbid product he again cultivated the whooping-cough. Other fresh preparations showed yellow patches on the right side of the heart, on the liver, and acini of the kidney. The result is calcification, degeneration and necrosis of the vessels frequently met with in influenza, which may explain the alteration. Bordet a year ago, in a perfectly recent case of whooping cough, isolated the same bacteria which he believed to be the cause of the disease, but from the transitions we meet with in experiments it is difficult to decide with our present knowledge.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

CEREBRO-SPINAL MENINGITIS IN GLASGOW.—The outbreak of this disease is discussed by Dr. A. K. Chalmers, Medical Officer of Health, in a report to the Health Committee of the Town Council. There is a considerable volume of evidence that under average conditions cerebro-spinal fever is possessed of a limited range of infectivity; that it in most instances spreads through the agency of an intermediary, but that under conditions which tend to produce air impurity in confined spaces, it may assume the characters of an air-borne disease, like typhus or measles and attack a considerable proportion of the persons breathing the same air. The adult cases occurred mostly among the artizan section of the population. In such cases of the disease as were recognised the death rate was excessive. Of cases treated to a termination in hospital up to March 31st, 1907, numbering 312 male, 230, or 73.7 per cent., were fatal. Of the total cases 175 were verified bacteriologically and 145 died—82.9 per cent.; 137 were not bacteriologically identified, but on clinical grounds were regarded as cerebro-spinal fever, and of these 85 died, giving a rate of 62 per cent. The outbreak has consisted mostly of single cases in separate households distributed over a wide area. It occurs chiefly in children, and no common centre of infection is discoverable. It may be that the prevalent habit of kissing children is the method by which an organism is transferred to them from the "carrier" cases. At present we know little of the disease clinically, except in its most malignant forms. The disease appears to be diminishing in Scotland, the deaths for the week ending May 25th, being 28, as compared with 39 in the preceding week.

BRIDGE OF WEIR CONSUMPTION SANATORIA AND EPILEPTIC COLONY.—Mrs. Quarrier, the widow of the founder of this charity, writes that the new sanatoria block for 40 patients is now open, giving a total accommodation of 140 beds. The new ward has been alloted to men, and within the next two months it is hoped that there will be provision for children. The recently equipped epileptic colony is fully occupied by 30 male patients, and a donation has been received which will enable Mrs. Quarrier to open a similar one for young women. The Bridge of Weir Sanatorium is one of the best known and best organised charities in Scotland: it originated in an orphan home, and this part of its work still goes on prospering, there being at present 1,320 orphans under Mrs. Quarrier's care. Arrangements are made for settling suitable boys in Canada, and on March 30th a draft of 30 was sent there.

EDINBURGH HARVEIAN FESTIVAL.—The 125th Festival was held in the Royal College of Physicians on May 17th, when the oration was delivered by Dr. Dow, Dunfermline, who selected as his subject "The Evolution of Diseases." After this the annual dinner took place, Dr. Dow being in the chair. Dr. T. S. Clouston is the President-elect.

GLASGOW MEDICAL DISPENSARY.—A department for the treatment of mental diseases has been opened at this dispensary, Dr. Oswald, Superintendent of Gartnavel Asylum, having undertaken to supervise it.

BELFAST.

QUEEN'S COLLEGE.—During the four days from Wednesday to Saturday of last week the students of Queen's College assumed command of the city, and all sorts and conditions of men have been visiting the Athletic Ground Fete at the College. When the scheme for the better equipment of the College proved a success; the students came forward and asked for help to procure a proper athletic ground, and were promptly promised by Sir Donald Currie a quarter of the necessary amount, £5,000, if they could raise the remainder. Further, he gave them a piece of advice: to get the ladies to help them, and every married medical man in the city knows how well they have acted on the advice, for our wives have spent their time and our money without stint. The Fete was opened by Mrs. Wisely, Sir Donald Currie's daughter, the Marchioness of Londonderry presiding. The latter lady made an eloquent appeal for help, urging the necessity for a due consideration for athletics in the Collegiate life, and especially for cricket. On the second day the Fete was opened by the Dowager Marchioness of Dufferin, who delighted her audience with a most charming speech, referring to the late Lord Dufferin's long-continued interest in the College, and then to the present needs. Though the weather has been at its worst, ruining the outdoor entertainments, the Fete has been a great success, and promises to attain the object aimed at.

The Health of the City.—Dr. Gardner Robb believes that the worst of the epidemic of cerebrospinal meningitis is now over, as the number of cases is becoming steadily less each week. The deaths during the past quarter have been 154; 94 males and 60 females. This preponderance of males over females was entirely in the first five years of life, for between 5 and 20, 34 males died, and 37 females. The total deaths over 20 were only 19, and only 1 was over 40. No less than 83 of the deaths occurred after not more than three days' illness. The prosecutions begun by the authorities for breaches of the public health by-laws continue, and will no doubt in time do much good. Last week a publican was fined for keeping milk for sale in a vessel which was not thoroughly clean. Other summonses were for keeping pigs less than 15 ft. from a dwelling-house, and for carrying rubbish in a milk-cart.

Belfast Water Supply.—It may be remembered that when suspicion was thrown on the water supply of the city some months ago by Professor Symmers, Professor of Bacteriology in Queen's College, owing to some bacilli of the typhoid group which he had found in the water, several experts were hastily summoned from England to examine the water on behalf of the Water Commissioners. The chief of them was Professor Percy Frankland, whose report has just been made public. He "goes" in a manner more warmly human than coldly scientific for Professor Letts, of Queen's College, who gave evidence before the Health Commission on the water supply. He says that that evidence is based wholly on chemical standards, which might have held twenty-five years ago, but which have been profoundly modified by bacteriological science. Professor Letts replied in the next day's papers that he would answer fully later, but meantime wished to say that he was a chemist, and never professed to give anything but a chemical view of the question, and that from that point of view the water was far from satisfactory, and as for the modernity or otherwise of methods of examination, he pointed out that perhaps Professor Frankland was not quite as modern as might be expected, for his bacteriological examination took account of numbers only, and had no reference to the species of organisms found, and whether they had any relation to sewage pollution! It is a pretty scientific duel, and will be followed with interest by the medical profession in the city.

LETTERS TO THE EDITOR.

A PERINEAL HORN.

To the Editor of The Medical Press and Circular.

Dear Sir,—Messrs. Fannin and Co., of Dublin, have made to my design a simple instrument which may be called a perineal horn. It is practically the principle of the shoe-horn reversed. I have put it to many tests, and am convinced that by its use rupture of the perineum will become a complication of much less frequency. In every case in which it has been used, the perineum has never caused the slightest anxiety, and needles and sutures are now omitted from my midwifery bag.

The action of a perineal horn is that of a protector to the material tissues and a distributor of the pressure over the internal surface, preventing that initial rupture of the posterior wall of the vagina of which the perineal tear is only the outward and visible sign.

It will be observed that the rent generally takes place after the birth of the forehead, and occurs simultaneously with the elastic rebound of the perineum.

The perineal horn inserted between the child's face and the posterior vaginal wall takes all undue strain off the tissues, internal and external, and equalises the pressure, and affords a smooth surface along which the child's face glides. By manipulation, the pressure on the thinned outer margin of the perineum can be transmitted posteriorly.

I am, Sir, yours truly,

John F. Elliot, L.R.C.P. and S.I.

Indian Medical Officer, Verulam, Natal, S.A.

THE INTERNATIONAL NURSING CONFERENCE.

To the Editor of The Medical Press and Circular.

Sir,—The International Nursing Conference, to be held in Paris on June 18th, 19th, and 20th, organized by the International Council of Nurses, is already an assured success, and must do much to promote the *entente cordiale* between French nurses and those of other nations. Many distinguished nurses from Great Britain and Ireland and her Colonies, Germany, Holland, Denmark, Finland, and the United States of America, have signified their intention of being present, and eminent French men and women in the medical and nursing worlds are taking much interest in its organisation. Mons. Mesureur, Directeur de l'Administration Général de l'Assistance Publique, which controls 20,000 nurses in the Paris Hospitals, will, as President, open the first session of the Conference, with an address on "The Work of the Assistance Publique for Nursing Education." He will be supported by Dr. Bourneville, a veteran worker in connection with the laicisation of nursing in France; Mme. Alphen Salvador, who has established a training school for nurses in Paris on modern lines; Dr. Lande, Administrator of Civil Hospitals in Bordeaux; and Dr. Anna Hamilton, whose notable "Thesis on Nursing," is arousing the most earnest consideration for the care of the sick all over France.

Other Sessions of the Conference will deal with (1) "The Practical Training of Nurses," when Mrs. Bedford Fenwick, founder of the International Council of Nurses, will preside. (2) "The Public and Social Responsibilities of the Nurse." (3) Most interesting sessions will be those on "Professional Organisation," and the "History of the Professional Nursing Press." (4) "International Reciprocity." In all these sections various papers will be read and discussed.

The members of the Conference will be received by the Municipal Council of Paris at the Hotel de Ville, by Mons. Mesureur at the Salpêtrière Hospital, and at Chantilly by the Baroness James de Rothschild, and other invitations to visit hospitals and kindred institutions have already been received.

I am, Sir, yours truly,

M. Breay,

Hon. Treasurer.

431, Oxford Street, London,
June 1st.

THE ALCOHOL MANIFESTO.

To the Editor of the Medical Press and Circular.

Sir,—I am much obliged to Sir Edwin Perry, the Superintendent of Guy's Hospital, for pointing out a slight error in my letter of May 15th.

In the figures I quoted from the *Westminster Gazette* in proof of the declining use of wines and spirits at our general hospitals, it is interesting to note that these figures "relate to alcohol supplied to patients only."

The scientific value of this correction is of great importance to us as it distinctly separates the regulated prescription of alcohol for the treatment of disease, which I hope we all approve of, from the indulgence of "alcoholic drinks" day by day as a beverage. The profession does not manifest its approval of this even in moderation.—I am, Sir, yours truly,

F. Churchill, M.D., F.R.C.S.

Cranley Gardens, Queen's Gate, May 31st.

HOSPITALS AND THE WORKMEN'S COMPENSATION ACT.

To the Editor of the Medical Press and Circular.

Sir,—In cases where the insured is taken to a hospital for medical treatment, may I enquire if the hospital will not be entitled to claim the amount the Insurance Company will have contracted to pay for such medical treatment? I am, Sir, yours truly,

J. H. Carson,
A Governor of The Prince of Wales' General
Hospital, Tottenham.
26, Welbeck Street, London, W.

OBITUARY.

MAXWELL T. MASTERS, M.D. St. And., M.R.C.S., L.S.A.

We regret to announce the death of Dr. Maxwell Tylden Masters, of Ealing, from heart failure following pneumonia. Born at Canterbury in 1833, he was educated at King's College, London, and was admitted a licentiate of the Society of Apothecaries in 1854 and a member of the Royal College of Surgeons, England, in 1856. In 1862 he took the M.D. degree at St. Andrews, and from 1865 till 1868 was lecturer on botany at St. George's Hospital. He was also examiner in botany at the University of London. It was, however, by his connection with the *Gardeners' Chronicle*, of which he was editor for forty-one years, and his contributions to botanical literature, that he was best known. Dr. Masters was an Associate of King's College, a Fellow of a number of learned societies, including the Royal and the Linnean, was an Officer of the Order of Leopold, a corresponding member of the Institute of France, and an honorary or corresponding member of the principal horticultural societies of the Continent and America.

SPECIAL ARTICLE.

DROITWICH.

OPENING OF ST. ANDREW'S BRINE BATHS EXTENSION.

Droitwich was *en fête* on Saturday last, and with good reason. A further and more decided step forward has been taken in the development of the natural therapeutic resources of the town by the erection and equipment of large additional accommodation at the St. Andrew's Baths, and it was to celebrate the completion of this task that a large number of representative medical men, distinguished visitors, and pressmen were made the guests of the Mayor and Corporation. Everything that hospitality could do to make the visit a pleasant one had been thought out by the entertainment committee, and Droitwich and the surrounding country were, if the weather be excepted, seen under the most favourable circumstances. Most of the guests arrived on the Friday afternoon, and were comfortably housed in the various hotels; the rest came on Saturday in time for the opening ceremony. The latter was performed by the Earl of Coventry, who, in the course of his speech, remarked specially on the fact that whereas medical men send numbers of their patients to foreign spas, they seem chary of recommending similar establishments in their own country. The baths having been formally opened and a silver key in commemoration of the occasion presented to Lord Coventry by the Mayor, a very large company sat down to an excellent and particularly well served luncheon in the Salters' Hall. Among those present were the Earl of Coventry, Viscount Cobham, Mr. Cecil Harmsworth, M.P., Member for the Droitwich Division, Mr. Willis Bund, Chairman of the Worcestershire County Council, Mr. R. H. Amphlett, K.C., Recorder of Worcester, the Mayor of Abergavenny, Dr. de Havilland Hall, Dr. Hamilton Cumming, Dr. Shirley Jones, Dr. Robert Collie, Dr. Leonard Williams, Dr. Frank Collie, Dr. Foulds, and a large number of members of the Balneological and Climatological Society. After the usual loyal toasts Dr. de Haviland Hall proposed "Success to Droitwich," and mentioned that he and other London physicians who had had experience in their practice of the effect of Droitwich brine baths in certain rheumatic and gouty affections, entertained a high regard for them. Several of the other speakers dealt on the fact that Droitwich seemed to them to be insufficiently known to the medical profession, and they urged that the many advantages to be derived by invalids from a sojourn there should be brought more directly under the notice of practitioners. Dr. Shirley Jones, who replied for the local profession, dwelt on the general tonic and rejuvenating effect of the baths, particularly in elderly people. Many of the guests proceeded to put this advice to the practical test, and the baths were largely patronised by representatives of medicine and the press. Others took advantage of the opportunity given them by the Humber Company of seeing the neighbourhood. This enterprising firm sent over for the occasion four of their new type of motor-cars designed specially for medical men. The car is admirably adapted for the particular purpose for which it is built, all the requirements of a doctor being catered for in ingenious fashion. It is of 10-12 h.p., and runs with a smoothness and absence of vibration which contrast very favourably with the uneasy motion of many small cars of other types. All who used the Humber cars were enthusiastic in their praise, and we ourselves do not remember to have seen so many advantages combined in one car of moderate price.

A visit to Droitwich is something of an education both in history and in therapeutics. The town was well known to the Romans, but whether it served them as a bathing-station or as a salt manufactory is not known, but the remains of two Roman villas are still present to attest the importance of the neighbourhood in the opinion of the most pragmatical of nations. It is certain, however, that the Saxons recognised the commercial value of the brine, as in 816 a.d. Kenulph, King of Mercia, endowed the church at Worcester with ten salt furnaces at Droitwich, and all through the middle ages the industry of evaporating brine for the recovery of salt was carried on. The fact that there are medicinal virtues in the water was not recognised till 1832, and, curiously enough, it was Sir Charles, then Dr., Hastings, the founder of the British Medical Association, who was instrumental in founding the Royal Brine Baths. Since then there have been several enlargements and developments, but they have all been on a comparatively small scale, and the celebrations on Saturday last, it may be hoped, mark the inauguration of a new era in Droitwich history. For in its own way there is no spa in this or any European country with which Droitwich comes into competition, the nearest approach to its balneological advantages being presented by the Dead Sea, and the waters even of that notorious spot contain only a quarter of the amount of solid constituents that the brine of Droitwich possesses. Droitwich, then, is a spa *sui generis*, and while Harrogate may suit this sufferer, Homburg that, and Vichy the other, Droitwich is adapted by its unique resources for a special class of patient which is reached by none of them, and for that class it is invaluable. Droitwich brine contains the enormously high proportion of 22,250 grains of total salts to the imperial gallon, nearly 22,000 of which consist of sodium chloride, the bulk of the remainder being sulphates of soda and lime. The specific gravity is so high that in the hot swimming-baths the bathers float with the body and limbs raised well above the surface of the water, and in ordinary swimming the legs merely beat the air. A person can easily stand upright in the deep water without performing any movements except such as prevent his feet coming to the surface. What the "molecular bombardment" of such a water must be we can only faintly conceive, but if the ions in normal sodium chloride solution are a state of briskness, in Droitwich water we must suppose that the bather is exposed to a whirlwind of anions and kations compared with which the bombardment of Cronje's camp on the Modder River would be child's play. As the result of experiment it may be said that the sense of *bien-être* conferred by a brine bath is as unmistakable as the stimulation of the air of the Alps; as a matter of fact, it may be added that the testimony of invalids from certain affections, such as sciatica, is emphatic.

The St. Andrew's Baths, which it was the purpose of Saturday's function to speed on their way, are held upon trust under the will of the late Dr. Thomas Corbett, and it may be to this fact, or perhaps to the irony of fate, that they are inscribed with the singularly infelicitous motto for a health resort, *Deus pascit corvos*. It is, doubtless, salutary in a general way that the brevity of life should be kept before our eyes, but there are certain stages in chronic illness when such a thought is apt to have a depressing effect. Perhaps the trustees might be persuaded so to adapt the motto as to suggest the idea that the crows are intended to be employed on similar eleemosynary errands to those they carried out for Elijah when he lay by the brook Kedron.

REVIEWS OF BOOKS.

RECENT WORKS ON DISEASES OF CHILDREN.

The title of this work (*a*) gives a very inadequate idea of the nature of its contents, for it is really a wonderfully complete and able monograph on the subject with which it deals. The various diseases met with by the physician in children are accurately described, and stress laid on the differences which they present from similar diseases as they affect the adult. That this is necessary is soon impressed on anyone who has to deal with such a disease, for instance, as rheumatism in children. We think it a pity that the author has not laid more stress on eye-strain as a cause of disease in children. It seems to have been abundantly proved that many cases of migraine and epilepsy are greatly benefited if not cured by correction of errors of refraction, yet the condition is not even mentioned in connection with the latter disease. A description of the condition known as *status lymphaticus* might also have found a place in this edition, for it is one with which every physician dealing with children should be familiar, even though its recognition has up to the present been chiefly *post mortem*. We point out these deficiencies not in any captious spirit or with any desire to detract from the many merits of the book, but with the hope that they may be rectified in future editions which we have no doubt will soon be called for.

We have received from Messrs. Lippincott the fifth edition of Professor Rotch's well-known work on the diseases of children. (*b*) The book has been re-arranged and re-written, the principle alterations being made in the sections dealing with the care of premature infants, infant feeding, diseases of the gastro-intestinal tract, diseases of the nervous system, rheumatic fever, and the acute and chronic affections of the joints. Twenty-eight new photographs and radiographs have been added. Professor Rotch's work is such a standard authority on all things connected with the management of children in health and disease, that we need say nothing further about the present edition save that it more than maintains the high reputation possessed by its predecessors.

Messrs. Lippincott have also sent us a new work on the diseases of children (*a*) by Dr. A. C. Cotton, Professor of Pediatrics in the Rush Medical College, University of Chicago. This book although of considerably smaller size than is that by Professor Rotch, still contains a large amount of information on the different subjects with which it deals. The book is divided into two parts, the first of which treats of the anatomy, physiology, and hygiene of the developing period, and also contains a chapter devoted to congenital malformations; while the second part is devoted to the diseases of children. The arrangement adopted in the latter part seems to us to be very suitable. The first two chapters deal with diseases of the new-born; Chapters III., IV., and V., deal with disorders of digestion and diseases of the digestive system; Chapters VI. and VII. deal with diseases of the gastro-intestinal tract and of the liver; Chapter VIII. with diseases of the heart and pericardium; Chapter IX. with diseases of the respiratory tract; Chapter X. with diseases of the urinary and genital organs; and Chapter XI. with diseases of the nervous system. Then follow chapters on diseases of the bones and joints, blood, and glands; on the eye and ear; on specific infectious disease; on diseases of the skin; and, lastly, on general diseases such as diabetes and rheumatism. There is also an appendix dealing with sick-room hygiene. Dr. Cotton's style is, on the whole, good, and his manner of expressing himself is clear. His book teems with information, and we can heartily recommend it to all students and practitioners who desire a handy work on the diseases of children. In addition to expressing our approval of the subject matter of the book, we also desire to express our approval of the manner in which the book has been turned out by its publishers. In this respect it is a model of what such a book should be.

ST. BARTHOLOMEW'S HOSPITAL REPORTS (*a*).

This annual volume of reports is always a welcome addition to the library, and one looks forward to finding in it many things both interesting and instructive and, generally, as in the present instance, the anticipation is justified by the result. It is not possible in the space at our disposal to even enumerate the various articles which it contains, but we may safely say that every medical man will find something in it to interest him. Sir Lauder Brunton contributes an interesting communication on the treatment of disseminated sclerosis by full doses of sulphates. He was led to this idea by observing the similarity of the toxic action of some of the benzine compounds on frogs with the symptoms of sclerosis in man, and the slight toxic action of the sulpho-carbolates. He has not yet had sufficient opportunity of testing the treatment to enable him to speak dogmatically about it, but in the two cases in which it has been tried very marked improvement followed. Sir Lauder publishes his cases in hopes that others will give the treatment a trial, since it is simple and at all events can do no harm. Dr. Elmslie, in a very interesting paper, deals with the continuation of active rhachitic processes in the bones into the adolescent period and records three cases in which active rhachitic processes were present in the bones at the ages of nine, fourteen and fifteen years respectively. The diagnosis in these cases was established by X-ray examination of the bones. The paper also contains a tabulated list of the recorded cases. The statistical tables of the patients treated in the wards of the hospital during the year 1905 are issued with the volume.

(*a*) "Aids to the Diagnosis and Treatment of Diseases of Children." By John McCaw, M.D., Physician to the Belfast Hospital for Sick Children. Third Edition. London: Bailliere, Tindall and Cox, 1907. 8vo., pp. xiv. and 385. Price 4s. 6d.

(*b*) "Pediatrics: the Hygiene and Medical Treatment of Children." By Thomas Morgan Rotch, M.D., Professor of Pediatrics, Harvard University. Fifth Edition, rearranged and rewritten. Illustrated by numerous engravings and coloured plates. Pp. xxv. and 1,060 London: Lippincott and Co.

(*a*) "The Medical Diseases of Infancy and Childhood, with points on the Anatomy, Physiology, and Hygiene Peculiar to the Developing Period." By Alfred Cleveland Cotton, M.D., Professor of Pediatrics, Rush Medical College, Chicago, &c., &c. Pp. xvii., and 670. With numerous illustrations. London: Lippincott and Co. 1906

(*b*) "Saint Bartholomew's Hospital Reports," Vol. XLII. Edited by A. E. Garrod, M.D., and W. McAdam Eccles, F.R.C.S. London: Smith, Elder and Co., 1907. 8vo., pp. xxxii. and 248.

ANÆSTHETICS (*a*).

When Dr. Blumfeld's little book on anæsthetics appeared in 1902 we were able to accord it high praise. The second edition is now to hand, and it presents certain improvements. There is a fuller account than formerly of the various forms of chloroform inhaler, and there is also an account of ethyl chloride as a preliminary to ether. We are glad to note that ether is recommended to the beginner as the routine anæsthetic agent, and the dangers of chloroform are properly emphasised. These are points to which we have not always been used in the writings of authorities on the subject. In spite of his cautious attitude Dr. Blumfeld recommends chloroform in the extraction of a large number of teeth at one sitting; although experience will seem to be against the administration of chloroform under any circumstances for dental operations. Again, although (page 82) chloroform is prohibited for operations on tonsils and adenoids, at a later part of the book (page 98) it is recommended for operations on the nose, *with the patient in the sitting position*; this seems to us to be courting disaster. On the whole, however, the author's advice may be safely followed. His directions are clear, precise and practical. His writing, if not always in unimpeachable literary style, is at any rate not ambiguous, and we know no book more likely to be of use to the student or practitioner who requires a concise guide to ordinary anæsthetic work.

A SYSTEM OF MEDICINE. (*b*)

The first part of the second volume of the new edition of Allbutt and Rolleston's "System of Medicine" commences with an article by Professor James Ritchie, "on the General Pathology of Infection." This is followed by the continuation of the series of articles on "Infective Diseases of Established Bacteriology," which commenced in Volume I. These articles deal with glanders and farcy, anthrax, tuberculosis, streptothrix infections, actinomycosis, and syphilis, and are contributed respectively by Professor Sims Woodhead, the late Dr. John Bell, and Dr. Legge, Dr. Sidney Martin, Mr. Foulterton, Dr. Acland, and Mr. Jonathan Hutchinson.

The infective diseases of established bacteriology are followed by a further series of articles dealing with "Infective Diseases of Doubtful Nature." These articles deal with measles, German measles, scarlet fever, chicken-pox, small-pox, typhus fever, infectious coryza, whooping-cough, mumps, glandular fever, rheumatic fever, and the acute rheumatism of childhood, and are followed by others dealing with fevers communicable from animals to man. Amongst the contributors we notice the names of Dr. Dawson Williams, Sir John Moore, Dr. Eustace Smith, Dr. Acland, and Sir John McFadyean.

The last 200 pages of Part 1 are occupied by articles on "The Intoxications," and these deal with food poisoning, grain poisoning, alcoholism, opium, and other intoxicants, and metallic and other poisons.

The second part of Volume II. is issued as a separate volume, and is entirely new in arrangement and largely so in substance. All the tropical diseases and animal parasites have been grouped together, with the intention of forming a complete work on tropical medicine. In order to make the volume more complete special articles by well-known zoologists have been included.

This volume commences with an introduction by Sir Patrick Manson. Next comes a series of zoological articles on protozoa, mosquitos, blood-sucking flies, flies known to be concerned in the spread of disease, and ticks. Following this comes a lengthy series of articles dealing at considerable length with tropical diseases. The articles are contributed by, amongst others, Lieutenant-Colonel Leishman, Professor Thayer, Professor Ronald Ross, Dr. L. Sambon, Sir Patrick Manson, Dr. Andrew Davidson, Sir Joseph Fayrer, and Dr. Phineas S. Abraham. The volume closes with a series of articles on Animal Parasites and the Diseases they Cause, and includes such subjects as psorospermosis, worms, and hydatid disease.

There can be little difference of opinion as to the great improvement which the editors have effected by dividing Volume II. into two parts and by the system of rearrangement which they have adopted. The entire work is a notable addition to British medical literature and redounds to the credit of its editors and contributors.

THE SURGERY OF THE RECTUM. (*b*)

The "Surgery of the Rectum" is undertaken by Mr. Wallis, the author, with the idea of presenting this subject in a practical and condensed form for the guidance and help of young surgeons and practitioners.

The work is divided into thirteen chapters. The first five of these, the writer states in his preface, are his original views of the cause and treatment of most of the inflammatory affections in and around the anus. These chapters discuss ano-rectal ulceration, pruritus ani, anal fissure, ischio-rectal abscess, and rectal fistula. Over 90 per cent. of cases of pruritus ani are due to small superficial ulcers below the internal sphincter, which when treated by cauterization cause a rapid disappearance of this troublesome condition. Chapter VI. deals at some length with hæmorrhoids. Of palliative methods of treatment, Mr. Wallis considers that an injection into the pile of 3 to 8 minims of 10 per cent. carbolic acid in glycerine and water is perhaps the best. Whitehead's operation is described fully in the text as being the only radical treatment for hæmorrhoids. Chapters VII. to X. are devoted to prolapse, ulceration, strictures, and growths in the rectum. Chapters XI. and XII. describe the operative procedure in excision of the rectum and in colotomy. The last chapter is a short one on the diagnosis of rectal disease.

"The Surgery of the Rectum" contains short clinical histories of cases, exemplifying symptoms accompanying the diseases described. This constitutes a useful feature in the book. The work is remarkably free from anatomical and pathological details, which doubtless is an advantage when brevity is an object in view. This omission is in a great measure compensated for by a number (55) of very excellent diagrammatic drawings and illustrations by Miss E. Stone, and by Mr. S. A. Sewell, the well-known pathological artist. They very graphically portray the appearances and anatomical situations of various morbid conditions and operative procedures.

Medical Societies' Conversazione.

The Medical Society of London last week at its rooms in Chandos Street, Cavendish Square, gave a reception which was attended by fellows and members and their visitors to the number of about 200. In the absence through illness of the President, Mr. C. A. Ballance, the guests were received by Sir John Tweedy and Sir Edgcumbe Venning, of whom the first named made sympathetic reference to the loss sustained by the society through the death of Sir Joseph Fayrer, one of its most distinguished past presidents. Following the custom which has prevailed for a century the oration, which is delivered in alternate years by physician and surgeon, was given by Dr. George A. Gibson, taking for his subject "The Cause of the Heart Beat." A highly successful conversazione with music followed.

(*a*) Medical Monograph Series, No. 7. "Anæsthetics: A Practical Handbook." By J. Blumfeld, M.D. (Cantab.). Second Edition. London: Bailliere, Tindall and Cox, 1906. Pp. 117. Price 2s. 6d.

(*b*) "A System of Medicine by Many Writers." Edited by Professor T. Clifford Allbutt, M.D., F.R.S., Regius Professor of Physic in the University of Cambridge, and H. D. Rolleston, M.D., Physician to St. George's Hospital, and to the Victoria Hospital for Children. Vol. II., Part I, pp. xii. and 1087; and Part II., pp. xvi. and 1,055. London: Macmillan and Company, Limited. 1907.

(*a*) "Surgery of the Rectum." By Fred C. Wallis, B.A., M.D., B.C.Cantab., F.R.C.S., Surgeon to Charing Cross Hospital, St. Mark's Hospital, and the Grosvenor Hospital for Women and Children. London: Bailliere, Tindall and Cox. 1907. Pp. viii. and 168. Price 6/- net.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT GYNÆCOLOGICAL LITERATURE.

Prophylaxis and Treatment of Post-operative Phlebitis.—Brothers (*Amer. Jour. of Obst.*, May, 1907). Strictly speaking, we cannot dissociate phlebitis and venous thrombosis, both together constitute the clinical entity which we ordinarily understand as post-operative phlebitis. An injury to a vein is the most frequent direct cause of phlebitis; whereas the absorption of septic fluids from contiguous structures that are septic is the common indirect cause. Thrombi result from alteration of the endothelium of the vein in the vast majority of cases; accessory causes include the presence of micro-organisms and their products in the blood; clots carried from other parts and acting as foreign bodies; necroses, gangrene, inflammatory and degenerative processes occurring in and about the vessel walls. The Mayos and others believe that inaction due to prolonged rest in bed, combined with low blood pressure, plays a very important *role* in the ætiology of post-operative phlebitis. Excluding direct injury to a vein or its involvement as a result of cellulitis in its vicinity, we face two conditions in the study of the prophylaxis of post-operative phlebitis, sepsis and blood retardation. Next to asepsis comes the question of the importance of rest in the prophylaxis of post-operative phlebitis. Given a case of suppurative appendicitis or adnexitis with a drained wound, we are unanimous in advising rest in bed. Beyond this point we reach the "parting of the ways." "If, after an aseptic operation with closure of abdominal incision without drainage, the surgeon is convinced that:—phlebitis always precedes and induces thrombosis, the only safe rule is to keep his patient in bed during the time which this complication is likely to occur, two or three weeks. If, on the other hand, one feels in this class of cases retardation of the blood current is one of the chief factors in producing coagulation, and, later, thrombosis and phlebitis, and questions the possibility of infection after aseptic work, the logical indications will be early movement and early removal from bed. After reviewing the statistics and reports of Ries, Boldh, and Hertoz from Landau's clinic in Berlin, the author summarises as follows: (1) Careful asepsis and antiseptic detail; adequate drainage in purulent or infected conditions, using the Fowler position to carry out this end. (2) In aseptic, non-purulent intra-abdominal conditions which are submitted to other than fixation operations, the occurrence of post-operative phlebitis will be reduced in frequency by getting such patients out of bed before the end of the first week. In regard to the treatment of phlebitis, rest, elevation of the affected limb, and an icebag meet the indications. F.

Mesosigmoiditis and its Relations to Gynæcological Affections.—Emil Ries (*Amer. Jour. of Obst.*, May, 1907). Mesosigmoiditis is a condition of chronic inflammation of the connective tissue, as well as the peritoneal covering of the mesentery of the sigmoid flexure. This chronic inflammation leads to shrinking of this mesentery and shortening of the base of the mesosigmoid. The sigmoid is thereby hindered in its normal free excursions, and becomes a fertile source of grave and sudden danger. Of the causes of this condition, two are firmly established in the ætiology—one the so-called Groser's diverticula in the sigmoid, the other, chronic inflammatory conditions extending from the neighbouring structures, particularly the rectum and the female sexual organs. Fæcal matter entering Groser's diverticula, stagnates there and may lead to inflammation, ulceration, and sometimes even perforation. The consequence of the absorption of septic material from these diverticula is the cause of the chronic inflammation of the meso-sigmoid. Mesosigmoiditis by extension of inflammation occurs in connection with prostitis, stricture, or ulceration of the rectum, chronic inflammation of the left appendages, or of the tumours of the latter leading often to adhesions of these organs to the mesosigmoid. The symptoms are not, as a rule, very marked; they consist mainly of constipation, flatulency, and more or less pain in the region of the sigmoid. Patients often complain of a feeling of stiffening in the bowel, localised bloating, with acute sharp pains in this locality. But, as a rule, the symptoms are not sufficient for a reliable diagnosis, until, perhaps, a typical ileus develops, due to volvulus of the sigmoid to which the mesosigmoiditis has given the predisposition, and then the patient's previous history becomes illumined by the pathological condition found in the operation for relief. F.

Induction of Labour in Prolonged Pregnancy.—McKerron (*Jour. Obst. and Gynæco.*, May, 1907.) Making allowance for possible errors of calculation, there would seem to be no doubt that the duration of pregnancy exceeds the physiological limit of 285 days in about 2 or 3 per cent. of cases. When pregnancy is unduly protracted, effects are produced which have an unfavourable influence on the course of labour, and which involve increased risk for both mother and child. (1) The child is longer and larger than normal. (2) The circumference of the head is usually greater, while the cranial bones are unduly ossified and do not mould so readily as in the normal fœtus. (3) In excessive intra-uterine development the shoulders, as pointed out by Herman, are larger in comparison with the head than is normal. Owing to the difficulty of extraction, the child is liable to be lost, but death not infrequently occurs *in utero* before the onset of labour. A possible explanation of this is that the thrombotic changes in the placenta, which normally precede labour, may become so advanced as seriously to interfere with the fœtal circulation and lead to the death of the child. Prolonged gestation presents danger to the life of the mother, from over-distension of the uterus and fatty degeneration of the uterine walls, leading to uterine inertia, and tendency to post-partum hæmorrhage. The treatment consists in the induction of labour, where there is clear evidence that pregnancy has exceeded the physiological limit, and that its further continuance may lead to serious difficulties. F.

Paralysis of the Intestine with Regurgitant Peristalsis following Delivery.—Robert Jardine (*Jour. Obst. and Gynæco.*, May, 1907). The writer records a case of very difficult forceps delivery occurring in a four-para, æt. 28, full time. The retraction ring was apparent, and the child weighed 9¾ lbs. The day after delivery the patient was sick, and vomited some dark-coloured bilious material. She complained of abdominal pain, and there was considerable distension, especially of the stomach and colon. Urine was passed involuntarily, the bowels did not act. The temperature ranged from 99° to 99.8.; pulse 84-110. Next day the vomiting was incessant, of a dark material, with a faint fæcal odour. The abdomen was much distended, rigid, and painful on pressure. Temperature, 97.6°—98.2°., and the pulse 92—116. The stomach was washed out every third hour with normal saline solution, and several basinfuls of dark pultaceous material with an admixture of bile and altered blood were flushed out at first; at the fourth washing the fluid was comparatively clear. A turpentine enema had no effect, but in the evening flatus was passed freely and a well-formed motion. On the third day the patient was much improved, there was no sickness, and abdominal distension had decreased. Henceforth the recovery was rapid. The general treatment adopted consisted of a turpentine enema daily, linseed-meal poultices to relieve pain, champagne half-ounce hourly, strychnine hypodermically 1-60th gr. every fourth hour, nutrient enemata, and peptonised milk was begun on the fourth day. By the sixth day she had regained complete control over her bladder. F.

A Contribution to the Operative Treatment of Chronic Inflammatory Diseases of the Adnexae through Ventral Laparotomy is made by Esch (*Zeitschrift für Geb. und Gyn.* Bd. LIX, Hft. 1).—Patients suffering from these diseases are only operated on in Olshausen's Klinik when all conservative methods of treatment have failed. In cases of pyosalpinx the period since infection must be about nine months. The removal of the diseased adnexae is accomplished either by first tying off the broad ligament with three ligatures, or according to Henkel's method by which the interstitial portion of the tube is extirpated, and the mesosalpinx immediately under the tube is cut through, then after ligature of the ovarian artery the peritoneal wound is closed with a continuous catgut suture. Flushing out the abdominal cavity is never practised, even when it has been soiled by pus. It is important that the field of operation should be made as dry as possible before the abdomen is shut. In the 2½ years from January 1st, 1904, to June 31st, 1906, 83 women were operated on, 63 on account of unilateral or bilateral pyosalpinx and 20 for hydrosalpinx or simple salpingitis. Among the cases of pyosalpinx, there was no rupture of the tubes during removal in 23 patients, and the mortality was nil. Rupture occurred in 40 cases, 12 of those being complicated with ovarion abscesses. Among the 28 cases which were not thus complicated, there were five deaths of which two may be accounted for by the infection of the peritoneum by the pus. For only two patients was drainage adopted. They both recovered. The mortality among the 83 cases was 7.2 per cent. When one compares both methods of operation as regards exudate formation, having added the 20 cases operated on for non-purulent disease, in 53 cases with stumps projecting into the peritoneal cavity, exudates arose 17 times, while among 21 operated on by Henkel's method, an exudate could only be discovered in one case. G.

Diffuse Adenoma of the Myometrium.—According to Schütze (*Zeitschrift für Geb. und Gyn.* Bd. LIX, Hft. 1) the diffuse deep adenomatous new-growths in the myometrium are so rare, that there are only 14 cases on record. In this paper the author describes three new cases. The age of the patients varied between 46 and 50 years. Two had had several confinements One was a nullipara. Two of them suffered from profuse metrorrhagia, and one from severe menorrhagia. Repeated curettage only succeeded in temporarily lessening the hæmorrhage, although microscopical examination revealed each time nothing but benign hyperplastic endometritis. Definite cure could only be produced by extirpation of the diseased organs. The author comes to the following conclusions. Deep diffuse endometrial growths in the myometrium of old women produce a definite disease of unknown ætiology. The severe clinical symptoms require extirpation of the diseased organ. Anatomically it consists of an infiltrating and destructive growth of hyperplastic mucous membrane into the peripheral layers of the myometrium. Even though neither extension into the neighbourhood of the uterus, nor the formation of metastases have so far been observed, one must consider this morphologically benign overgrowth of the endometrium as a serious disease, and as an early stage of adeno-carcinoma of the uterine body wall. G.

Experiments Regarding Artificial Sterilisation of Women are recorded by Offergeld (*Zeitschrift für Geb. und Gyn.* Bd. LIX, Hft. 1.)—The experiments were conducted on bitches, cats, and rabbits, who at the time of experiment were certainly not pregnant. After opening the abdomen the tubes were ligatured, or they were cut through or crushed with or without the addition of a catgut or silk ligature. Healing followed in every case without disturbance. At the succeeding rut the animals were paired and kept under observation to see if pregnancy ensued. The results were that none of these procedures were sufficient to prevent conception. The only certain method of sterilisation is to remove the tubes completely having resected the interstitial portions from the uterus. The openings so produced must then be closed carefully. G.

Pseudo-Carcinomatous Infiltration of the Intestinal Wall with Inflammatory Diseases of the Adnexae.—Füth (*Monatssch für Geb. und Gyn.* Bd. 25, Hft. 3) describes a case in which during a laparotomy for tumours of the adnexae a great thickening of the intestinal wall was revealed which was thought to be carcinomatous. Examination afterwards showed that it was only an infiltration of the intestinal wall. In a second case there was in addition to a myomatous uterus, and a tumour of the right ovary and tube, a tumour the size of a pigeon's egg in the sigmoid flexure. It was considered to be carcinomatous and was removed. Microscopical examination of the resected portion of the intestine proved it to be only a small celled infiltration. In a third case the author operated on a left-sided pyosalpinx which was firmly adherent to the sigmoid flexure. The latter was most suspiciously infiltrated in quite a circumscribed manner. Remembering the former cases the author decided not to resect the intestine. Only an appendix epiploica was removed which proved microscopically to be benignly infiltrated. The patient recovered completely after the operation. On the other hand the author relates the history of a case operated on by Sänger, where in the same manner with tumours of the adnexae an infiltration of the rectum was found which at the time was considered to be benign. Three months later carcinoma high up in the rectum was diagnosed. G.

Pubiotomy in Private Houses.—Sigwart (*Zentralbl für Gynäk*, March 20th, 1907) records five cases in which he did this operation among the poor of the extern maternity department of the Charité in Berlin. Three cases were operated on by the light of a kitchen lamp, two in daylight. The first case was a IV gravida without a living child. Conj. vera. 7 cm. a rachitic flat pelvis. Vertex presentation. The indications for operation were prolonged powerful labour, fœtal heart becoming bad, retraction ring rising very high, only a small segment of the head through the brim. The pelvis separated to a distance of 6 cm., the woman delivered herself very easily. The child was 52 cm. long, circumference of the head 36 cm. From the 4th to the 7th day there was a slight rise of temperature. The patient was up after the third week. The second case was a I gravida. Flat rachitic pelvis. Conj. diag. 9½ cm. Labour began at 3 a.m. December 10th, 1906. Membranes ruptured at 5 p.m. December 11th. Vertex presentation. Head mobile above the brim in spite of very strong contractions. 7.30 p.m. pubiotomy. The pelvis separated at first 2 cm., but during the pains as the head descended it separated 4 cm., only to close up again after the pain ceased. At 2 a.m. next morning the patient delivered herself. Child 51 cm. long, circumference of head 36 cm. Puerperium free from fever except for a temp. of 38.9 on the evening of the sixth day. The patient, who got up on the twentieth day, walked to the hospital on the twenty-fourth. Third case, a II gravida. First child dead after three days labour. Rachitic flat pelvis. Conj. diag. 9 cm. After very prolonged labour, as the mother's temp. was 38.5, pulse 110, and the liquor amnii was smelling badly, pubiotomy was performed as only a very small portion of the head had moulded through the brim. The child was delivered with forceps. In this case, during the puerperium an abscess developed which pointed at the left side of the posterior wall of the vagina. When it was emptied the patient rapidly recovered. The fourth case, a V gravida. The third child was delivered with high forceps and still lives. The others were stillborn. Rachitic flat pelvis. Conj. diag. 9 cm. In spite of very powerful labour the head did not enter the pelvis, and as the fœtal heart fell to below 100, pubiotomy was performed. The child was delivered with forceps. Convalescence uneventful. The fifth case, a IV gravida, without a living child. The first child was perforated, the second pregnancy ended in abortion at the fourth month. The third child was perforated. Flat rachitic pelvis. Conj. diag. 9 cm. Transverse presentation. Pubiotomy was performed, and the child turned and extracted. Puerperium uneventful except for an evening temp. of 38. from sixth to tenth day. The patient got up on the twentieth day. The five children were delivered alive, and all survived except the second, which was killed by an accident on the evening of the second day. The women were all able to walk without pain, none of them suffered any pain other than the ordinary labour pains when delivering themselves after the bone was cut. G.

Medical News in Brief.

The Royal College of Surgeons in Ireland—Election of Officers.

The annual meeting of the College was held on Saturday, June 1st, when a very favourable report was submitted to the Fellows. During the year 17 candidates having passed the examinations, were admitted to the Fellowship; 73 candidates, having passed the conjoint examination with the Royal College of Physicians, received the Diploma in Surgery and Midwifery; 29 candidates, having passed the conjoint examination with the Royal College of Physicians, received the conjoint diploma in Public Health; 10 candidates, having passed the examinations, received the licence in Dental Surgery; 64 candidates, having passed the conjoint preliminary examination with the Royal College of Physicians, received certificates.

The obituary list showed the death of six Fellows, 51 Licentiates, and 3 Licentiates in Dental Surgery. There are at present living 15 Honorary Fellows, 466 Ordinary Fellows, 2,908 Licentiates, six Honorary Diplomates in Public Health, 269 Ordinary Diplomates in Public Health, and 531 Licentiates in Dental Surgery.

The annual election of officers of the College was held on Monday last, when Mr. H. R. Swanzy and Mr. John Lentaigne were respectively re-elected president and vice-president for a second year. The following were elected on the Council:—William Stoker, Sir Charles A. Cameron, John B. Story, Sir Charles B. Ball, Sir Thomas Myles, Sir Arthur Chance, Richard D. Purefoy, Sir Lambert H. Ormsby, Henry G. Sherlock, R. Bolton McCausland, R. John S. M'Ardle, Robert H. Woods, R. Lane Joynt, Thomas Donnelly, William Taylor, Edward H. Taylor, R. Charles B. Maunsell, William Ireland Wheeler, and D. Edgar Flinn. Among the new candidates which came forward for election were:—Lieutenant-Colonel Edgar Flinn, Mr. Louis A. Byrne, Mr. F. T. Porter Newell, Mr. R. Lane Joynt, Mr. Thomas E. Gordon, Mr. Louis Werner, Mr. H. W. Oulton, Mr. Robert J. Harvey, Mr. Thomas O'Connell Redmond, Mr. George P. Meldon, and Mr. Andrew Charles. Of the existing members of Council, Dr. E. H. Bennett has retired on account of very serious ill-health, and Mr. Jameson Johnston has been elected a member of the Court of Examiners and is consequently ineligible.

Royal College of Surgeons of England—Annual Election.

The annual election to the Council of the College will take place on Thursday, July 4th next. The retiring members of the Council on this occasion are:—Sir John Tweedy, Mr. Mansell Moullin, Mr. Herbert Page and Mr. Frederic Eve. Sir John Tweedy was to have retired in the year 1904, but being president, retained his seat on the Council in accordance with custom until vacating the president's chair. Both Mr. Moullin and Mr. Eve were last elected as substitute members of the Council, the former for the late Sir William MacCormac and the latter for the late Mr. T. R. Jessop. It is understood that Sir John Tweedy does not intend to offer himself for re-election. The other three candidates, however, stand for re-election, and there are at present three intending new candidates, viz.: Mr. Bruce Clarke, Surgeon to St. Bartholomew's Hospital; Mr. Charles Higgens, Consulting Ophthalmic Surgeon to Guy's Hospital, and Mr. W. D. Spanton (Hanley), Consulting Surgeon to North Staffs. Infirmary. Voting papers will be sent to each Fellow of the College without application in the United Kingdom whose address is registered at the college. The poll will be open at the College between the hours of 3 and 5 for personal voters.

The Irish University Bill.

The Prime Minister announced in the House of Commons on Monday night that this contentious measure would be dropped for the present Session, but Mr. Birrell would give special attention to the Irish University question during the recess, with a view to legislation next year.

Asylum Workers' Association.

The annual general meeting of the Asylum Workers' Association, founded in 1895 to improve the *status* of asylum nurses and attendants, and to enlist public sympathy in their work, was held last week at the Medical Society's house, 11 Chandos Street, W. Sir William Collins, M.P., was elected president of the association, and in his presidential address said that he could conceive no calling in which active sympathy was more needful or more helpful, and at the same time, perhaps, more difficult to maintain and to retain and to cultivate, than that of the asylum worker. Asylum workers had by taste or inclination embarked on a calling demanding no mean attainments if their work was to be well done; their services to the State were accordingly ranked high. The State or municipality should see to it that such work was justly recognised and adequately requited. The hours of duty should not be excessive. The strain was great in the acute wards, and the tedium of the chronic demented was no less exhausting. He had done his best in other capacities to foster the scientific study of the pathology of insanity. He carried through the London County Council a proposal for a laboratory at Claybury Asylum, and assisted in equipping it, and he rejoiced that, under Dr. Mott, that laboratory was adding to their knowledge of the dark continent of mental disease. He moved the adoption of the report. The Bishop of Croydon, in seconding, said the insane suffered from morbid sensitiveness and, therefore, it was necessary that they should have nurses and attendants who did their very best, morally as well as physically, to minister to their wants. Two gold and silver medals were afterwards presented by the president for long and meritorious nursing service.

Stauts Lymphaticus.

Dr. R. L. Guthrie, Deputy-Coroner, held an inquiry at Shoreditch, on May 22nd, respecting the death of Frank G. S. Scott, æt. six months, the son of a packer.

The mother stated that the child was one of twins and was perfectly healthy up to Monday. She fed him shortly before six o'clock on Monday morning, and a few minutes later noticed he had changed colour. He died shortly afterwards.

Dr. Rustun Coolawalla stated that he had made a *post-mortem* examination, and he attributed death to an excess of lymphatic growth, which predisposed individuals to death from trivial causes. It was a case of status lymphaticus. In answer to the Coroner witness said that he was of opinion that the child had been partially suffocated. The slightest pressure over the face in such a child would be fatal. The Coroner: From a medico-legal point of view this is very important. A man might be charged with "murder" or "manslaughter" through giving another a slight blow, and the medical man who by chance overlooked this status lymphaticus would be losing a valuable point for the defence. The doctor further stated that a child suffering from the complaint might be killed by being put into a cold bath, and would be more liable to succumb to any slight ailment. The jury returned a verdict to the effect that the child was "accidentally suffocated while suffering from status lymphaticus."

Curious Epidemic at Prestwich.

A DISEASE, which is at present epidemic at Prestwich, is said to be puzzling the medical men there. The illness begins with swelling and soreness in the throat, which causes difficulty in breathing and loss of voice, and the symptoms are accompanied by a rapid rise of temperature, sickness, loss of appetite, and weakness Dr. Stephenson, the medical officer of health for Prestwich, estimates that there are now a hundred and fifty people in that district suffering from the malady. Fresh cases are reported daily, and at least three hundred persons, mostly children, have been attacked. Fortunately the illness runs its course rapidly, and does not appear, if rightly treated, to be fatal. Dr. Stephenson thinks the disease is probably air-borne. Bacteriological tests made at Manchester University show that the ailment is caused by a very minute globular bacillus which settles in the throat, causing irritation and swelling.

Room for Medical Men in South Africa.

So great is the dearth of medical men in South Africa, reports *The Express*, that an advertisement of a vacancy on the resident staff at Kimberley Hospital, carrying a salary of £300 a year, with board and quarters, did not bring a single application.

Royal Medical Benevolent Fund Society of Ireland.

A QUARTERLY meeting of the Central Committee of this Fund was held at the Royal College of Surgeons on Wednesday last, Dr. Richard Hayes in the chair. It was unanimously resolved that the best thanks of the Central Committee be given to Dr. Redmond, President of the Royal College of Physicians, for his generous donation of £21 to the funds of the society.

Hospital for Sick Children, Great Ormond Street, London.

THE following is a list of lectures, which are free to medical practitioners, to be delivered during June and July on Thursdays, at 4 p.m.:—June 6th, Mr. Corner on "Torsion of the Testicle"; June 13th, Dr. Voelcker on "Enlarged Abdomens"; June 20th, Mr. Kellock on "Affections at and about the Umbilicus"; June 27th, Dr. Garrod on "Diabetes in Children"; July 4th, Dr. Still on "Bilious Attacks in Children"; July 11th, Dr. Thursfield on "The Diagnosis, Prognosis, and Treatment of Pleural Effusions in Children"; and July 18th, Mr. Lane on "Fractures."

Women's Health Society.

At Christ Church Vicarage, Forest Hill, at the invitation of Mrs. C. R. Bailey, a number of ladies assembled on May 29th to hear a lecture by Dr. Marion Hunter, one of the London County Council medical inspectors of schools on "The Hygiene of Child-life and its Effect on National Physique." The gathering was arranged under the auspices of the Borough of Lewisham Women's Health Society, the president (Mrs. G. S. Warmington, of Lee) presiding.

The Sanitas Company.

AT the annual meeting of this company, whose disinfectants are so well-known and appreciated by the medical profession held on Wednesday last, the Chairman, Mr. Kingzett, F.I.C., referred to the uninterrupted progress of the company side by side with that of sanitation during the past quarter of a century, the sales of their various manufactures having exceeded those of any previous year. He drew special attention to two recent introductions which he had made, viz.: "Bacto:." a very powerful germicide, having a co-efficiency of about thirteen times that of pure carbolic acid, and "Okol," which he considered the most powerful germicide yet produced, having a co-efficiency on the B. typhosus test of 22 as compared with carbolic acid. It may be added that the company has acquired larger premises in which to carry on their manufactures and that the usual dividend of 7½ per cent. per annum was declared.

PASS LIST.

Royal (Dick) College of Veterinary Surgeons.

AT the recent sitting of the Examining Board of the Royal College of Veterinary Surgeons held at the Royal (Dick) Veterinary College, Edinburgh, the following students passed their several examinations:—

First (or Class A) Examination:—William Aitken, Edinburgh; Haylett Allison, Ballarena, Co. Derry, second honours; J. L. Cormack, Colinton, Mid-Lothian; J. N. Cooper, Ballymoney; S. C. Currey, Workington, second honours; M. G. Fox, Atherstone, second honours; Hugh Fraser, Inverness; J. R. Greig, Leith; J. B. Idle, Harrowgate; R. C. W. Lacey, London; W. S. Lornie, Newburgh, first honours; A. D. McGregor, Edinburgh, second honours; Thomas M'Clintock, Londonderry; C. E. M'Crea, Newry; John Nicol, Markinch.

Second (or Class B) Examination:—John Anderson, Caledon, County Tyrone; G. F. Banham, Cambridge; Frank Chambers, Dudley, Worcester, second honours; D. R. Crabb, New Aberdour; C. S. Hunting, Sunderland; John de Merza, London; W. M. Mitchell, Sunderland; G. T. S. Mower, Sheffield; J. A. M'Menamin, Mayherafelt; E. J. Nicholson, Budlington, Yorks; J. A. Robertson, Sydney, N.S.W., second honours; B. A. Searby, Louth; J. H. Spreull, Dundee; C. G. Thomson, Lurgan.

Third (or Class C) Examination:—William Brown, Banchory; H. D. Gilmore, Kircubbin, Co. Down; Charles Johnstone, Dumfries; J. R. A. Jones, Oswestry; William Kennedy, Whiting Bay, second honours; R. G. Linton, West Kensington, W.; Alex. Matthew, Edinburgh, second honours; R. H. Miller, Edinburgh; J. W. Morron, Coleraine, first honours; John Robson Bellingham, Northumberland; W. P. Ruthven, Kinross; P. T. Saunders, Hull; J. J. M. Soutar, Edinburgh; J. C. Storie, East Linton, Thomas Woods, Preston.

Class D, and were admitted members of the Royal College of Veterinary Surgeons:—James Anderson, Keith, Banffshire; James Andrew, Haddington; W. King Clark, Gullane, East Lothian; Frank Davidson, Gollanfield Jt., Inverness; W. A. Grant, Tomintoul, Banffshire; Peter Haugh, Kirkcudbright; Frank Macdonald, Portobello; J. Gillray McGregor, Greenock; Alex. Mackenzie, St. Andrews; F. W. Medlock, Inverness; Alex. Niven, Rothienorman, Aberdeenshire; Bruce Selous, Birmingham; L. L. Steele, Beckermet, Cumberland; John Taylor, Edinburgh, second honours: Thomas Wilson, Nantwich; A. M. Wylie, Kirriemuir.

The session just ended has been a most successful one, the members of the final year's class especially distinguishing themselves, 100 per cent. obtaining their diplomas; while the passes in the other classes has been exceedingly satisfactory. Students of the junior classes have now mostly left to see practice with veterinary surgeons during the summer, returning again at the opening of next session on October 1st.

A CONSULAR report from the Washington Bureau of Manufactures, contains the following: "The reports of the Public Health and Marine Hospital Service shows that in 1902 there were reported to the Bureau 55,857 cases of smallpox, with 1,852 deaths, while in 1906 there were 12,503 cases, with 90 deaths. The Bureau states that the result is due to increased diligence on the part of State and national authorities. In Germany, where vaccination is compulsory and universal, during the year 1906 there were only 26 cases, with five deaths in the whole empire, and these cases were largely imported."

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

R. H.—It is much wiser not to allow any animal in the room of a patient suffering from scarlet fever. Although no animal is known to suffer from the disease, a hairy animal, such as a pet Yorkshire terrier, might easily convey dried secretions in its coat to healthy children, and we cannot advise you to introduce any such source of danger into a household, even if the child be lonely.

Pestis.—Up to September last the deaths from plague in India (including native States) numbered 5,012,000. For the first three months of this year the numbers are: January, 58,438 deaths; February, 98,397; and March, 171,522. The Punjab, Bengal, Bombay, and United Provinces are those chiefly affected.

R. J. M. (Leeds).—Our correspondent will find all that he desires to know in the last (fourth) edition of Dr. J. A. Shaw-Mackenzie's work on cancer, published by Messrs. Bailliere, Tindall and Cox.

THE DECREASE OF MEDICAL STUDENTS.

Viator.—There appears to be a steady decrease in the number of students entering the medical schools of late; from the *Medical Register* for 1907 we learn that the number of medical men registered last year was only 444, against 545 in the previous twelve months, and 703 in 1901. With one exception (1899) the number was lower in 1906 than in any year during the last decade. The decline has been ascribed to the increased cost of medical education, and the outcry that the profession is overcrowded.

Dr. R. L.—Your letter is unavoidably crowded out "at press"; we hope to have space for it in our next.

Meetings of the Societies, Lectures, &c.

Wednesday, June 5th.

Obstetrical Society of London (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Dr. Longridge, Mrs. Scharlieb, The President (Dr. H. R. Spencer), and Dr. McCann. Short Communication: Dr. H. R. Andrews: Two cases of Pregnancy in a Rudimentary Uterine Horn. Papers:—Mr. H. T. Hicks: Primary Vaginal Embolic Chorion-epithelioma.—Dr. Griffith and Dr. Williamson: A Case of Chorion-epithelioma complicated by Hæmatometra.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. M White: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. F. W. Mott: The Causes of Insanity.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr Whipham).

Thursday, June 6th.

Neurological Society of the United Kingdom (11 Chandos Street, Cavendish Square, W.).—8.30 p.m.: Discussion on Posterior Basal Meningitis and its Relation to Epidemic Cerebro-spinal Meningitis (to be opened by Dr. F. E. Batten).

North-East London Clinical Society (Tottenham Hospital, N.).—4 p.m.: Clinical Cases.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique (Surgical.) 5.15 p.m.: Lecture:—Dr. F. W. Mott: The Causes of Insanity.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m. Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting). Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

University of Birmingham, Faculty of Medicine (Medical Lecture Theatre).—4 p.m.: Post-Graduate Lecture:—Dr. J. Miller: Opsonins.

Friday, June 7th.

West London Medico-Chirurgical Society.—8.30 p.m.: Papers:—Dr. A. W. Addinsell: Chronic Metritis.—Dr. D. Arthur: The Diagnosis of Chest Diseases by the X Rays. (Both papers will be illustrated by lantern slides.)

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Dr. H. Tilley: Clinique. (Ear.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—9.30 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

Dr. Steevens' Hospital.—Anæsthetist. Applications to the Secretary. (See advt.)

Manchester University.—Junior Demonstrator of Physiology. Salary £100 per annum. Applications to the Registrar.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon. Salary for six months £20, washing allowance £2 10s., with board and residence in the Hospital. Applications to the Secretary.

City of London Hospital for Diseases of the Chest, Victoria Park, E.—Resident Medical Officer. Salary £120 per annum, with board, etc. Applications to the Secretary.

Halifax Union Poor Law Hospital.—Resident Medical Officer. Salary £105 per annum, with apartments, rations, and washing. Applications to Arthur T. Longbotham, Solicitor and Clerk to the Guardians, 4 Carlton Street, Halifax.

Corporation of the City and County of Newcastle-upon-Tyne.—Assistant Medical Officer of Health. Salary £300 per annum, with board, lodging, etc. Applications to the Medical Officer of Health, Town Hall, Newcastle-upon-Tyne.

Egypt.—Sub-Inspector of Ophthalmic Hospitals. Salary £500 a year, with two months' salary in lieu of travelling expenses to and from England. Applications to the Director-General, Department Public Health, Cairo.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—An Anæsthetist. An honorarium of 15 guineas. Applications to Stewart Johnson, Secretary. (See advt.)

Royal Albert Hospital, Devonport.—Resident Medical Officer. Salary £100 per annum, with apartments, board, fuel and lights, and laundry. Applications to the Chairman of the Selection Committee.—Chas. W. Dickinson (Capt. R.N.), Secretary, Royal Albert Hospital, Devonport.

Bradford Children's Hospital.—House Surgeon. Salary £100 per annum. Applications to C. V. Woodcock, Secretary, Bradford.

Brixton Dispensary.—Resident Medical Officer. Salary £150 per annum, with furnished apartments, attendance, coal and gas. Applications to the Secretary at the Dispensary, Water Lane, Brixton, S.W.

Appointments.

Bradley, Frederick H., M.B., Ch.B.Edin., Senior House Surgeon at the Liverpool Stanley Hospital.

Costouros, J. M.D., L.M., Clinical Assistant to the Chelsea Hospital for Women.

Crosby, Harry Mair, M.B., C.M.Edin., Honorary Surgeon to the General Hospital, Stroud (Gloucestershire).

Fleury, K. F., L.R.C.P. and S. Irel., Medical Officer for the Riverstown Dispensary District of Birr, King's County, Ireland.

Jubb, Archibald, M.D.Glasg., Extra Honorary Physician to the Royal Hospital for Sick Children, Glasgow.

Morris, William David Joseph, M.R.C.S., L.R.C.P.Edin., L.S.A., Medical Officer to the Cardiff Post Office (Eastern District).

Patrick, J. King, M.B., Ch.B.Glasg., Extra Honorary Physician to the Royal Hospital for Sick Children, Glasgow.

Russell, W. K., M.B.Glasg., Medical Officer and Public Vaccinator for the No. 1 (Ilminster) District by the Chard (Somerset) Board of Guardians.

Sibbald, Ian Graham, M.B., C.M.Edin., Medical Officer of Health by the Chard (Somerset) Rural District Council.

Stevens, Bertram Crossfield, M.S., M.D.Durh., F.R.C.S.Edin., L.R.C.P.Lond., Additional Honorary Anæsthetist to the Lancaster Royal Infirmary.

Treasure, William Beeson Crawford, M.D.Durh., M.R.C.S., L.S.A., Medical Officer to the Cardiff Post Office (Western District).

Vintras, G. C. Louis, M.D.Durh., Director of the French Convalescent Home at Brighton and of the Annexe for the Preventive Treatment of Tuberculosis.

Births.

Caie.—On May 30th, at 76 Guildhall Street, Bury St. Edmunds, the wife of W. J. Caie, M.A., M.B., Ch.B., of a son.

Gadsden.—On May 27th, at Newquay, Cornwall, the wife of A. H. Gadsden, M.R.C.S., L.R.C.P., of a daughter.

Holland.—On May 25th, at Grayswood Pines, Halsemere, Surrey, the wife of Henry F. Holland, M.D., J.P., of a son.

Ormerod.—On May 31st, at Redlands, Burgess Hill, Sussex, the wife of Charles E. Ormerod, M.D., M.R.C.S., of a son.

Schofield.—On May 29th, at 1 Phillimore Gardens, Kensington, the wife of S. Robert Schofield, M.B., of a daughter.

Sikes.—On May 28th, at 8 Manor House, Marylebone Road, London, the wife of Alfred W. Sikes, M.D., D.Sc., F.R.C.S., 57 Wimpole Street, London, of a son.

Marriages.

Fullarton—Page.—On May 28th, at St. Mark's Church, New Brompton, Chatham, Surgeon John Fullarton, M.B., R.N., Royal Marine Head Quarters, Chatham, to Margaret Alice, second daughter of the Hon. Alfred Page, of Hobart, Tasmania.

Lowis—Mackay.—On May 29th, at St. Paul's Church, Mill Hill, London, N.W., Alfred Edmond Lowis, Chamberlain of Argyll, Inverary, to Harriett Sealy, younger daughter of the late F. R. MacDonald, M.D., Inverary.

MacWatters—Richards.—On May 1st, at St. John's Church, Peshawar, Cecil MacWatters, M.D., Indian Medical Service, to Nona, youngest daughter of the late Dr. George Richards, of Ross-on-Wye.

Death.

Biden.—On May 28th, at "Penrith," Wallington, Surrey, George Henry Biden, L.R.C.P.Lond., aged 41 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, JUNE 12, 1907. No. 24

NOTES AND COMMENTS.

Professor Koch and Sleeping Sickness.

PROFESSOR KOCH is the most unfortunate of scientists; he is always making discoveries which are no discoveries. No one in a position to form a reasonable opinion doubts Koch's genius, but the channels by which his discoveries reach the public ear are so uniformly fallacious—that is the kindest word to use of them— that one is almost forced to believe that like Eliza Hawkins he has only himself to blame. His latest fiasco is the atoxyl business. A few months ago the newspapers were trumpeting forth a cure for sleeping sickness discovered by Professor Koch. English research workers had been studying sleeping sickness for years without finding a cure, whereas Koch and his party sent by the German Government lighted on one in a few months. Thus again was the superiority of the Teutonic science demonstrated. Atoxyl, the "cure" in question, it was subsequently pointed out, is a preparation of arsenic which had been introduced to Koch's notice by English medical men in East Africa, who, with their colleagues in Uganda, had been using it experimentally in the treatment of sleeping sickness for a long time. The only difference between the Englishmen and the German was that whereas the former knew that though atoxyl could control the disease powerfully for a time, the effect was not permanent; yet the scientific German jumped to the conclusion that it was a specific cure. Last week Colonel Bruce, Director of the Royal Society Commission for the Investigation of Sleeping Sickness, wrote to the *Times* that there is at present no evidence that a single case of sleeping-sickness has been cured by anything, and Colonel Bruce is a man who can speak out of full knowledge. Although we have a high regard for the scientific ability of the German race, we have a far higher one for the accuracy of our own scientists, and we hope that the present lesson will help to keep Professor Koch's enthusiasm confined to the pursuit rather than to the publication of knowledge.

The "Medical Press" and the "Beacon Light."

LIKE Byron, we have awakened to find ourselves famous. The June number of the *Beacon Light* in its leading article deals with the subject of "Throat Troubles," and lo! a *quondam* editorial utterance of ours is quoted as an authority. To those on whom the *Beacon Light* has not shed its effulgence we may remark that it is the official organ of the British Anti-Tobacco and Anti-Narcotic League, and they will promptly gather the cause of the throat troubles in question. The editor has discovered that the ills and diseases of the throat are increasing in an "assuredly alarming" fashion, and at the risk of being stigmatised as biased, he believes this result is the outcome of the universal habit of smoking. "True," says he, "physicians' reports and obituary records do not state this, but it is not an uncommon thing in these days to ignore or hide the real cause of disease and death." We agree that it is not usual to state in the obituaries of physicians whether they smoked themselves to death or not, but we hardly fancy the fact would escape record did it occur. The MEDICAL PRESS AND CIRCULAR is invoked because of the innocent statement that excessive, and in some cases even the moderate use of tobacco affects the pharyngeal mucous membrane, and that it would be desirable to know under what exact circumstances this occurs.. Such is no doubt the fact, but we are faced with the extraordinary paradox that while the yearly sales of tobacco go up by leaps and bounds, the death-rate in England and Wales is steadily dropping. Perhaps the editor of the *Beacon Light* could get together a committee to study the causes of this puzzling phenomenon.

Crutches for Cripple Children.

IT is very difficult to say "No" to a Lord Mayor of London during his year of office, and Sir William Treloar is making use of his occupancy of the civic chair in a way that appeals to all kind-hearted people by endeavouring to raise a fund of £60,000 to provide for the cripple children—some seven thousand in number—of the metropolis. One of the devices he is employing for this purpose is the production of a book on the lines of the well-known *Printer's Pie*, containing pictures and stories by well-known people. This book appeared last week at the moderate price of one shilling, and the charitably, and even the uncharitably, inclined may be assured that the investment of that homely sum will bring its full return in material value. *Crutches to Help Cripple Children* contains a large number of really beautiful three-colour reproductions of pictures by well-known and talented artists, one alone of which—The Brooklet—is well worth the money. Besides, the pictures there are some capital black-and-whites, and some sixteen contributions in prose and verse by such writers as Mr. W. S. Gilbert, Max Pemberton, George R. Sims, William Le Queux, and George Manville Fenn. If we could stop at this point we should have nothing but complimentary things to say, but when we look on through the advertisements and see the Lord Mayor's appeal made the medium for bombastic self-laudation on the subject of deformities by such people as "Dr. Walford Bodie" and "Sandow," we think the limits of good taste—to put it mildly—have been far exceeded.

Cape Medical Libel. WE have to congratulate—and we do so very sincerely—Dr. Darley-Hartley, editor of the *South African Medical Record,* and Chairman of the Cape Medical Council, on having successfully sued a local newspaper proprietor and a newsagency for publishing a libel. It seems that a Dr. Crozier-Durham had been brought before the Medical Council charged with unprofessional conduct, and the libel complained of in the defendant's journal ran thus: "If it comes to advertising, there is no one more guilty of this than Dr. Darley-Hartley, and yet he has the effrontery to act as chairman of the Medical Council which sat on Dr. Crozier-Durham's case. But then Darley-Hartley does his advertising through skilfully engineered paragraphs in the local press, and he also uses politics as a medium for advertisement, just as some use church. Fancy a politico-medico of this type talking about observing the spirit as well as the letter. Why, he ought to be proceeded against." When the case came to trial, the defendant newspaper-proprietor put in the lamest excuse for the statement that press paragraphs were engineered, and, indeed, the whole defence fell through. The newsagency admitted the libel, and paid £5 into court as damages. The judge, however, raised their indemnity to £20, and assessed the damages against the other defendant at £30, costs going with the verdict. We cannot say that in our opinion the sums were adequate, but they were sufficiently substantial to mark the decided view of the Court, and completely to exonerate Dr. Darley-Hartley. In a comparatively new and markedly commercial community such as inhabits South Africa, it is highly important that the standard of medical conduct should be held high.

Movement Against Motherhood. IT has generally been assumed in the innumerable discussions about the falling birth-rate, that the policy of limiting families is one pursued by subterranean methods, and certainly its apologists have generally been half-hearted and apocryphal in their utterances compared with the full-blooded Malthusian days. However, it seems that the policy of passive resistance to procreation is to give way to one of active propaganda, in France, at all events, as in several towns—Lille, among the number—an anti-motherhood league has been formed, and the doctrine of limitation is being vigorously preached. Women are among the most prominent of the agitators, and special conferences are held once a month under the presidency of a well-known lady. The doctrine of the league is that large families are the work of illiterates, fools, and idiots, and that a well-filled quiver is a sign of ill-filled cranium. It must be rather amusing to see these orators, who are doubtless of the epicene suffragette type, lecturing married women on the sin of having children. But the grapes must be exceedingly sour before they could have brought themselves to it.

LEADING ARTICLES.

THE MEDICAL MAN AS CITIZEN.

IT is generally admitted that medical education has not yet reached the stage of perfection. Many suggestions have been made from time to time with a view of meeting real or imaginary defects in the scientific side of the matter. To ensure a happy professional life, however, some more practical guidance is required than that furnished by mere scientific ardour. The material interests of the medical practitioner, both individually and collectively, demand careful and intelligent protection. Should he aim at high scientific ideals alone, he is apt to find himself hopelessly handicapped in the daily struggle for existence. He apparently lacks the shrewd organising capacity of the lawyers, who, themselves under the protection of the most stringent trades-unionism in the world, are ever ready to condemn the propriety of medical fees, and the action of practitioners in the assertion of their pecuniary and ethical rights. No one blames the legal profession for having secured privileges by the ceaseless exercise of every possible extramural and intramural influence. On the other hand, everyone is inclined to laugh at the unpractical men of medicine, who grumble and agitate, but rarely achieve any real measure of reform either within or without their walls. One of the most encouraging advances of the past generation has been the foundation of the collective medical defence societies, whereby one part of the functions that should properly have devolved upon the General Medical Council has been admirably organised by the members of the medical profession. The reform of the Council, indeed, so as to render it an efficient representative and protective body armed with statutory powers, in our opinion, lies at the basis of the future welfare of the medical profession. At present the Council is little more than an anachronism. It constitutes an autocratic and non-representative body, in the main advisory as regards the Privy Council and Parliament. It is further armed with penal authority over duly qualified practitioners, which it administers with clumsy and, in many instances, contradictory procedure. But in the long run medical men must look to their own right hands for salvation. Recently they have shown signs of placing some effectual check upon unfair hospital competition. They will find it far more practical, however, in our opinion, if they exercise their vast power as citizens having the local and Parliamentary franchises. Reform of the Medical Acts is urgently needed, so as to give a governing body with extended powers on a representative basis. Consolidation of medical corporations into a one-portal system is a second much-needed measure. Stringent laws against irregular medical practice, again, would do more at a single stroke of the legislative pen to relieve the unfair competition against the medical profession than a century of internecine squabbling over ethical offences and jealousies, often of a trivial and technical nature. Then there is the vast question of the patent medicine trade, the suppression of which would not only release the public from a standing menace, but would also tend to bring the people back to sane and skilful medical treatment. There are many other directions in which medical men would be able to protect their own legitimate interests and at the same time to do incalculable service to the community. They might, to take one more instance, educate the public as to the desirability of a Royal Commission of Enquiry into the evils of the patent medicine trade. The most bitter opponents of progress and upholders of privilege could hardly venture to oppose so reasonable a request. In these and many other matters, then, we contend that medical men would do well to assert themselves as citizens. In the past it has been too much the fashion to regard the medical man as a being who should hold aloof from the busy doings of the world around him. The fruits of that policy are writ large in the increasing difficulties to which a harried profession has been reduced. If such a course were feasible, it would be of advantage to have some sort of education in medical economics, which should form part of the curriculum of every student of medicine. In that way he would learn from the first to regard himself as a factor of some importance in the development of his country. It is time that the prejudice which still lingers in many quarters against the participation of medical men in public affairs should be done away with. When the members of our learned but at present unpractical profession recognise more fully their private and national obligations, then there will be hope of a bettering of the general status and prosperity of an indispensable class of society.

TUBERCULOUS MEAT.

THE finding of the recent Royal Commission has convinced the sanitarians of the United Kingdom, at any rate, of the desirability of excluding the flesh and milk of tuberculous animals from human consumption. Hitherto, there has been no scientific protest against enforcing a precaution of the kind, so far as diseased flesh is concerned. Nor has there been any serious question with regard to milk, although it is true that in our own columns the absence of positive proof of infection by milk was pointed out by a gentleman whose views it is impossible to disregard. The objection, however, appears to be somewhat hypercritical, and it might be argued with almost equal subtlety as regards the origin of small-pox, mumps, and a number of other diseases that we know are communicable from the infected to the healthy. The truth appears to be that tubercle of the intestines is, in many cases, a primary infection, and, inasmuch as tuberculous cows may and do produce milk tainted with the tubercle bacillus, it follows that milk may in some instances be the vehicle of tubercular infection. That view appears to be accepted almost, if not quite, universally by medical officers of health throughout the country. Clearly, it is that of Dr. Mearns Fraser who is entrusted with the care of the sanitary welfare of Portsmouth. His views upon the risks arising from tuberculous meat are no less emphatic. In that belief he has recently issued a report that reveals an amazing picture of human selfishness and degradation. Briefly, he shows that an extensive trade is carried on in diseased animals, chiefly tuberculous cows, the market for which is mostly found in London. In one year, he states, no less than fifty-four cows were sold in Petersfield market for sums ranging from 10s. to 30s. each. During the same period seven cows were sold at Chichester at sums ranging from 5s. to 65s. each. The carcase which fetched 5s. as its market price appears to have been destined for consumption in Portsmouth, but on reaching that place the carcase was condemned and destroyed on account of tuberculosis. Dr. Fraser adverts to the well-known fact that cooking is no effectual safeguard as regards the destruction of the bacillus, and that raw meat-juice is often prescribed for children. In view of these considerations, not to mention the wider and more general probabilities involved in the systematic disposal of tuberculous flesh and milk, it becomes evident that stringent legislative interference is necessary in the interests of the community. The recent revelations as regards the American meat trade sent a thrill of horror throughout the civilised world. We have little hesitation in saying that they are hardly, if at all, less inhuman, revolting, and economically reckless of human life and happiness than the barbarous atrocities involved in the trade in diseased flesh that goes on within the four corners of the United Kingdom.

CURRENT TOPICS.

The King Edward Hospital Fund.

WE are pleased to state that an amendment of the King Edward Hospital Fund Bill has been framed, so far as the presidency of the Fund is concerned. The choice of any successor to the Prince of Wales is in future to be referred to a committee, consisting of the Prime Minister, the Lord Chancellor, and the Governor of the Bank of England, who will make their selection from the Royal Family. The status of the Council is also, we learn, somewhat changed, in accordance with earlier criticisms. It is to be hoped, however, that the Commons will not rest content until the desirability of a representative control of so important a public trust has been at least freely discussed in the House. There is no need to repeat our previous arguments in favour of a representative Council, especially in a small body that is not called upon to justify its decisions, no matter how arbitrary or unjust they may appear. We submit that in the present day the existence of a trust on the lines indicated is an anachronism likely at any time to lead to undesirable complications.

The Indian Government and Mr. Haffkine.

PROFESSOR RONALD ROSS, we are glad to note, is actively fighting for the reinstatement and adequate recognition of Mr. Haffkine by the Indian Government. As we have said more than once, Mr. Haffkine's treatment has been shabby in the extreme, and now that the full truth of the Mulkowal *contretemps* has come out, it is inexplicable that the grudge should be kept up. For every bit of evidence points to the contamination of the plague-prophylactic having taken place during the operation of injecting, and there seems no reasonable suspicion even that the contamination could have occurred in the laboratory. The bottle used was precisely the same as all the others; there was no cloudiness nor smell, such as there would have been if the tetanus-germs had been actively growing in it, and the incubation period in all the patients was long, as would not have been the case had a solution strong in toxins been injected. But even supposing the fault to have taken place in the laboratory, which no reasonable man would now admit, is Mr. Haffkine to be punished for the rest of his life because of a piece of carelessness on the part of an assistant for whom he was only nominally responsible? If every general whose subordinate made a mistake were politely dismissed from the Army, we should hear even more than now about the dearth of candidates for commissions. But considering what Mr. Haffkine has done and the enormous number of lives his prophylactic has saved, and considering that his magnificent discovery was freely given to the Government, it is shameful that his career and prospects should be ruined for an error which it now appears was due to the fumbling of a native assistant who was helping the medical man with the injections.

St. Maws and Consumptives.

IT is not often that a town objects to springing into favour as a health resort, but if we are to believe the statements we see, the inhabitants of St. Maws, in Cornwall, are stirred to indignation that their pretty village should be regarded as a suitable spot for consumptives. By way of choking off visitors with tuberculous tendencies, a circular letter has been drawn up and signed by the Rector, the Wesleyan Minister, a medical man, a matron, and several leading residents, warning the keepers of lodging-houses and inns of the danger they and their children run in receiving consumptives into their houses. The signatories say that there has recently been an increase in the number of visitors suffering from consumption, that when that disease has reached the expectoration stage it is a dangerous infectious disease, and that though they are sure the inhabitants would wish persons so afflicted to be treated with the greatest kindness and consideration in their own homes, they appeal to the community to keep them out of St. Maws. Now this action is one of a type which has been growing more and more common, and if the boycotting of consumptives is to become a recognised policy in every community, it is difficult to see what will become of these unfortunates. The degree of infectiveness of pulmonary tuberculosis is known with some degree of accuracy, and no properly-tended consumptive should be a source of danger to anybody, but it seems to be as necessary to start a campaign against overdoing precaution as it recently was to awaken people to the fact that consumption was infectious at all.

Immune Serums and the Opsonic Index.

AMONG our original communications in the present issue will be found one of much interest from Mr. Montgomerie Paton, of Melbourne. It deals with the passive raising of the opsonic index by immune serum administered by the mouth. Last year the same observer published some original papers in the MEDICAL PRESS AND CIRCULAR upon the use of serums in many pathological conditions. His results were of a striking and suggestive nature. In the present instance he has adduced the cases of a gentleman, subnormal to the staphylococcus, whose normal index of .84 was raised to 1.34 after the ingestion of one ounce of the author's anti-diphtheritic serum, and on another occasion from .72 to 1.78 after a similar dose. Should these observations stand the test of extended clinical experience they may possibly advance the science and art of serum-therapy by leaps and bounds.

The Presidential Address to the Irish Medical Association.

THE fact that Mr. McArdle was paid the unusual compliment of a unanimous election to a second year of office as President of the Irish Medical Association, may have been in part responsible for the optimistic spirit which permeated his Presidential address. He is satisfied with the Local Government Board, who "have done everything possible within the law in support of the just claims of our people." Does Mr. McArdle intend a sly hit at his predecessors for their involvement with this benevolent Board in the Drumcourath case, the costs of which have crippled the Association for years? Mr. McArdle is also satisfied with "the manner in which the public boards are now dealing with the rank and file of the profession." Has the President heard of New Ross, or of Irvinestown, to go no further back than the past few weeks in the history of the treatment of their medical officers by the public Boards of the country? The only things apparently with which the President is dissatisfied are the fact that the membership of the Irish Medical Association is not as great as it might be, and that the executive is occasionally subject to criticism. We entirely agree with Mr. McArdle, however, in his advice to the profession to hold together, and strive for their common objects. Without acquiescing in the view that the Local Government Board and the public boards throughout the country are all that they should be, we believe that the profession is its own chief enemy. The medical profession, being necessary to the community, is, if united, master of the situation; if divided against itself is reduced to servitude.

The Irish University Question.

The announcement of the Prime Minister in the House of Commons that the Government did not intend to introduce during the present Session a Bill dealing with the Irish University Question, withdraws from the arena of dispute a subject which has aroused great turmoil in Ireland. It is to be the task of the Chief Secretary in the autumn "to discover harmony among the jarring interests and views upon the subject in Ireland." Commenting on this suggestion, Mr. John Redmond, who, we think for the first time, expressed a half-hearted approval of Mr. Bryce's scheme, remarked that the task set the Chief Secretary was an impossible one. From Mr. Redmond's elegy on the dead scheme, it is clear, however, that whatever support it had got was only due to the fact that it had been put before the Irish public with the formula, "This or nothing." We are inclined, moreover, to think that Mr. Birrell's task need not be as difficult as Mr. Redmond anticipates. A perusal of the Report of the Robertson Commission, of that of the Dublin University Commission, and of the recent expressions of opinion called forth by Mr. Bryce's pronouncement, may lead him to find in the recommendations of the Robertson Commission a solution of the question which, if it does not receive universal approval, will, at least, escape the fierce opposition roused by Mr. Bryce's scheme.

A Quack's Agent.

The ramifications of the trade in illegal medical practice are no less manifold than remarkable. The story recently revealed in the Court of the Dewsbury Coroner, however, presents several features of much interest. It appears that a factory overlooker of the town mentioned was suffering from post-influenzal weakness, from which he was recovering under the care of a local medical man. Unfortunately, he fell into the clutches of a man named Hall, by whom he was persuaded to put himself under the treatment of a "Dr. Hall," of Manchester. The police evidence was to the effect that "Dr." Hall had no medical qualification. The case, therefore, becomes one in which the man Hall can be prosecuted under the Apothecaries Act, as he was stated to have sold medicine and to have assumed a medical title. That aspect of the case may, perhaps, be referred to the Medical Defence Union. There is also the extremely discomforting evidence that Hall had an agent at Dewsbury, who persuaded deceased to go to his principal. It appears that £2 10s. was paid for Hall's advice and medicine, and of that sum £1 10s. was handed to the agent as commission. In a matter of this kind it seems not unlikely that the law would regard both agent and principal as equally answerable for the offence indicated. In any case, the matter deserves careful attention in the interests of medical practitioners generally, not to mention those of the public, for in this particular instance the deceased appears to have succumbed to post-influenzal debility, a condition notoriously amenable to skilful medical treatment, although otherwise of a highly hazardous and fatal nature.

PERSONAL.

Mr. Holbrook Gaskell has added another to his numerous benefactions by contributing a further large donation (£5,000) to the building fund of the Liverpool Country Hospital for Children.

The fourth annual dinner of the Welsh medical profession was held at the Criterion Restaurant in London on the evening of May 31st, under the presidency of Sir Isambard Owen, M.D., F.R.C.P., Senior Deputy Chancellor of the University of Wales.

The annual meeting of the Royal Medical Benevolent Fund Society of Ireland was held on June 3rd in the College of Physicians, Dublin. The chair was occupied by the President of the Royal College of Physicians of Ireland.

Mr. David James Galloway, M.D., C.M. Edin., has been appointed an Unofficial Member of the Legislative Council of the Straits Settlements.

Mr. Arthur Greene, M.A., M.D., has been elected Assistant Surgeon to the Norfolk and Norwich Eye Hospital.

Mr. W. C. Stevenson, M.D., and Mr. W. S. Houghton, M.B., have been elected Surgeons to the Orthopædic Hospital, Dublin.

Dr. Robert J. Rowlette has been elected President of the Dublin University Biological Association for the Session 1907–8.

Principal MacAlister was entertained last week at a complimentary dinner at his old College of St. John's by the Regius Professor of Physic and the resident medical graduates of Cambridge in appreciation of his election to the headship of Glasgow University.

The will of Mr. Thomas Henry Wakley, F.R.C.S., editor and proprietor of the *Lancet*, whose death was recorded in these columns at the age of 86, a few weeks since, was "proved" last week under the sum of £35,607.

The will of Dr. Andrew Scott Myrtle, who died recently at his residence in Harrogate, at the age of 82, has been "proved" at £15,947. Dr. Myrtle was a J.P. for the West Riding of Yorks, and an esteemed contributor to this journal.

Mr. J. Dundon, F.R.C.S., and Mr. L. G. Gunn, F.R.C.S., have been elected additional Examiners in Surgery at the Royal College of Surgeons in Ireland.

Mr. J. Bland-Sutton, F.R.C.S., has kindly lent his house in London, at 47 Brook Street, for a *cafe chantant*, the proceeds of which are to be devoted for the funds of the Royal Eye Hospital, Southwark. A number of well-known artists have promised their services.

Dr. A. Wynter Blyth, after a service of thirty years as medical officer of health of the London parish of Marylebone, has resigned his appointment.

An important article on anti-typhoid inoculation appears in the May number of the journal of the Royal Army Medical Corps. It is written jointly by Brevet-Lieutenant-Colonel W. B. Leishman and Major W. S. Harrison.

A Clinical Lecture

ON

FOODS AND FEEDING IN CERTAIN CONDITIONS (a).

By SAMUEL WEST, M.D.Oxon., F.R.C.P.Lond.,

Physician to and Lecturer on the Principles and Practice of Medicine at St. Bartholomew's Hospital.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

Gentlemen,—Last week I spoke to you of foods. To-day I propose to speak of feeding. In some conditions, the kind of food given is an important—sometimes the most important—part of the treatment I propose to take a few of these; I cannot in such a lecture as this speak of all.

The first which I will take is that of newly-born infants. There can be no doubt that the best food for the newly-born baby is the mother's milk. However, sometimes mothers are ill, and I am afraid that, still more often, the attractions of society and the inconvenience of having to suckle a child every two or three hours causes mothers to be anxious to give up the nursing of their children. It then really becomes a question with which medical men have to deal, for one reason or another, in the course of their practice.

There are certain general principles of feeding infants, and the usual substance chosen is cows' milk. Recently I showed you that the dense curd which forms in cows' milk causes it to be difficult of digestion with babies or invalids, and I demonstrated to you how that, by the addition of a little citrate of potash to cows' milk, a grain or two to the ounce, the curd is rendered quite loose and therefore more suitable for infants' food. Another way that I explained of dealing with the milk, so as to make it more digestible, was by diluting it largely with either water or barley water, the proportions being one of milk to two of water; by partially digesting it, or by humanising it, *e.g.*, altering the amount of casein fat and sugar so as to approach the constitution of mother's milk But other kinds of food are very often chosen, as, for instance, some of the condensed milks. Swiss milk. though it contains too much sugar, is a food which children can live on fairly well.

But besides this kind of food there are two important principles to bear in mind in the feeding of babies. First, the amount which should be given at each meal; and, secondly, the frequency of the meals, *i.e.*, the intervals between them.

As regards the amount, you know that in the first days after confinement the breast of the mother has very little milk, and the child wants but little then; a few ounces of milk and water is sufficient. As the child grows, more food is required, and the meals have to be gradually increased in amount. The size of each meal and the total amount of milk required daily as the baby develops, all this I dealt with the other day.

As to the intervals, the general rule is that babies should be fed at first every two hours. In this connection you should bear in mind that all healthy babies vomit—that is to say, if they take a little more than their stomachs want they regurgitate it, and in that way it is disposed of. But if a baby really vomits a large portion of its food, it is evident that the food does not suit it. As the child grows the intervals between meals should become longer. Children three months old ought to be fed about every three hours, instead of two. There is no commoner mistake made by mothers, in feeding babies, than by giving the meals too often. When the child cries, the first thing done, either by the nurse or the mother, is to give it the bottle. In all probability the child is crying because it has got the stomach-ache, and if it gets more food at such a time it will cry all the harder, for it will have more pain. Whether the child cries or not, the same intervals should be rigidly observed, and with that in view you should have a diet chart with the diet written out that should be given every two or three hours. And it is quite as important in the case of the baby as in that of the adult, that you should have an efficient nurse where the services of such a person are needed. The so-called "experienced" children's nurse is an extremely conceited and lazy individual; she does not want to give herself any more trouble than she deems necessary. These "experienced" nurses are very risky people to deal with. Look with some suspicion on any person who calls herself an "experienced" nurse. Such people are experienced very often in evil ways, and, to get an undisturbed night's rest may give the child a sleeping draught or "soothing powder." There is a certain amount of worldly wisdom in the advice: If the baby does not thrive without any good reason, change the nurse.

Another fact about little babies is that they cannot digest starch. When they begin to cut their teeth they salivate copiously, but up to this time their saliva does not act properly on starch. For this reason, a child should not have starch in any form, however little the amount, until it is at least six months old. The best food to give babies is pure milk, or sterilised milk. If you have got your own cows, and know all about them, then you may give fresh milk. If, however, you have to deal with the kind of milk supplied in towns, and you do not know where it comes from, you have to be more careful and the milk should be sterilised. Either Pasteurise the milk at 150° F. for twenty minutes, or boil it. Of course, another very important thing is that all feeding-bottles and teats, by which the child is supplied with milk, should be kept perfectly clean. To this end they should always be well washed and kept in water that has been boiled. What led me to speak of sterilising the milk was, first, that a great deal of infantile diarrhœa and troubles of that kind which occur in childhood are really due to infected milk. In spite of all the precautions we take, we have even here in the hospital from time to time little epidemics which can be traced to milk. That being the case, how much more likely these epidemics are to happen where no such precautions are taken.

A great deal has been written lately as to the effects of giving sterilised food to babies. One statement, which is made on good authority, is that rickets is the result of feeding with sterilised or Pasteurised milk; but there are many authorities on the other side who do not accept this view. Personally, I do not think the evidence sufficient to justify so sweeping a conclusion.

Another condition which may arise from improper food is hæmorrhagic rickets, or, as it is called, scurvy rickets, or infantile scurvy. This is a very peculiar form of disease in children, not common, but very interesting, in which the limbs become greatly swollen and the swelling which is between the periosteum and the bone is largely due to extravasation of blood. No doubt, hæmorrhagic rickets is the result of errors in diet, just as ordinary rickets is. It will be recognised, therefore, that the feeding of little children is a very important matter. If a child be fed with improper food, it is starved, for it cannot digest that food. One reason why rickets is common among the poor is that they have improper foods, often starchy artificial foods, when they ought to have milk or some of its preparations. That is all I propose to say now about infants.

(a) Delivered at St. Bartholomew's Hospital, February 13th, 1907.

THE FEEDING OF FEVER PATIENTS.

I pass to another class, a very important group, namely, fever patients, and for the sake of being clear I will include for the moment any fever excepting typhoid. The best food for these patients is milk, or milk with egg beaten up and mixed together. An adult would require three pints of milk per diem, *i.e.*, five ounces every two hours or so, night and day, and to this might be added a couple of eggs beaten up. That is a very good diet for any fever patient. But supposing the milk does not suit, and, as a result the patient suffers from flatulence and vomiting, and passes undigested curds in his motions, greyish, flaky motions, with which we are familiar enough in children, though not so much in adults—the curd should be taken out, and an extremely good diet can be made of the whey and barley water, or the milk can be peptonised, or Benger's food should be given sometimes, and meat essences.

As regards the general question of beef-tea and meat essences. In fevers, if you look at the patient's tongue, you will find it coated; the mouth is dry, and there is defective secretion of saliva. The same thing holds in the stomach and intestines; there is a catarrhal condition of the mucous membrane, and, therefore, the digestion is impaired. The extracts of meat are very good in their way—beef-tea and such like—but they contain a very large amount of extractives, which are a sort of stimulant rather than food; they contain a large amount of nitrogen, and this must be got rid of by the kidneys. But the kidneys are in much the same condition as the digestive tract, and should not be given too much work to do. I am, therefore, against giving any large amount of these extracts in fevers. The patients are much better with barley water and milk. Beef-tea might be given once a day, perhaps, but not the concentrated essences. But, supposing you have a fever patient who cannot keep anything down, then you may find raw meat juice made in the cold a very useful thing. It is easily digested and readily absorbed, and very nutritious for its bulk. These patients will retain a fair amount of it in twenty-four hours, if given in teaspoonful doses; cooked essences they generally dislike, and the stock manufactured essences often disagree.

This brings me to another point. Should fever patients have water to drink? Certainly; and much good may result from it, because water helps the secretions of the skin and kidneys and bowels. They may have water slightly acidulated with phosphoric acid, but only a little at a time; or a little ice to suck, or a small piece of lemon. This will help to take away the thirst. Stick to your rules. Give the patients food every two hours, and if they are thirsty let them have water between, but nothing else. The old-fashioned imperial drink, composed of acid tartrate of potash, lemon and water, is an excellent fever drink, and acts as a diuretic as well.

A question to be considered, in all cases of fever, is whether the patients should get alcohol, and, if so how much? The great majority of young healthy people do not require alcohol at all, and in ordinary acute fevers, where there are no special symptoms, they are best without alcohol. In pneumonia, for instance, which, as we know, is a short, acute fever, a young patient gets on perfectly well without alcohol. But typhoid is a long fever, and the patient will very likely need some alcohol towards the end of it. The indications for giving alcohol are obtained from the pulse and the heart. A pulse of poor tone, little tension, and slightly irregular, especially if it be dicrotic, indicates the administration of alcohol. But a better indication still is the condition of the first sound of the heart. If the first sound of the heart be toneless, or if, as in some cases, it can hardly be heard at all, alcohol is clearly indicated.

What I have said, up to the present, will apply to typhoid fever, just as to any other fever. But there are one or two other points which I must add with reference to typhoid fever. It is sometimes extremely difficult to find a food which will suit typhoid patients at all. Half the diarrhœa which occurs in typhoid is due to defective feeding. The milky and curdy stools which used to be so common, and which are sometimes seen even now, were due to milk being given in quantities too large to be digested. In the present day, constipation is almost the rule in typhoid, and not diarrhœa. People talk about "a change of type" in the disease. It is not a change in type at all, but a change in method of treatment. As to the food to be given in typhoid, it is highly important that it should be suitable, and that the patient should stick to it. It is well in typhoid not to give meat essences, beef-tea, and such things. But what I want to point out is this: It is not so much the food, as change of food, that does harm. A typhoid patient, we will suppose, is beginning to get well, and his temperature is down, and the question arises, should he have a change of food? I should say that such patients ought to have no change of food until the temperature has never risen above normal for ten days. There can be no doubt, from clinical observation, that, for some reason or another, a change of diet in the early days of convalescence, in typhoid, does frequently result in relapse. I have, for instance, seen relapse occur from taking orange juice, egg, and other things. When working some years ago upon the excretion of urea, I was very much struck with the fact that in some cases the yolk of an egg, which does not contain much nitrogen, sent up the percentage of nitrogen in the urine from 1 to 3.5. It is just the same as in diabetic patients. A few grains of sugar given on one day may cause them to pass as many ounces of sugar, for some days, in consequence. Nearly all the relapses that come in typhoid fever come in the first week; some come in the second week, but it is quite unusual to get relapse after a fortnight, and, therefore, by carefully dieting of the patient for the first ten days of convalescence, the chances of food producing relapse are very small.

FEEDING IN NEURASTHENIA.

There is a disease called neurasthenia. It used to be called grave hysteria, though it is not, perhaps, hysterical at all. In some forms of insanity patients refuse their food and vomit everything they take. These cases are very closely allied to cases of neurasthenia. Neurasthenic patients can be temporarily cured by forced feeding. They will tell you that they vomit everything they take. But if they are put under close observation and fed, and, when they refuse their food, are forcibly fed with a nasal tube, a large number of them will retain the food given them, even when in large amount. If feeding be supplemented by massage, the nutrition is still further improved. Most of these cases go on very well up to a certain point, but many relapse subsequently.

FEEDING IN PHTHISIS.

A great deal is written just now about the sanatorium treatment of phthisis. Part of this consists in over-feeding, or excessive feeding. But it is no use putting food into the stomach unless it goes farther and gets out of the stomach into the blood vessels and lymphatics. It was quite ridiculous to prescribe for these patients a large diet which they could not or did not retain, but vomited almost at once. Excessive feeding, irrational stuffing, is being largely given up now in sanatorium treatment, and wisely. Such patients should, of course, be fed well, but it is no earthly good upsetting their digestion and comfort in the way described.

FEEDING IN GASTRIC ULCER.

Take another class of case—gastric ulcer. Students as they go round the wards do not seem to value much these questions of diet and treatment. Yet one of the first questions when you get into practice may well be how you are to manage a case of gastric ulcer, what diet you are to put it on, and how you are to manage it afterwards. Let us suppose a typical case: A young woman has got a good deal of pain just after anything has been taken into the stomach. She vomits frequently and, occasionally, vomits blood.

It is no good putting into the stomach food which is going to be vomited, and which causes pain, and might bring on hæmorrhage. Therefore, the first thing to do with such patients is to stop everything by the mouth and feed them by nutrient enemata. In the first place, the bowel must be washed out once or twice a day with water to keep it clean. Then, every four hours, a nutrient enema should be injected slowly; otherwise it will not be retained. Patients may live on nutrient enemata for many weeks. But we do not, as a rule, find it necessary to employ that method of feeding for more than two or, perhaps, three weeks in ordinary cases. At the end of that time all the symptoms in the stomach may have vanished, and you may be able to feed the patient by the mouth again. You would begin with small amounts of food, like barley water or whey, which is nutritious and leaves no residue. That would be gradually increased in amount. Next you would give a little peptonised milk, and then a little pure milk, in small quantities. Give one or two meals of this kind a day to begin with. Let the nutrient enemata be gradually discontinued as the patient is able to take more by the mouth. Then, perhaps, a little Benger's food may be given, or a little custard, or a lightly boiled egg then some pounded meat or pounded fish, and then solid food, fish, or fowl, and so on.

Feeding in Diabetes.

In Mellitus Diabetes diet is by far the most important line of treatment. It is necessary to eliminate from the food so far as possible all things likely to increase the production of sugar, *i.e.*, sugar itself and starchy substances. In this disease of such long duration as it is, the problems of diet will tax all the skill and resources of the physician.

Feeding in Scurvy.

Scurvy is a disease of which defective diet is the cause, and which can be cured by proper food. It is produced by the want of vegetable or vegetable acids, and cured by their addition to the diet. In this way this disease has been practically banished from our Navy, though it used to incapacitate whole ships' crews. We occasionally meet with scurvy in the middle of London, although we are not far from Covent Garden and other vegetable markets.

Feeding in Renal Diseases.

Another condition to which I may refer is renal disease, and, in connection with this, diet is of great importance. Why? Because the kidney is the only organ by which nitrogenous substances, after they get into the body, can be eliminated. Therefore, we must not in the food increase the amount of nitrogen. The nitrogen in the urine has two sources—the food, and the decomposition of the tissues. You cannot reduce very much the natural exchange of substances in the tissues. Metabolism may be increased, or decreased, to some extent, but that we cannot effect much by diet. But we can reduce very considerably the amount of nitrogenous substance in the food. Albuminuria in renal disease is not an indication for treatment. You hear it said: "This patient has got albumen in his urine, and therefore he has had this or that diet." But there may be albumen in the urine, and yet the kidneys may have nothing the matter with them. The albumen is a very common indication of something being wrong with the kidney, but it is not itself a thing that requires treatment. If you come to the conclusion that a patient's kidneys are not sound, consider the diet of that patient. In acute renal disease the less nitrogen given the better, because the whole kidney is in a condition of acute inflammation, and is able to do very little work, and when anything more than the minimum of nitrogen necessary is given the work of the kidney is increased. There is something more to be borne in mind about kidney disease. If a patient is going to get well of kidney disease, how is that going to be? The cells of the kidney have undergone a peculiar degeneration and a great many of them have been shed; they may be seen in the casts. The kidney will not get well until it grows new cells, and if it is to grow new cells these cells must be properly fed; otherwise the cells will not be healthy and sound. As a matter of fact that is a daily experience in renal disease. If a patient with acute renal disease is placed on milk diet, he may improve up to a certain point, but the time comes when he will get no better upon milk alone. Then the diet is changed and immediately renewed improvement follows.

Let me take another group of renal disease—granular kidney, chronic interstitial nephritis. These patients are going to be ill a long time. They have got a disease which cannot be absolutely cured, although much may be done for its relief. In chronic nephritis the mischief is done before the patient comes under observation. Then very often there is only a slight trace of albumen in the urine, and yet the albumen is made the test of the treatment, and the patients are put upon strict diet and they begin to flag. A large number of these patients are best treated by giving them the minimum of nitrogen that they can digest. Treat them on common-sense principles, and they will improve very much.

The great thing to avoid in all renal disease is such food as meat extracts and meat juices. These extracts of meat contain all the extractives you can get, and sometimes very little of the nutritious part of the food. A little piece of fresh meat would be very much better than most of those extracts of meat.

Feeding in Skin Diseases.

Skin affections form another group of cases in which diet plays an important part. Acne is a very common skin disease, which you often have to treat, and it is affected largely by diet. Acne is no doubt a germ disease. Diet, I suppose, must act by altering in some way the chemistry of the tissues so that the skin offers less resistance to the ubiquitous germ.

Another skin disease in which diet forms an important part is eczema. There are two lines of treatment of eczema—the local treatment, varying with the particular form of the affection, acute or chronic; the general treatment, depending on the patient's general health; and in this diet is of great importance, especially in babies. There are many babies who have eczema simply because they are improperly fed. I remember seeing a baby covered with eczema, though otherwise quite a healthy-looking little child. I asked the mother, "What ought a baby six weeks old to be fed upon under ordinary circumstances?" She said, "I do not know what you mean," and then it suddenly dawned upon her that it should be fed upon the breast only. "Now go away," I said, "and feed it upon the breast-milk only, and nothing else." I never saw that child again, but I heard that in a week's time it was well.

There are, of course, a great many other things that I might have mentioned in relation to diet in disease, but I have only had time to-day to indicate in some special diseases some of the general principles which should guide you in treatment.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Peter Horrocks, M.D.,Lond., F.R.C.P., Senior Obstetric Physician, Guy's Hospital; Lecturer on Obstetrics and Diseases of Women in Guy's Hospital Medical School, etc. Subject: "Disorders of Micturition in Women." (Two lectures delivered at Guy's Hospital).*

Dr. George William Armstrong, of Treorky, was summoned at Newport on June 3rd for driving a motor-car (DW 144) in a manner which was dangerous to the public in Bridge-street and Commercial-street on Sunday afternoon, May 26th. Mr. Abbott (from the town clerk's office) appeared for the prosecution: Mr. L. H. Hornby defended. The bench imposed a fine of £3 and costs.

ORIGINAL PAPERS.

REPORT OF TWO SUCCESSFUL CASES OF CÆSARIAN SECTION, WITH OBSERVATIONS.

By C. YELVERTON PEARSON, M.D., F.R.C.S.
Professor of Surgery, Queen's College, Cork; Surgeon to the County and City of Cork Victoria Hospital for Women and Children, &c.

Cæsarian Section is an operation which up to the present time has very rarely been performed in Munster. Apart from this fact, to which I shall again allude, and the general interest of the subject, the cases which I am about to report present some features of special interest, which induces me to bring them under the notice of this section of the Academy.

Case I. *Radical Cæsarian operation for obstruction due to large pelvic fibro-myoma.*—Mrs. "M. D." æt. 35 years, farmer's wife, recommended by Dr. Reid, of Bandon, consulted me on February 23rd, 1906.

She was a woman of rather sallow and somewhat anæmic appearance, but had always been healthy up to date of marriage, which took place on July 29th, 1905. Menstruation, which had previously been regular, had ceased after marriage. According to her first account there had been no menstrual period since the early part of July, but she subsequently stated that she was unwell about a week after marriage.

Two months ago she noticed a swelling in the hypogastrium to the right of the middle line; about a month after she suffered from intermittent pain of a darting character in the same situation, which had become more constant for the past ten days, and for which she consulted Dr. Reid, who, on examination, found a large tumour in the pelvis, but was unable to detect any sounds of the fœtal heart. There had not been any sickness, and the woman had no suspicion of pregnancy.

On examination.—The breasts were found to contain milk, and presented all the characters associated with a first pregnancy. The abdomen was considerably enlarged, and on palpation a small, hard tumour about the size of a hen's egg was felt in the right iliac region, a few inches above Poupart's ligament. There was a sensation of marked resistance in the hypogastric region produced by a tumour, and a general fulness was detected, dull on percussion, extending two inches above the umbilicus, which corresponded in feel with what might have been a pregnant uterus.

On vaginal palpation a large, apparently solid tumour was felt through the anterior vaginal wall, which, though very fixed, could also be felt by the hand placed above the pubis. The cervix was lying behind the tumour, and was so high up that it could be reached with difficulty. On auscultation, though a soft systolic souffle was heard over the hypogastrium, no sounds of the fœtal heart were perceptible. The patient had not experienced any distinct sensation of quickening.

A problematical diagnosis of pregnancy, associated with pelvic fibro-myoma, was arrived at, which was confirmed on further observation of the patient while in hospital. She was sent home on March 3rd with instructions to return during the first week of May.

Shortly after her return home the patient experienced distinct sensations of quickening, and when visited a few weeks afterwards by Dr. Reid, he was able to hear the fœtal heart sounds distinctly.

The patient returned on May 7th, and was re-admitted to the North Infirmary. There had been no change in her general appearance save those produced by the more advanced condition of gestation. The pelvis was so completely blocked by the presence of a large fibroid tumour that it was with extreme difficulty the os uteri could be reached, lying behind the tumour and high up in the hollow of the sacrum. It was evident that delivery could not be accomplished in the natural way. So far as I could calculate from the woman's statements the onset of labour would be likely to occur during the second week of May. I determined to anticipate this by operation, and made all the necessary arrangements.

On careful palpation of the abdomen the position of the fœtus was found to be as follows:—The body was placed obliquely, the dorsal aspect to the front, and the head being placed upwards and to the right of the fundus. The position of the placenta could not be determined by palpation, but was believed to be posterior. The fœtal heart sounds were quite distinct and best marked to the right of the umbilicus.

All arrangements were made for operation, which was performed on Saturday, May 12th, in the presence of the other members of the staff and several medical friends. I was assisted by my colleague, Dr. Henry Hobart, the anæsthetic was administered by Dr. Hegarty, whilst Dr. Richard Byrne stood ready to receive the child. The operation presented no feature of difficulty. The abdomen was laid open by a five inch incision, the parieties were pressed backwards, the uterine walls were incised till the membranes were exposed, and the incision was then increased to about four and a half inches in length in an upward direction with scissors, the membranes having been divided the child was seized by the neck and extracted without difficulty, the head being delivered first. The cord was divided between two pairs of compression forceps, and the child, a well developed boy, was handed over to Doctor Byrne.

The uterus was then seized and drawn forwards through the abdominal wound, and immediately began to contract. On making firm traction on the uterus in an upward and forward direction the large pelvic tumour was drawn out of the pelvis. The remainder of the operation was completed as an ordinary supra-vaginal hysterectomy, silk ligatures being applied, the stump and peritoneum over it being sutured with iodised catgut.

The bleeding, which was very free during the division of the uterus, practically ceased after delivery of the child, and gave no further trouble. The placenta was left *in situ*, but very soon became separated by the contractions of the uterus. The ovaries were not removed.

The woman and her child progressed in a most satisfactory way, and both left the hospital on June 9th.

Case II. *Ordinary Cæsarian section for spondylolisthesis and contracted pelvis.*—Mrs. "S. D." æt. 33 years, consulted me on December 27th, 1906, by the advice of Doctor O'Meara, of Skibbereen, who had previously written to me about her, and expressed the opinion that he regarded it as a suitable case for Cæsarian section.

The patient was of healthy aspect and of small proportions, though well formed. Judging by her appearance at the time, I should have thought that her height did not exceed 4 ft. 6 in., though when she was measured some weeks after operation her height was found to be 4 ft. 9 in. She had marked lordosis, and the abdomen was unusually prominent even for advanced pregnancy.

History.—She was married 4½ years, and had no living children, though she had three confinements. Delivery at the first was accomplished by turning followed by craniotomy. At the second she was delivered with great difficulty by forceps of a dead fœtus, but the exact period of gestation was not known. On the third occasion she was delivered naturally at about 6½ months, and the child was said to have lived a few hours. This was in April, 1905. It appeared from her statements that she had now reached full term, and that labour might come on at any moment, though she had been advised to come to me at an earlier date. I advised her to immediately go into hospital, but it appeared that she had no intention of submitting to any severe operation, and wanted me to undertake the delivery *per vias naturales*, which I firmly declined to do. She wanted to return home immediately, but finally consented to go into hospital and think over the matter till the following day. She left my house on the understanding that she would go into hospital, but on getting there changed her mind and determined to stay somewhere in the City for that night. About 11 p.m. her husband presented himself at the hospital saying that she was in labour, and asking to have her admitted. I was communicated with by telephone, gave instructions for her admission, and ordered a bromidia draught and quarter grain of morphine hypodermically, with the understanding that I would be summoned if labour continued. The pains ceased soon after her admission, and she passed a good night. On the next day preparations were made for operation, but I determined not to operate until the day following unless obliged to do so, in order that more methodical preparatory treatment could be carried out. On examination *per vaginam* the pelvis was found to be small and imperfectly developed, but no systematic measurements were made either then or subsequently.

Cæsarian section was performed at 10 a.m. on December 29th, in which I was assisted by my colleague, Dr. Hobart, the anæsthetic (C.E. mixture) being administered by Dr. Michael Cagney. In less than five minutes from the commencement of the operation a healthy male child was extracted, which at once cried lustily, and weighed 6½ lbs.

The placenta was partially divided before the membranes were reached, owing to its occupying an anterior position, and though the bleeding was free at the moment it practically ceased when the child, which lay in the left occipito-anterior position, was extracted. The moment this was accomplished the uterus spontaneously delivered itself through the abdominal wound. This was easily explained by the prominence of the lower lumber vertibræ, which were now found to be on a level with the anterior abdominal wall. As the uterus did not contract very rapidly the placenta and membranes were separated and extracted. The uterus did not even then seem disposed to contract satisfactorily, and as the patient seemed at the moment to suffer from shock, I douched both the exterior and interior of the uterus with hot saline solution, to which it at once responded in such a marked manner that it became quite anæmic in appearance. The uterine wound was closed by two rows of continuous suture of iodised catgut, and the abdominal wound was sutured in three successive layers.

The case pursued an uneventful course, the subcuticular suture was removed on the fourteenth day after operation, and both mother and child left hospital on January 19th, 1907, twenty-one days after operation.

Observations.—The special points of interest in the preceding cases have already been sufficiently alluded to. It will be noticed that in both cases, acting on the experience of Dr. Howard Kelly, I appointed a particular time for operation, and did not wait for the onset of labour, though in the second case I was very nearly anticipated. From the experience gained in these cases I would follow a similar course if possible in future cases.

Further, I think it is unnecessary to stop during the course of the operation, previous to the extraction of the fœtus, to arrest any uterine or placental bleeding. Firm pressure of the assistant's hands placed on the abdominal wall on either side of the wound will sufficiently control it. After extraction of the child it does not appear that there is much danger of hæmorrhage, as if the uterus does not take on action immediately it can be stimulated by extracting the placenta and hot douching.

I should like to advise all those practitioners who meet with cases which are likely to require surgical assistance to see that the patient is placed in suitable surroundings and all necessary arrangements are made for operation before the onset of labour, even though it may be thought wiser not to operate till the pains have commenced.

The great rarity of Cæsarian section in the South of Ireland can be easily explained on the following grounds, viz. :—(1) Cases of pelvic deformity of such a degree as to necessitate such an operation are comparatively few. (2) In the majority of cases of difficult labour among the poorer classes the medical attendant does not get an opportunity of recommending such an operation, as his services are not sought for at a sufficiently early period. I have no doubt with the improved education which midwives receive, and an increased confidence in surgical measures, the number of such operations in the future will increase.

NOTES ON THE PASSIVE RAISING OF THE OPSONIC INDEX BY IMMUNE SERUMS.

By D. MONTGOMERIE PATON, M.R.C.S.Eng., L.R.C.P.Lond.,

Of Melbourne.

Since the publication of my work on the "New Serum Therapy" (*a*), which advocated the oral use of serums, both normal and the product of acquired immunity, for various diseases, the writer has continued his work and can only confirm the results already stated. "Tissue resistance" was given as the cause of the effects

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(*a*) "The New Serum Therapy," pp. 320. Price 6s. Lond. Bailliere Tindall and Cox. 1906.

produced by the serums used. The conclusions arrived at were that this resistance was a constant factor in immunity, whether natural or acquired, that it might be present along with antitoxins and bacteriolysms (and might be the whole resistance itself), and yet was distinct from either of them; that it rendered the soil insusceptible to the action of the organisms present, so that the patient's functions were restored to normal even while the organisms were present. For these and other clinical reasons, such as the action of normal horse or sheep plasmata in tubercle in which infection the results obtained were identical with those of Professor Wright by his tuberculin treatment, both as regards the class of cases benefited and the benefits obtained, the idea presented itself that the oral use of the serums must cause the production of some sort of opsonins. To test this, the following experiments were made by Dr. Julian Smith, of Melbourne, a recent pupil of Professor Wright. The writer is subnormal in his resistance to the staphylococcus, and became the subject himself. The experiments were carried out under the strictest rules :—

Results.—Normal index, October 7th, 1906, ·84; normal index, October 10th, 1906, ·93. After ingestion of 1 oz. of "Paton's" Anti-diphtheritic Serum (P. D. & Co.) during previous eighteen hours, October 14th, 1906, 1·34. No further serum taken and normal index was again taken, October 25th, 1906, ·72. One ounce same serum during previous eighteen hours, serum heated to 60° C. before use, October 29th, 1906, 1·78.

The heating of the serum was done so as to preclude the possibility of the presence of opsonins. The age of the serum and the antiseptics in it were practically sufficient to do this without the heating.

Thus the result obtained showed that no opsonins being present in the serum, there must have been some reaction which produced them. In any case the opsonic index was passively and immediately raised by the oral use of the serum employed. Now the serum employed was the product of the direct attack by a toxin on the tissues and the organisms producing the toxin had nothing else to do with the production of the immunity. Hence the serum contained the elements necessary to protect the tissues from the toxin, and they were thus the product of a tissue reaction. But the product of a tissue reaction caused the production of opsonins in the patient as it was intended to do in the animal supplying the serum. The conclusion therefore is that the serum produces a tissue reaction which in turn produces an opsonin and the two combined form the "tissue resistance" which has been described in "New Serum Therapy." Thus the action of the serum described as causing a recuperative effect on the involuntary muscle is a tissue reaction, and the action on staphylococcic infection is due to the reaction plus the opsonin.

Natural immunity in the sheep and horse to tubercle is the same in character as in the human, but in efficiency it is much greater. If the elements producing opsonins are transferred by the oral use of the serum, then the normal serums of these animals should be beneficial in tubercle. This is so, and the results are the same as those in patients under Wright's tuberculin treatment.

The reaction alone is required in cases of debility and lowered nutrition arising from nonmicrobic causes. Abnormal lactation from such causes is specifically rendered normal by the oral use of the normal plasmata. The passive raising of the opsonic index and the maintenance of the tissue reaction demand the use of the serums till they are no longer required.

The object of antitoxin is to neutralise toxin, and this is done like any other chemical reaction, but the object of the tissue resistance is to maintain the tissue integrity and function and hence it has to be maintained till the attack upon them has ceased and the infection eliminated.

They can be given in any stage of a disease, as there is no negative phase following their exhibition, but naturally the earlier the better.

We know the value of Professor Wright's methods, limited as is their scope, to prevention and local infections, but what must be the value of a method which can raise the specific resistance of the patient after the onset of disease and in any stage of it thereafter?

This is a principle which has acted all through with me, not only in anti-diphtheritic serum, but also in anti-streptococcic serum, and in the normal plasmata of the horse and sheep to tubercle.

Reading "New Serum Therapy" in the light of the above will give thoughtful men much fruitful suggestion.

NOTES AND COMMENTS ON A CASE OF LATE RICKETS.

By J. A. COUTTS, M.B.Cantab., F.R.C.P.Lond.,
Physician to the East London Hospital for Children.

The estimation of the frequency of occurrence of "late rickets" varies largely with the conception of the individual observer as to what constitutes that complaint. With those authorities who claim that the complaint may be limited to a single bone, and who ascribe coxa vara, scoliosis, and many other deformities to a late rachitic condition of the affected bones, "late rickets" is far from a novelty. But to those of us who restrict the term "late rickets" to a complaint in which the whole of the osseous system is affected in a manner closely resembling that occurring in the infantile disorder, cases of "late rickets" are extremely rare. In a long experience at a children's hospital, I have only met two examples of the complaint in my personal practice, but owing to the kindness of Mr. Muirhead Little, I have had the opportunity of examining three or four more at the National Orthopædic Hospital. From what I gather, indeed, the complaint would seem to be more frequent at orthopædic than at children's hospitals, and often, too, the chief manifestations of the disorder occur at an age beyond that of the patients seen at the latter institutions.

Not very infrequently the osseous changes produced by an infantile rickets are unduly prolonged, and are still demonstrable in the sixth or seventh, or even later, years. Such cases must be clearly differentiated from those of true "late rickets," where the osseous changes do not start until the age of infancy is past. The age of onset in accepted cases varies widely, in some being as early as the fourth, and in others as late as the seventeenth year. It is noteworthy that in a large majority the onset has been preceded by some prolonged and debilitating complaint, such as a chronic diarrhœa, and in some by a definite and protracted colitis.

My second case was one of some half-a-dozen others that were shown at the first meeting of the present session of the Clinical Society to illustrate Mr. Clutton's Presidential Address on "late rickets." The appended notes of her condition are brief, as the chief interest in the case lay not in the bony manifestations themselves, but in the time of their onset.

I—H., a girl, æt. 7, was admitted into the East London Children's Hospital on October 3rd, under my care. She was one of a family of seven children, of whom one suffered severely from rickets in infancy, whilst the other six, including the patient, had escaped the disorder at that period. The patient, as far as the mother could recollect, had been suckled for three or four months, and after that bottle-fed. She was early in teething and talking, but did not walk until about 18 months old. Once acquired, her walking had been perfectly normal until the onset of her present complaint. She had been considered "delicate," but had no definite illness until 4½ years old, when she had a severe attack of measles. Since the measles the bowels have been irregular, diarrhœa alternating with constipation. Shortly before five years old it was noticed that her ankles, knees, and wrists were growing big, and the enlargements have increased until the present time. During the past year her walking, which had formerly been good, had become more and more defective, and this, together with a supposed decrease in height, had been the main cause of her being brought to hospital.

On admission she was a pale, red-haired child of short stature (height 3 ft. 1¾ ins.), but looked bright and intelligent, in spite of the loss of most of her temporary teeth. The most striking feature in her case was the extreme epiphyseal enlargements of the ends of the long bones entering into the formation of the ankle, knee, and wrist-joints. One noticeable point was the amount of enlargement of the upper epiphyses of the tibiæ and fibulæ, the enlargement being greater than that usually seen in the same parts in infantile rickets. The same feature was seemingly constant in the other cases shown at the Clinical Society's meeting, and was commented on by several observers. In addition to the enlargement of the epiphyseal ends, the femora were distorted, having one bend with the convexity anterior, and another with the convexity outwards. Both tibiæ and fibulæ were bent to the same degree and in the same directions as the femora. The gait of the child was somewhat "waddling." Her frontal and parietal eminencies were somewhat excessive, but the skull was not flattened on the vertex, nor was any vestige traceable of the former situation of the anterior fontanelle. There was marked beading of the ribs, but no other deformity of the chest. The liver and spleen were not enlarged, and beyond that in the osseous system there was no evidence of constitutional disturbance. A volumetric analysis of the urine showed that the phosphates were markedly increased, being nearly double the normal amount for a child of her age.

The close resemblance of the bony changes in such cases to those occurring in infantile rickets is not to be gainsaid. We have it, too, on high authority, that both the macroscopical and microscopical changes in the epiphyseal cartilages are undistinguishable from those occurring in the same parts in infantile rickets. But whether the two complaints are identical may be open to question. Contrasting "late" with infantile rickets, in the older patients the disease is much more persistent, lasting usually for many years; there is an absence of constitutional disturbances, the shafts of the affected bones become much softer, and in later stages multiple osteotomies are much more often called for at the hands of the surgeons.

In a large proportion of cases of "late rickets" there is a history of the patient having suffered and recovered from rickets in infancy. The frequency of this association has led many observers to assert that every case of "late rickets" is a recrudescence of an infantile rickets that has been recovered from, and the name "recrudescent rickets" is sometimes used in preference to the one more commonly employed, to prove a negative is as impossible as it is to guarantee the absolute freedom of an older person from having suffered from some degree of rickets in infancy. But in many cases of "late rickets" there is no history of rickets in infancy obtainable, and this was so in three out of five cases of which I have personal knowledge. On these grounds I prefer the more commonly accepted term "late rickets" to that of "recrudescent rickets," and agree with Mr. Clutton that rickets may have its primary onset at periods of life far beyond the infantile age.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

Charcot's Disease of the Knee Joint.

J. P. Legg, M.S., F.R.C.S.

A man, æt. 35, came to the Out-Patients' Room complaining of a swelling of the right knee which had come on suddenly three weeks previously. There had been practically no pain, and he was able to walk quite well.

On examination the joint was found to be very much swollen, the swelling being due to a large quantity of fluid. Fluctuation was readily obtained, and the synovial membrane did not appear to be particularly thickened. On the inner side of the joint the skin was reddened and œdematous, this was partially due, no doubt, to the patient having rubbed in turpentine vigourously. The movements of the joint were not at all impaired, flexion and extension could be carried out to the full amount; in addition, a very great degree of lateral movement was obtained. All the movements were painless, and much coarse grating was felt on carrying them out. The popliteal space was occupied by a globular fluid swelling on the inner side, and behind this the upper end of the tibia, or the lower end of the femur was easily made out to be displaced backwards. It was quite easy to push the bones forward, and when they were allowed to slip back again a coarse grating was detected. Around the upper end of the tibia, a number of bony or cartilaginous nodules were present, especially on the inner aspect of the bone. The inner articular facet of the tibia appeared to be hollowed out into a cup-shaped depression. The lower end of the shaft of the femur was thickened by a uniform bony mass all round the circumference, and the patella was about half as big again as that of the opposite side. When he walked the only things noticeable were the limping, and the fact that the whole limb was bowed outwards, the knee being the maximum point of the curve. All the other joints were apparently healthy. Mr. Legg pointed out that in this man all the characters of Charcot's disease of the joint were present; the patient had also an interesting past history. Two years ago he was in the hospital with cellulitis of the left foot, and a perforating ulcer of the right foot on the ball of the big toe. On investigation, he was found to have no knee jerks, to have lightning pains, and unequal pupils, the right being the smaller; both pupils reacted to accommodation and to light—to the latter sluggishly. The cellulitis got well, and he left the hospital. A few weeks later he came back again, and said that whilst going upstairs the right thigh bone suddenly snapped. The whole thigh at the time was distended and tense from a large effusion of blood; and there was a fracture in the lower third of the femur. He was treated by the means of a long Liston's splint and weight extension. A large mass of callus formed. The fracture eventually united firmly, and has caused him no trouble except from the shortening, which has resulted in a limp. Up to the present time the signs of tabes have not advanced; he has unequal pupils which still react sluggishly to light; there are the lightning pains and the knee jerks are absent. When he walks there is no ataxia, and it was interesting to notice, Mr. Legg thought, how well a patient with such a joint condition was able to get about.

This patient then, Mr. Legg said, showed three of the most important complications of tabes, and all occurring in the apparently early stages of the affection, whilst at the same time the primary disease does not seem to have advanced during the last two years. It was usual for these conditions to occur whilst the signs of tabes were not very evident or not noticed by the patient; in fact, the affection of a joint, the spontaneous fracture of a bone, or the perforating ulcer might be the reason for the patient seeking advice, and it was only on careful examination that the early evidences of the tabes were discovered. As to the diagnosis of Charcot's disease of the joints, the most important points were the rapid onset and rapidity with which the joint is destroyed. Every structure in the joint is involved, the ligaments being singled out quite early. In this man, the capsular ligament was rapidly expanded, and the marked lateral mobility, which was a very characteristic sign, together with the displacement backwards into the popliteal space of the ends of the bones, could only be the result of destruction of the lateral and crucial ligaments. Whilst this destruction was going on, new bone was being deposited in the capsule, and around the margins of the joint surfaces, as was shown by the nodules which could be felt and the enlargement of the patella. Painlessness was another characteristic, though some patients complained of "rheumatism" in the joint, and very often of the lightning pains.

The elastic swelling in the popliteal space was probably one of the bursæ distended with fluid. It was not uncommon to find such bursal swellings in connection with Charcot's disease, and the bursa here involved was that which frequently communicates with the joint, namely, that under the semi-membranosus muscle. Possibly this swelling might be the back part of the joint capsule bulging into this region owing to the weakness of the posterior ligament of the joint, but the characters of the swelling were more like those of a distended bursa.

Now as to treatment, something, Mr. Legg affirmed, could be done. (1) By means of a moulded leather splint embracing the leg and the thigh. The great thing, he considered, was to limit the lateral mobility, which could be done by metal supports on each side. Sometimes these might be hinged to allow flexion and extension. (2) If the joint continued to be increasingly distended, or if the amount of fluid was very great, aspiration of the fluid was useful; he mentioned too that the amount of fluid varied from time to time.

A skiagram taken the same afternoon showed extensive alteration in the shapes of the joint surfaces; a large mass of callus around the site of the fracture of the femur, the lower fragment being twisted and displaced backwards, and nodules of bone attached to the upper end of the tibia and in the capsule away from the bone.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

Rupture of the Lateral Sinus.—Mr. Arthur Edmunds operated on a man, æt. about 40, who had been admitted to the hospital suffering from an injury to the skull. The history of the case was that the patient had fallen, striking his head over the left side of the occipital region. At the time of his admission, four days before the operation, his symptoms were slight and equivocal; he was conscious, had no paralysis; indeed, the only sign of cranial injury was pharyngeal hæmorrhage; there was no hæmorrhage from the ear. After he had been in the hospital, however, for three days, he began to exhibit a slight degree of facial paralysis and a squint. On the day of the operation the facial paralysis was complete on the left side, and careful examination of the ocular movements demonstrated a complete paralysis of the left external rectus; apparently the other ocular muscles were intact. The patient was conscious, answered questions rationally, but was if anything a trifle excitable. The knee-jerks and other tendon reflexes were normal. His pulse had not slowed, his respiration was unembarrassed; the condition of his pupils could not be ascertained as homatropine had been instilled for examination of the discs, which were normal. In short, the case presented paralysis of two nerves: the seventh and sixth. Paralytic symptoms, the onset of which is delayed for some days after the infliction of the head injury strongly point, Mr. Edmunds said, to venous hæmorrhage, and the whole aspect of this case was consistent with this view.

The fact that the whole of the muscles supplied by the facial nerve were equally involved pointed to a lesion of the nerve trunk beyond its nucleus and the implication of the sixth nerve as well suggested that the lesion would be found at or near the apex of the petrous portion of the left temporal bone. The slow onset of the symptoms and the absence of any very marked signs of cerebral compression pointed as before referred to. Venous extravasation, hæmorrhage from the lateral sinus would account quite satisfactorily for the symptoms; the blood in this region tends to be confined beneath the tentorium and would exert pressure on nerves in the vicinity without affecting the cerebral hemispheres as a whole. Acting on this diagnosis the patient was anæsthetised, the head shaved and a large flap turned down over the left side of the occipital bone. The skull was trephined over the left lobe of the cerebellum and a sufficient quantity of bone was removed; the dura mater bulged, but did not pulsate. This membrane was now incised and a finger insinuated along the wall of the posterior fossa towards the internal auditory meatus; on withdrawing the finger there was a sharp spurt of blood from the tracts which had been thus temporarily opened up. Hæmorrhage from venous sinuses was not, as a rule, Mr. Edmund said, serious as regards loss of blood, and accordingly it was thought sufficient to pack gauze on to the site of the bleeding so as to allow for any further extravasated blood to escape. The wound was sutured, leaving an opening through which the gauze could be withdrawn. The patient was put back to bed when his condition, unfortunately, did not improve; he gradually became comatose and died.

At the *post-mortem* it was found that there was a fracture of the base of the skull, involving the tip of the petrous portion of the temporal and lacerating the lateral sinus. Hæmorrhage from this region had been relieved, but there was a considerable amount of hæmorrhage round the medulla and cord which had led to the fatal issue.

Measles Epidemic Subsiding.—The measles epidemic which has been raging in Nottingham for three months is showing signs of subsiding. Only eight deaths from this cause were reported last week. Altogether, over 220 children have died from measles in Nottingham.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Medicine.

President—J. M. **Redmond**, M.D., P.R.C.P.I.
Sectional Secretary—F. C. **Purser**, M.D., F.R.C.P.I.

Meeting held Friday, May 17th, 1907.

Dr. **Kirkpatrick** in the Chair.

LYMPHO-SARCOMA IN THE LEFT LUNG.

Dr. **Craig** read the clinical notes on a case of lympho-sarcoma of the left lung, and exhibited the *post-mortem* specimen. The patient was a man, æt. 46, who thought he had caught a cold in October, 1906. He was treated in hospital for bronchitis. His most marked symptoms at that time were orthopnœa, cough, and occasional blood-stained sputum. He came under Dr. Craig's care on March 12th, 1907. He had orthopnœa, cough, frothy expectoration, œdema of the lower limbs, slight ascites, albuminuria, systolic aortic murmur. The left lung showed physical signs of complete solidification, with thickened pleura. His abdomen was tapped on March 30th, 1907, and chylous fluid drawn off. His voice became husky, and he had severe pain over the cardiac region. He died on April 4th 1907. *Post-mortem* revealed chylous fluid in the abdomen, enlarged and congested liver; nothing else abnormal. Pericardium was distended with sanguineous fluid and subserous hæmorrhages were observed in many spots. Cardiac valves were healthy. A white opaque, homogeneous spherical tumour occupied the greater portion of the left lung. Section of enlarged lymphatic glands showed in the substance of the tumour. Secondary growths were present in the rim of lung tissue which the primary growth had not invaded. Portions of the tumour extended along the course of the left pulmonary veins, pulmonary artery, and the aorta, so as to appear within the pericardium. The entire adherent left pleura was about one-eighth of an inch in thickness, but had no connection with the tumour. The tumour appeared to have started in the bronchial glands and spread outwards.

SOME CASES OF TUBERCULOSIS TREATED BY PROFESSOR DENY'S TUBERCULIN.

Dr. **Frank J. Dunne** exhibited six cases of tuberculosis treated by Professor Deny's tuberculin in the South Dublin Union Hospital.

The **Chairman** desired to know if Dr. Dunne considered that the local and general reaction, which was so marked in some of the cases, was a necessity, or whether it would not be better to reduce the dose, so as to reduce the initial reaction, and try and spread it over a longer period.

Dr. **Stevenson** showed X-ray photographs of the case, in which the wrist was involved and said he could not say from the photographs alone whether there was any disease in the bone; clinically there did not seem to be any disease now, but the photograph simply showed that there had been diseased bone removed.

Dr. **Craig**, General Secretary, expressed the thanks of those present to Dr. Dunne for his exhibits; they were, he said, greatly impressed by the excellent results obtained, and highly appreciated Dr. Dunne's work.

Dr. **Moorhead** asked if the cases were all in which the treatment had been tried, or were a selection. He had seen two of them when they were very bad, and was much impressed with the improvement. He was also desirous to know if Dr. Dunne had found the opsonic index raised by the injection of Deny's tuberculin.

Dr. **Dunne**, in reply, said he agreed with the Chairman, in regard to the reduction of the dose. In fact, he commenced the girl with the wrist with five parts in a million, and did not know what would have happened if he had given her the dose of half a milligramme, which is recommended of Koch's tuberculin. Tuberculin at present had to be used with very great care, and he believed the ordinary trial doses were too stron The cases were selected from the one-third of the tot (150) which he injected. He selected them becau they were affected in a way that could be seen; b many of his pulmonary cases—which were difficult t demonstrate—were quite as good. He hoped later t present a tabulated return; pressure of work ha prevented his making it, as well as trying the opson index.

AN OBSCURE CASE OF NERVOUS DISEASE.

Dr. **Winter** exhibited an obscure case of nervou disease. The symptoms were, he said, vague. The mai thing was exaggerated reflexes, and the patient had a sensation, sometimes of pain and sometimes of numbness and tingling, in his left arm and leg when he go out of bed. Sometimes he got a spasm in his calf an the three outer fingers of his left hand. His superficia reflexes were normal.

The **Chairman** said he would hesitate to diagno the case. There were a number of points which rendered it almost certain that it was a case of disseminated sclerosis; but he was not familiar with th marked spasm as a symptom.

A CASE OF SPLENO-MEDULLARY LEUKÆMIA.

Dr. **A. R. Parsons** read a paper on a case of spleno-medullary leukæmia which had undergone a very remarkable improvement under treatment with arsen —improvement both in the size of the spleen and th condition of the blood.

Dr. **Craig** recalled a case in which the spleen unde arsenic treatment, used to disappear quite beneath the costal arch, so much so that he thought the man was cured. He returned, however, a couple of times to hospital, although taking fairly large quantities o arsenic. In the end he died of general tuberculos and at the time of death the spleen was fairly larg though not so large as on previous occasions. Dr Parsons had shown them a remarkable cure, but wit his own case in view, he would hesitate before sayin that the condition would not recur.

The **Chairman** asked Dr. Parsons if he had formulated any opinion as to the relative merits of the treatment by arsenic and by X-rays, or by both in combination. Dr. Craig's case showed that it was possible to cause the disappearance of the symptoms by drugs but it was important to find whether not only a disappearance of the symptom, but a cure, could be effecte by the X-rays.

Dr. **Drury** cited the case of a woman who had a much larger spleen than Dr. Parson's case. Every drug treatment was tried without result. Then they tried the X-ray treatment alone, and the spleen was enormousl reduced. Ultimately she died of syncope.

Dr. **Parsons**, in reply, said he had purposely avoide using the word *cured*. So far as he knew there was no case of *cure* on record. The improvement in the cas had continued even after the arsenic was stopped. In another case, a lady, æt. 55, who had bee on arsenic for about five months, the treatment had produced diarrhœa and vomiting. She then cam to him, and, as the arsenic had made no improvement he put her under X-rays. After twenty sittings th spleen commenced to subside, and there was also a marked diminution in the white corpuscles. The case therefore proved that the X-rays alone could brin about a remarkable improvement.

NOTES ON A CASE OF CEREBELLAR-PONTINE CYST.

Dr. **Peacocke** read notes of a case of cerebellar-pontine cyst, which occurred in a man æt. 30. His symptoms were frontal headache, giddiness an staggering gait, failing sight, and deafness of the le ear. There was no vomiting. Examination showe paralysis of the muscles supplied by the seventh nerv on the left side, and loss of sensation in the left side o the face. There was no loss of power or sensation in the legs or arms. The thoracic and abdominal organ were healthy. Examination of the eye showed optic neuritis, with small hæmorrhages and white patch in the neighbourhood of the optic disc. There was no elevation of temperature, and the pulse was norma He died quite suddenly, about six months after th first onset of symptoms. *Post mortem* made thirty hours after death, showed a cystic growth involving both cerebellum and pons on the left side. Microscopic examination showed that the brain tissue adjoining the cysts showed two different tissues:—(1) Composed of spindle-shaped elements very cellular, and resembling in all respects a spindle-celled sarcoma. (2) A tissue composed of smaller cells (neuroglial).

Dr. Parsons said that hardly any cases were more trying than brain cases, and he desired to know if the question of operative inferference had been raised. If the surgeon had been able to strike the cyst, the eyesight might have been saved.

Dr. Craig instanced a case in which loss of hearing gave a fair opportunity of localising the tumour, but the operation failed, and the girl died.

Dr. Moorhead said the question raised by Dr. Parsons was very important. In cases where localising symptoms made the position certain, he thought that early operation should be recommended.

Dr. Peacocke, in reply said that the question of operation did suggest itself to him, but no one else who saw the case suggested it.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Meeting held at Edinburgh, May 25th, 1907.

The President, Priestley Smith, F.R.C.S., in the Chair.

Mr. George Coats gave a lantern demonstration on the pathology of rupture of Descemet's membrane. They were first discovered microscopically by Becker, in 1875. Coats had found them in 12 out of 13 cases of buphthalmos, and in 2 out of 8 cases of glioma with increased tension. They were absent in 4 cases of high myopia. The ruptured ends were sometimes found to be flat, and sometimes curled up, but the rupture itself was almost always covered with endothelium. At times extensive detachment of the membrane was found.

Experimentally he found that the globe would give way before the membrane would rupture, but if the membrane was first scratched, many fractures of the rupture could be reproduced.

Dr. Edridge-Green gave an account of his observations with Lord Rayleigh's colour-mixing apparatus, and showed a table which brought out the fact that there were extraordinary differences in the way in which people were able to match the colours. This was not due to any physical condition present, but could be readily explained physiologically in accordance with the author's theory of colour vision.

Dr. Alexander Bruce gave a lucid lantern demonstration of the third nerve nucleus and its surrounding parts.

Mr. Sydney Stephenson described the present position of the spirochæta pallida in relation to syphilitic affections of the eye. After briefly reviewing the evidence in favour of the spirochæta pallida being the specific element of syphilis, he described the special researches which had been made on the eyes of man and the lower animals. In congenital syphilis the organism had been found by Stock, Peters, Römer, Bab, and himself. He detailed the experiments of other observers who had produced interstitial keratitis in the eyes of monkeys and rabbits with syphilitic material from man, and had found spirochæte in the lesions thereby produced. As regards clinical syphilis of the eye, the organism had been found by himself and other observers, and he expressed his belief that the presence of Schandinu's organism was the strongest possible proof of the syphilitic nature of any given disease of the eye or of any of its appendages.

Dr. Leslie Buchanan showed a series of lantern slides of preparations of eyes of invertebrates, with the object of indicating that from the anatomical structure, a certain amount of information can be obtained as to the degree of functional activity of which the organ is capable. The preparations included sections of the eye of the octopus, the clam, the spider, the caterpillar, the house fly, the bee and the snail. Sections of the eye of the Australian mole and of the leech were shown to illustrate the fact that loss of functional activity leads to anatomical degeneration.

Dr. Buchanan also demonstrated a case of rupture of the pectinate ligament. A man was struck on the left eye by a broom handle in the end of June, 1906. Amongst other injuries to the eye, there was what appeared to be a large coloboma of the iris in a downward and inward direction, accompanied by high tension and loss of vision. The case was considered to be one of rupture of the pectinate ligament, with displacement of the iris and ciliary body backwards along the sclera. As the eye continued to be painful, it was excised in January, 1907, when, after histological examination, the diagnosis was proved to be correct. Microscopic preparations were shown.

Dr. Angus McGillivray read a paper on the treatment of after-cataract. To obviate the dragging on the ciliary body and the risk of cyclitis, he divides the capsule diagonally from above downwards and inwards by very short and steady sawing movements by means of a specially-designed cutting needle. Since adopting this sawing method of dividing opaque capsule after cataract extraction, little or no trouble had been experienced, so little, in fact, that he does not now hesitate to divide an opaque capsule when the vision is, from this cause, below $\frac{6}{12}$.

Dr. McGillivray also showed a very convenient storage battery for ophthalmic use.

Dr. Arthur Sinclair and Dr. Theodore Shennan described a case of Parinaud's conjunctivitis in a man, æt. 61, who was a painter's labourer. The left eye became affected during the third week in July, 1906. About three weeks later the surrounding lymphatic glands became enlarged. The patient was under observation for four months, and had not completely recovered when he ceased his attendance and could not be further traced.

Dr. Shennan described carefully the histological and bacteriological condition found. Two varieties of staphylococci were the organisms found.

Dr. Inglis Pollock described a case of telangiectasis of the retinal capillaries and venous radicles. The condition followed on fracture of the left side of the skull, due to a heavy weight falling upon the patient's head. He showed an opthalmoscopic drawing of the fundus.

Numerous card specimens were shown.

Dr. Arthur Sinclair showed a collapsible apparatus for testing the field of vision. He also showed the charts from a case of glaucoma, showing remarkable restriction of the fields of vision in both eyes.

He also showed a case of retinitis punctata albescens.

Dr. Alexander Bruce showed two cases of intracranial neoplasms.

Dr. Robert Fleming gave a microscopical demonstration of an optic neuritis in relation to intracranial tumours, with special reference to the changes in the neuroglia cells.

Dr. E. Bramwell exhibited a brain showing occipital abscess from a case in which epileptic fits were preceded by visual auræ and in which hemiachromatopsia developed. Also a case of ocular palsy, with congenital absence of cranial nerve nuclei.

Mr. Berry showed several cases. He exhibited a loupe for the use of myopes, and test objects for illiterates.

Dr. Mackay exhibited some unusual clinical cases and coloured drawings.

Dr. Sym showed a case of complete congenital anophthalmos and other cases.

Dr. J. V. Paterson showed a case of tubercle of the conjunctiva, and a very pretty case of reticular keratitis.

Dr. Maitland Ramsay exhibited an opaque projector for teaching purposes and some pathological specimens.

Lieut.-Colonel Herbert, I.M.S., gave a lantern demonstration of the sinuous lid border as a sign of trachoma.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 10th, 1907.

A Sure Sign of Pulmonary Tuberculosis.

Dr. Roux, of the Pasteur Institute, made a highly interesting communication before the meeting of the Académie des Sciences in reference to the diagnosis of consumption in its earliest stage, that is, before any tangible symptom, objective or subjective, can be discovered. The method, which was first indicated by Dr. Pirquet, of Vienna, consists simply in making a small incision in the skin as for vaccination, and rubbing in two or three drops of tuberculin of Koch. If the disease is not present, the incision heals rapidly without trouble; if, on the contrary, the patient is in the slightest way touched with the bacilli of Koch, the little wound becomes inflamed, and in five or six days a pustule appears, which, in its turn, dries up in a few days.

Similar experiments were made on animals by Professor Vallé, of the Veterinary School at Alfort, near Paris, and the same results were observed. He vaccinated healthy and tuberculous cows. In the former, the skin showed no signs of reaction, while in the latter the parts became swollen for a few days. As it is allowed by all modern authorities, and confirmed by facts, that phthisis can be cured if treated in its incipient stage, the importance of the above communication is far-reaching and cannot escape the attention not only of all practitioners, but also of the public at large. Other experiments are being made in the Paris hospitals to verify the statements of the director of the Pasteur Institute.

Specific Treatment of Grippe.

Dr. Barbary, of Nice, had a paper read at the Académie de Médecine, on the treatment of grippe by injections of one grain of cacodylate of guaicol in water. Over 100 cases were treated with success and the conclusion he arrived at was that cacodylate of guaicol was a real specific for grippe.

Ice Over the Heart in Febrile Diseases.

Professor Leduc strongly recommends the placing of the ice-bag over the heart as a powerful means of strengthening the organ in the course of high temperatures by which it is weakened in its energy.

This precordial frigo-therapy gives the same results as the cold bath, and has the advantage of easy application.

In all febrile maladies, where the fever is over 102° and the pulse over 110, the ice-bag should be applied; one or two folds of flannel should be placed between the skin and the ice.

Within two hours after the application, the temperature falls one or two degrees, while the pulse diminishes by fifteen to thirty beats and regains its strength.

No medical antithermic agent can act as regularly and as surely.

Under its influence a general improvement takes place in all the functions and in particular those of the nervous system.

When the temperature has remained for several days sufficiently low, the ice-bag may be removed, but frequently the temperature goes up again. The better plan would be to diminish gradually the antithermic action by doubling the folds of flannel.

One curious effect of this treatment is that it increases the antithermic action of pyramidon and quinine. A dose of ten grains of pyramidon which, before, had no effect on the fever, produced, after the application of the ice-bag, a sudden fall of the temperature with profuse perspiration, endangering the patient's life. Two grains of pyramidon were quite sufficient to obtain the desired result in all cases.

Professor Leduc concludes that the ice-bag should be applied to all patients whose temperature exceeded 102°.

GERMANY.

Berlin, June 9th, 1907.

At the Verein für Innere Medizin, Hr. Benda related a case of

Blastomycosis of the Brain.

On March 22nd, a body came from the Second Medical Abteilung of the Urban Hospital with a diagnosis of encephalitis. The autopsy showed first hyperæmia and clouding of the meninges, but no proper inflammation. On opening the ventricle small white mucous threads were seen in the otherwise clear fluid. On microscopical examination these were found to be small, rounded bodies, strongly refracted, light, and of irregular size. This led the examiner to say that they looked like the cells of the yeast fungus. This suspicion was confirmed on further examination, as by both staining and pure cultivation, they proved to be really yeast cells. The meninges were then found to be strewn with the cells. Macroscopically, on the brain surface were numerous vesicles, and in the cortex were numerous small cavities from the size of a millet to that of a hemp seed. The basal ganglia were also strewn with them. Microscopical examination showed that the patches consisted almost entirely of yeast cells. There had been no real inflammation, the only things seen were macrophaga filled full of yeast cells. Culture of the cells showed some biological peculiarities. They did not ferment, and were very oxyphile. No pathological explanation of the case could be given. No port of entrance could be made out; nothing was found in the frontal sinuses, and in the lungs there was no blastomycosis, only pneumonia. A similar case occurred at the Friedrich's Narri Hospital.

Hr. V. Hausemann remarked that the case at Friedrich's Narri was a similar one. A third case was observed recently in Vienna, but it had not yet been published. In his case, Krönlein had found the cells in the cerebro-spinal fluid after lumbar puncture, so that the condition was diagnosed *intra vitam*.

Hr. Plehn observed that in Benda's case, which had come from his own Abterlung, the yeast cells were also found in the fluid from the spinal punctures, but death took place before the examination was completed. As regarded clinical symptoms, the patient had had an attack of influenza a few weeks before, had recovered, and had again sickened with fever and somnolence. There were no brain symptoms whilst the patient was in hospital, the ophthalmoscope showed neuro-retinitis.

Hr. Grawitz showed a case of

Addison's Disease in which Recovery has Taken Place,

with observations on the pathogenesis of the disease He remarked that recovery from Addison's disease was so rare that such a case was extremely interesting. The patient, an official of the Charlottenburg Magistracy, entered his regiment as a one year recruit in 1902, and performed his duties with satisfaction for a time. During his free hours he occupied himself extensively with mental work, in order to prepare himself for the secretary's examination. His health suffered, however, and he spent some time in hospital. In November, 1902, he relapsed, had a brown look and as he got steadily weaker, he was admitted into hospital again; from here he was at last discharged from military service. He came into the Charlottenburg hospital early in 1903. There was strong pigmentation of the hands and face and of the axillæ, great weakness, intense gastro-intestinal symptoms, motor and functional insufficiency. The impression he gave was a bad one. The directions given were for washing out of the stomach, the injection of food into it, and nutrient enemata; no medicines. The nourishment was practically vegetable, albuminous material was only given in the enemata. The condition improved much, the strength increased. In three weeks the man gained 3 kgrm. in weight, the pigmentation was unchanged. The patient was discharged from hospital and sent to Thuringia for further recuperation. He lost ground there, however, and came back in a wretched state, strong adynamia, and the old pigmentation. The treatment was begun again with the same improvement, the pigmentation failed, and he was again discharged to service in the Bureau. Examination of the stomach showed absence of free hydrochloric acid. The patient followed a rigid *regime*, took no alcohol, and, since his discharge, he had been able to perform his duties. The pigmentation had almost disappeared. There was a slight trace on the lips only. During the last few weeks the patient had had a tuberculous testicle removed; otherwise no tuberculous signs were present.

In many cases of Addison's disease no change had been found in the supra-renal capsule, and also in many cases of disease of the capsules no bronzing was present. A chromophile substance had been shown to be present in the medullary substance of the supra-renal capsule, and the notion had been propounded that Addison's disease was associated with the loss of this substance. The question now arose whether this disease was an ætiological entity. We saw in the so-called "Vagabond's Disease" a similar pigmentation of the skin, which, according to Neisier, depended on the miserable condition of the body. Now in lethal diseases, pernicious anæmia for example, any demonstrable anatomical cause was sometimes not to be found. Perhaps it was the same with Addison's disease. How had treatment done its work in this case? Here it was to be observed that similar treatment was successful in intestinal pernicious anæmia. Perhaps toxic products were absorbed through the severe intestinal catarrh, that acted unfavourably on the function of the supra-renal capsules. It was well indicated, therefore, in cases of Addison's disease with intestinal symptoms to act on the intestines in the way pointed out.

AUSTRIA.

Vienna, June 9th, 1907.

Thyroid Epithelial Corpuscles.

Leischner gave his long promised report to the members of the Gesellschalft on his experiments with animals in removing the thyroid gland. Other experimentors have found that when the epithelial bodies are retained in the gland tetany is obviated. This has now been acknowledged by all operators, but the question arose: could the function of these epithelial corpuscles be retained if transplanted to the remaining portion of the gland? Leischner answers in the affirmative and avows that where the surgeon has a severe operation and must remove a large part of the thyroid gland, he should search in the part removed for every epithelial corpuscle he can find and transplant them into the portion of gland left in the wound, as he has done in animals with perfect success. Where intra-cystic enucleation is necessary, every epithelial body should be retained to avoid tetany.

Eiselberg said he had performed many operations lately for goitre, and has now set it down as a general rule that the fewer epithelial bodies you remove the greater is the success in recovery. He has also learned that one cyst can be removed from the human subject without doing much harm as the other three are quite able to perform the necessary functions of the body.

Aniridia Congenita.

Bergmeister next presented two patients with eyes having no irises, permitting the lens to fall forward on the cornea, producing ectopia lentis. In one of the cases the mother, æt. 42, and another daughter, æt. 10, had a similar congenital defect. The daughter's scleral surface had a porcelain appearance, with firm resistance to touch while the ciliary vessels had nothing abnormal. Astigmatism of 2½ dioptres was present, while the anterior chamber had a normal depth, but both irises were absent. The lens lay obliquely so that light from the side produced darkness although the lens was perfectly clear and transparent. The fundus of the eye was normal and strong light almost blinded the patient. Acuity of vision was reduced to one-tenth, and could read at 7 to 12 ctms. distant. Looking through an orifice of 1 millimetre the vision was improved three times, or ⅓. In the second case the mother suffered from glaucoma in both eyes, the bulbi being rigid, hard, and the cornea projecting and densely clouded, the left more than the right; in the latter around the cornea the absence of the iris could be observed as in the daughter.

In congenital aniridia glaucoma is a common result, which usually defies all treatment, and as iridectomy is impossible sclerotomy is the only relief which has never given any good result. In this case he thought "kyklo dialysis" as practised by Heine in glaucoma, might be of some service.

Carcinoma Mammæ.

Riehl showed a cast of a carcinomatous mammæ which came under his notice for treatment, and which was so peculiar that he has not yet found a description in medical literature that elucidates his case. The disease was distributed over the gland in small vesicular groups from a millet seed to the size of a pea, at first filled with clear fluid, but later tinged with blood. These miliary vesicles felt hard and resisting, and remained weeks in this condition till they collapsed by exudating matter, and on being pricked early discharged clear fluid. In these cysts very few epithelial cells of carcinoma were present at first, but at a later period they appeared at the base of the cavity increasing in number till a hard nodule was formed. These small cysts appear to have developed primarily in the lymphatic vessels, whose endothelium formed the sac and from which the carcinomatous cells wandered in the lymph vessel till another was formed, thus repeating themselves by metastasis, finally producing a wide area of carcinomatous tissue. The bleeding resulted from the destruction of the capilliary vessels and blocking of the circulation, as in lymphangioma.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Edinburgh Royal Infirmary.—At their meeting on June 3rd the managers promoted Dr. William Russell, assistant physician, and Mr. J. W. B. Hodsdon assistant surgeon, to the posts of ordinary physician and surgeon to the institutions. These appointments date from September 1st next, when Dr. James and Mr. MacGillivray, the senior physician and surgeon, domit office. There are now vacancies for an assistant physician and surgeon, and for these posts a number of candidates are in the field.

Edinburgh and Glasgow Medical Club.—The annual dinner of this club took place on May 31st in the College of Physicians, Dr. Playfair being in the chair. The club is purely of a social nature, and this dinner was unusually successful, as a much larger contingent of Glasgow members attended than is usual. The next dinner takes place in Glasgow, and it is expected that the attendance of Edinburgh members will be good. Such meetings do much to encourage friendly feeling between the members of the profession in the two cities, and to remove those sentiments of jealousy which are sometimes a hindrance to the advance of medicine.

Sir Henry Littlejohn's Annual Report on the Health of Edinburgh.—A Summary of this report, which is not yet in the hands of the public, has been issued. The birth rate of 22.41 per 1,000 is still on the down grade, and is lower than many other large towns save Perth. The death rate is 16 per 1,000, or deducting temporary residents and those who had come into the city for treatment, 1,426, practically the same as in 1905. The low death rate is in keeping with the steady reduction of the past twenty years. The zymotic death rate (excluding diarrhœa) was ·75 per 1,000, which is considerably below the five years' average of 1·25. No small-pox or typhus have occurred during the year. The deaths from phthisis and other tuberculous diseases show a decline. Typhoid fever is diminishing, whereas diphtheria has increased in frequency.

BELFAST.

Sewage Purification.—At a recent meeting of the Belfast Corporation particulars were given of the progress of the new sewage purification works. The experiments which have been carried on for some years have shown the best lines on which to treat the sewage, having regard to the peculiar conditions which prevail in Belfast Lough, and plans are being made to construct large septic tanks. Meantime the works already constructed are capable of dealing with one-sixth of the sewage of the city, obtaining a purification, judged by the free ammonia, of 60 per cent., while the new tanks, by means of sprinkling beds, will give a purification of 96 to 98 per cent. If this sanguine forecast proves correct, it will be a real boon to the city and neighbourhood, to which the state of the Lough caused by the sewage discharged into it has for years been a very real nuisance.

Mater Infirmorum Hospital, Belfast.—The annual report of this hospital, just issued, shows a large amount of vigorous and successful work on the part of the medical staff. During the past year the intern patients numbered 1,861, the surgical operations performed were 597, the accidents treated were 4,268, and the total number of patients treated in the extern department was 29,914. The total expenditure for the year was £5,100.

Cerebro-Spinal Meningitis.—During last week there were 22 cases of cerebro-spinal meningitis notified, the same as the week before. The deaths registered were 14, which is six less than the previous week, and there seems no doubt that the disease is showing a less virulent character than it did some weeks ago.

LETTERS TO THE EDITOR.

DOCTRINA.

To the Editor of The Medical Press and Circular.

Sir,—Although I naturally feel much interest in reading the excellent letters on the hospital question which your correspondents have addressed to you on this important subject, may I this week direct some attention to the question of education, which is at last beginning to attract such men as Mr. Balfour and others, who are gradually beginning to realise that reforms in universities and education generally are important matters? The question of interest to us is how to educate our rising doctors. We want those who are entering the profession to come with something more practical and less assertive or conceited than we fear is the consequence of cramming and examinations. I remember Sir William Lawrence telling me how he lived in the house of Abernethy, and how he learnt his art and science from that distinguished man. There is no doubt but that we feel very great interest in hospitals, not as charitable institutions, but as schools of medicine and surgery; and we cannot but regret that as such they have degenerated sadly from what they were in the time of the Hunters, Astley Cooper, Matthew Baillie, and the leaders of the early and middle periods of last century. To get the courses signed up, after paying the necessary fees, seems to be of more importance to the student now than learning anything from lectures. It is the examinations upon which the students' mind is fixed; and when these are over, then he may begin to learn. Mr. Balfour seems to think much of post-graduate study. He may perhaps not be familiar with the Hippocrates dictum—"Life is short; art is long; the opportunity fleeting." The post-graduate principle is somewhat like the Chinese. It would be well to be careful we don't drift into such a state as they have.—I am, Sir, yours truly,

R. L.

A PERINEAL HORN.

To the Editor of The Medical Press and Circular.

Sir,—The appliance described under above heading by Dr. Elliott in the last issue of your journal, is not new. Twenty years ago I designed and used a similar retractor, and found it a failure. Laceration depending very often more on the size of shoulders of the fœtus (and perhaps their unskilful delivery) than the size of fœtal head. A far simpler plan and one for which I claim priority, is the following which has *never yet failed me* in preserving intact the perineum (should I see the case in time), viz. intermittent traction backwards of the perineum during (and only during) the continuance of each pain, in humble imitation of nature, the dilatation of the os and cervix being effected in a similar way.

I am, Sir, yours truly,

London, W. Alexander Duke.

MEDICAL MEN AND NURSING HOMES.

To the Editor of The Medical Press and Circular.

Sir,—I am deeply pained to find that a limited liability company has been registered this week to run a nursing home, and that most of the shareholders signing, and nearly all the directors, are Fellows of the Irish College of Physicians.

I should not hesitate to detail the names of those doctors, were it not for the great personal respect which I have for them, but they must surely see, on reflection, that such a position is incompatible with the dignity of a Fellow of the College.

The rules forbid a Fellow to supply medicines, or even to be interested in a compounding establishment, so that nobody can suggest that he profits out of the drugs he orders; but certainly it is of far more importance that nobody could say that the physician will profit when he recommends a patient to a private hospital for some time.

Of course, the gentlemen in question are above suspicion, but their example will tempt humbler men to follow—with lamentable results.

I am, Sir, yours truly.,

J. C. McWalter.

OBITUARY.

J. S. HICKS, F.R.C.S.Ed., L.R.C.P., F.L.S.

We regret to announce the death, on June 1st, of Dr. John Sibley Hicks, of Sefton Park. The deceased gentleman served for some years as a medical attendant on one of the liners sailing between Liverpool and America, and finally settled in Liverpool, where he had practised for the last forty years. He was educated at Glasgow University and qualified as L.F.P.S. and L.M. in 1860. In 1871 he took the F.R.C.S.Ed. and L.R.C.P.Lond. He was much interested in natural history and microscopy all his life, and was an F.L.S. and F.R.M.S.

THOMAS M. BELLEW, L.R.C.S.I.

We regret to announce the death of Dr. Thomas Mulholland Bellew, of St. Helens, which occurred after a long and painful illness on June 4th. Dr. Bellew was a native of Strinagh, near Drogheda, but he had been in practice in St. Helens for the past twenty-five years, during which time he had been most popular. He was surgeon for the Lowe House Men's Guild, Holy Cross Boys' Guild, the Great Central Railway, and two of the local copper and smelting works. Over a year ago he was attacked by a serious malady, for which since October last, three operations had been performed. He leaves a widow and five children, with whom the greatest sympathy is expressed.

WILLIAM MAULE, M.B., C.M.Ed.

We regret to announce that Dr. William Maule, of Birkdale, and formerly of Wigan, died on June 2nd., aged fifty-four. He had been in failing health since February. He studied medicine at Edinburgh, and after qualifying in 1876 as L.R.C.S. and L.M., he proceeded to read for the University final, which he passed in 1879. He was surgeon to the Great Central Railway at Birkdale, and was known as author of "Medical Tracts for the Times."

SPECIAL ARTICLE.

THE IRISH UNIVERSITY QUESTION.

In the House of Commons last Monday the Prime Minister said :—

"It is clear to the Government, in regard to another great question, that of University education in Ireland, that no practical result could be expected to follow the introduction during the present session of a bill dealing with the question. During the autumn recess my right hon. friend, the Chief Secretary, contemplates being in Ireland, and devoting time and attention to the question. My friend the right hon. gentleman is of a cheerful and often sanguine temperament, and he believes that it is possible, and even likely, that there may be established or discovered harmony among the jarring interests and views upon the subject in Ireland—a task which I admit has often defied the efforts of the pacificator.

Mr. John Redmond said :—

"I confess I heard with great regret the statement made by the Prime Minister on the University question. Let me in two or three sentences recall to the memory of the House how the matter stands. The late Government declared that they could not deal with this question until there was practical unanimity of opinion in Ireland. That meant, of course, the practical shelving of the question, because you never can have practical unanimity on a question of this kind in Ireland any more than you can have practical unanimity of opinion on any educational question in England. Now, whatever differences there may have been as to the merits of the scheme in comparison with other schemes previously suggested, that at any rate was the result of that action—that all those who represented at any rate Catholic and national opinion, came out and declared that they would accept his scheme. The representatives of the Irish National party said so, the Irish Hierarchy said so, and practically all those in Ireland who may be classed in the terms Nationalist and Catholic declared that they would accept the scheme, although in many cases it was not the one that they individually would have preferred. But now, not only is the Government not going to introduce this bill this session, but we are face to face with the fact that they are not going to introduce it. I did not believe that they could pass it this session, but I did believe they could introduce it, as they are doing with reference to another bill mentioned, and introduce it for discussion in the autumn during the recess. Not only that, however, but they have absolutely reverted to the policy of their predecessors—that is to say, they (the Prime Minister and the Chief Secretary) are to spend time in discussing a scheme that will unite everybody in Ireland. Well, that is an impossible task. No one knows it more than the Chief Secretary himself, and I think it is most lamentable that this backward movement should be taken upon this question."

NEW BOOKS AND NEW EDITIONS.

The following have been received for review since the publication of our last monthly list :—

Sidney Appleton (London).
Physical Diagnosis. By Howard S. Anders, A.M., M.D. Illustrated. Pp. 456. Price 12s. 6d. net.
Bailliere, Tindall and Cox (London).
"A Synopsis of the British Pharmacopœia" (1898). By H. Wippell Gadd, F.C.S. Sixth Edition, containing a synopsis of the Poison Laws of Great Britain and Ireland. Pp. 227. Price 1s. net.
On Treatment. By Harry Campbell, M.D., B.S., F.R.C.P., Physician to the N.W. London Hospital &c. Pp. 421. Price 5s. net.
Rational and Effective Treatment of Hip-Disease By P. Bruce Bennie, M.A., M.D., B.S.(Melb.). Compiled by Alex. B. Bennie, M.A., M.B., B.S.(Melb.). Illustrated. Pp. 108. Price 5s. net.
A Dictionary of Medical Diagnosis for the use of Medical Practitioners and Students. By Henry Lawrence McKisack, M.D., M.R.C.P. Lond. Illustrated. Pp. 583. Price 10s. 6d. net.
John Bale, Sons and Danielsson, Ltd. (London).
The Psycho-Physical Aspect of Climate with a Theory Concerning Intensities of Sensation. By W. F. Tyler, F.R. Met. Society. Pp. 45. Price 5s. net.
George Bell and Sons (London).
The Gem-Cutter's Craft. By Leopold Claremont. Illustrated. Pp. 296. Price 15s. net.
Blackie and Son, Ltd. (London).
The Laws of Health : A Handbook on School Hygiene. By Carstairs C. Douglas, M.D., D.Sc., F.R.S.E. Illustrated. Pp. 240.
J. and A. Churchill (London).
St. Thomas's Hospital Reports. New Series. Edited by Dr. H. J. Turney and W. H. Battle. Vol. 34. Pp. 637. Price 8s. 6d. net.
Materia Medica Pharmacy, Pharmacology and Therapeutics. By W. Hale White, M.D., F.R.C.P. 10th Edition. Pp. 692. Price 6s. 6d. net.
Henry J. Glaisher (London).
Hay-Fever, Hay-Asthma: Its Causes, Diagnosis and Treatment. By William Lloyd. Pp. 95. Price 3s. 6d. net.
"The Guardian" Office. (London).
Our Sons: Their Start in Life. With Two Articles on Professions and Occupations for Women. 2nd Edition. Pp. 122. Price 2s. 6d.
The Health Resorts Bureau (London).
Some Summer Resorts in the South of France. By John W. Potter. Second Edition, enlarged. Pp. 134. Price 1s. 6d. net.
Henry Kimpton (London).
Medical Philosophy. By W. Russell. Pp. 504. Price 21s. net.
H. K. Lewis (London).
Modern Methods of Diagnosis in Urinary Surgery. By Edward Deanesly, M.D., B.Sc.Lond., F.R.C.S. Pp. 97. Price 3s.
McCorquodale and Co., Ltd. (London).
Metropolitan Asylums Board. Annual Report for the Year 1906. Pp. 350. Price 5s.
Macmillan and Co., Ltd. (London).
Alcohol and the Human Body. By Sir Victor Horsley, F.R.S., F.R.C.S., &c., &c., and Mary D. Sturge, M.D.Lond., with a chapter by Arthur Newsholme, M.D., &c., &c. Pp. 370. Price 5s. net.
G. P. Putnam's Sons (London).
The Muscles of the Eye. By Lucien Howe, M.A., M.D. In two volumes. Vol. I. Anatomy and Physiology. Illustrated. Pp. 455. Price 16s. net.
A Manual of Prescription Writing. By Matthew D. Mann, M.D., A.M., M.D. Revised by E. C. Mann, M.D. Sixth Edition. Pp. 232. Price 4s. net.
Rebman, Ltd. (London).
On Benign Cysts of the Long Bones. By Robert Jones, F.R.C.S., and Dr. David Morgan. Reprinted from "Archives of the Rontgen Ray and Allied Phenomena," April and May, 1907. Pp. 4.
F. R. de Rudeval (Paris).
Précis de Technique Orthopœdique. By P. Redard. Illustrated. Pp. 591. Price 12 frs.
La Grande Faucheuse. By Dr. Fernand Barbury. Illustrated. Pp. 340 Price 7 frs.
Alex. Thorn and Co., Ltd. (Dublin).
The Royal University of Ireland. The Calendar for the Year 1907. Pp. 547.
F. S. Turney (London).
Medical Priestcraft. A National Peril. By John Shaw, M.D.Lond. Pp. 246. Price 5s. net.
Cancer: A Working Theory for its Prevention and Cure. By John Shaw, M.D.Lond. Pp. 25. Price 1s. net.
J. J. Weber (Leipzig).
Deutsches Bäderbuch. Bearbeitet Unter Mitwirkung des Kaiserlichen Gesundheitsamts. Pp. 535.
B. T. and Co. (London).
The Diagnosis and Treatment of Pulmonary Consumption. By Arthur Latham, M.A., M.D., &c., &c. Third Edition. Pp. 259. Price 5s. net.
Ulceration of the Cornea. By Angus Macnab, B.A., B.Sc., &c., &c. Illustrated. Pp. 196. Price 5s. net

REVIEWS OF BOOKS.

CANCER—A HUMAN SCOURGE(*a*).

This is the least satisfactory addition to the series of volumes forming the well-intentioned, and in many respects admirable, "New Library of Medicine," edited by Dr. C. W. Saleeby. Its title is uninforming, and its sub-title is objectionable, and, as some will doubtless aver, misleading. Mr. Childe, with a youthful optimism hardly born of experience, has undertaken the peculiarly difficult and dangerous task of writing a book for the public on "cancer." He has undoubtedly succeeded in producing a smart and readable work. Realising that "offence must come" from the issue of such a book, he boldly faces the situation, and, with courage, if not discretion, hesitates not to proclaim his gospel of hope in surgery for the cancerous. The object of the book is very simple. It is to educate the public on the necessity for early medical—or should we not say surgical?—advice. Mr. Childe's axioms are :—1. "Cancer is, in its beginnings, a local

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(*a*) "The Control of a Scourge, or How Cancer is Curable." By Charles P. Childe, B.A., F.R.C.S., Surgeon Royal Portsmouth Hospital, Pp. 299. London: Methuen and Co. 1906. Price 7s. d.

disease, and confined at first to the part it first attacks." 2. "From its local site of origin it generally very soon disseminates itself into the system of its victim." These "facts," as he calls them, lead the author to insist that "a period exists in every cancer, longer or shorter as the case may be, when it is local, when it is operable, when it is curable." Special reference is made to mammary, uterine, oral and lingual, gastro-intestinal and cutaneous cancer, but the common occurrence of malignant disease in other parts of the body oftentimes inaccessible—if the surgeon will allow the use of such an obsolete word—seems almost to have been forgotten. We cannot but fear that the author has weakened his case by a dogmatism which must oftentimes bring disappointment. For instance, some would think that the following is at least but a partial truth:—"Cancer itself is not incurable. It becomes incurable from the simple fact that its unfortunate victims harbour and nurse their cancers till it is too late. It is not the disease which is incurable; it is the delay that makes it so." Mr. Childe is evidently not an experienced pathologist, else he would lay greater stress on the latency of malignant disease and the long-deferred appearance of localising signs in many cases of cancer of internal organs. The chapter on "Danger Signals" should enforce the author's text, "Seek medical advice without a moment's delay." Mr. Childe is candid, for he tells his reader that, "It must be frankly confessed at the outset that the cause of cancer is unknown," and he might have added that, as a consequence, the rest of his book was unavoidably little more than an uncertain groping in the dark. Mr. Childe is a bold writer, with an incisive, unconventional style, and does not hesitate to enforce his points by Scriptural allusions and slang phrases which, although jarring on hyper-sensitive susceptibilities, undoubtedly go far to grip the attention of a hustling public. The purpose of the book is excellent; the execution merits commendation, but the inherent difficulties of the subject and the situation can hardly be overcome by courage while knowledge lingers.

A STUDENT'S MANUAL OF HISTOLOGY (*a*).

A sound knowledge of histology is essential for the student. Dr. Hill's admirable manual forms a reliable guide and companion for the laboratory. Only fundamental and essential subjects are presented. The descriptions are concise and clear, and the matter is well arranged. The special feature of the work, however, is the excellent series of figures—some being coloured—which will be of the greatest service to the elementary student. Reference should also be made to the unusually detailed account of the teeth, and the illustrations of dissected skulls showing the development of the teeth are admirable. Good paper, clear printing, convenient size, and flexible covers makes this a book likely to be popular with many students.

INTERNATIONAL CLINICS. (*b*)

The present volumes of this quarterly contain, as is customary, a series of clinical lectures and original articles on therapeutics, medicine, surgery, and the various allied specialities, and number among their contributors writers of note from France and Italy, as well as American and British authors, who, naturally enough, between them have contributed the large majority of the articles. Very few, if any, of the papers can be regarded as adding much to our knowledge from a purely scientific point of view; but on the other hand many of them are excellent and practical expositions of the present state of our knowledge concerning ordinary cases such as are met with every day in general practice. The illustrations are numerous and well executed, special praise being due to the group that is included in the paper entitled "Tumours of the Mammary Gland," by Dr. Rodman, of Philadelphia, and to those that illustrate Dorland's paper on "The Female Perineum and its Rep In the therapeutical section the article of most int is that on Fournier's present treatment of syph As is well known, Professor Fournier has rece advised that mercurial courses should be give syphilitic patients not only during the first couple years after they have contracted the disease, but about the fifth and eighth years. He bases modification of his previous practice on the ana of a number of paretic cases, in which he found the first symptoms of general paralysis showed th selves most often in the sixth year after the prim chancre, and that from that year up to the twe after infection the onset of G.P.I. was more noted than during any preceding or subsequent ye The new method is designed to prevent such onset the use of mercury during those most danger periods. The present writer, Monsieur Saingery, Paris, does not believe in the syphilitic origin general paralysis, and expresses the fear that merc may, by weakening the individual's resistance, incre rather than diminish the frequency of the disea and criticises Fournier's treatment from that point view. The paper is interesting, but as his fun mental premise is, as far as we know, incorrect, attack cannot be regarded as a very serious c Another interesting paper is that by Rovighi on t "Surgical Treatment of Nephritis by Decapsulatio He has produced experimental nephritis in rabbits means of diphtheria toxin and cantharides, and cla to have cured the condition again by unilateral deco cation, while control animals, which were not opera on almost invariably died. The number of his expe ments, however, is not great enough to admit of t far-reaching conclusions that he has arrived at, does he seem to have observed the experime animals for a sufficient time after operation, to pr that the new formed capsule does not ultimate invade the kidney substance and lead to cirrho The clinical papers are too numerous to admit individual mention, but most of them well rep perusal, and as they deal with a large variety o subjects they should be of value to the general pract tioner. Dr. Abraham's paper on "The Irregu Heart," and Dr. Moffitt's on "Persistent Vomiti appear to us to be the best of them, while Ban views on "Leukæmia and Sarcomatosis" will a many in systematising their ideas on the very comp group of diseases included under that heading.

INTERNATIONAL CLINICS (*a*).

This, the last volume of the sixteenth series International Clinics, contains the usual miscella of articles on therapeutics, medicine, surgery, gyna logy, laryngology; twenty-two papers in all be included within the compass of about three hund pages. None of the papers can be regarded as ve original, but they are all without exception go clinical and practical expositions of the various subje dealt with, and as such are well calculated to pr of interest to the practising medical man, and to h him to attain to the utopian condition of being gen ally up-to-date. In the therapeutical section, t best contribution is that by Dr. Rhein, on elec therapeutics. In his paper a summary of a l important facts of the subject is to be found, a numerous practical tips are recorded, which can be found with ease elsewhere. The section on medic contains two valuable summaries, one on "Rec Progress in our Knowledge of the Adrenals," and anot on "The Physiologic Influence of Lowered Baromet Pressure." Dr. Dieulafoy, of Paris, contributes article on Syphilitis Aortitis, and a really helpful pap on "Obscure Renal Hæmaturia" is from the pen Dr. Elliot, of Chicago. In the surgical section Wallace writes on Vesical Tumours, and though he holds out hope that early cystoscopic examinations may in the future lead to better results from operat

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(*a*) "A Manual of Normal Histology and Organography." By Charles Hill, Ph.D., M.D., Assistant Professor of Histology and Embryology at the North-Western University Medical School, Chicago. Pp. 463, with 312 figures. Philadelphia and London: W. B. Saunders Company. 1906. Price not given.

(*b*) "International Clinics." Vols. II. and III. Sixteenth Series., Philadelphia and London: J. B. Lippincott Company. 1906.

(*a*) "International Clinics." Vol. IV. Sixteenth Series. Edited by A. O. J. Kelly, M.D., Philadelphia. Philadelphia London: J. B. Lippincott Co.

he is compelled to admit that at present the prognosis is undoubtedly bad. Some of his figures are interesting—thus he points out that the operative mortality in cases of benign tumours is 17 per cent., and in malignant cases 27 per cent.; in benign cases rapid recurrence was met with in 20.5 per cent. of cases, and in 26.8 per cent. of the malignant cases; while palliative treatment was adopted in 89 patients and few of these lived longer than six months. This paper is well worthy of study. Almost all the papers in the surgical and gynæcological sections are profusely and well illustrated, as is the rule in this quarterly journal. The illustrations alone, indeed, make the volume an object to covet.

A SYSTEM OF GYNÆCOLOGY. (*a*)

In dealing with a book which comprises articles from the pens of so many distinguished gynæcologists, we have many difficulties to contend with. In the first place, gynæcology, unlike medicine, does not lend itself to a great degree of sub-division, with the result that many of the articles overlap each other, and we find statements made in one which are practically contradicted in another. This must surely prove a deterrent to all but specialists in gynæcology, who, devoting themselves to this branch of the profession, usually possess the full works of many authors. So we are almost tempted to ask the question, "Cui bono?" with regard to the work before us.

The book opens with a very interesting chapter upon the development of modern gynæcology, and can only make the reader stand amazed at the giant strides this subject has made within recent years. The section devoted to the anatomy of the pelvis is clearly and concisely written, the illustrations being good and explanatory. The various methods of pelvic examination are fully described and stress is laid upon that most important one of all—the recto-vagino-abdominal—a method which receives as a rule too slight recognition at the hands of many writers.

Under the heading of "Disorders of Menstruation," the hæmorrhages are carefully considered; but there is no mention made of the treatment by atmocausis in these cases in which it has been of late considered suitable. Later in the book this treatment is briefly outlined, but it is curious to note the difference in the method of application between the writer and Dr. Ludwig Pincus. The latter, in his recently published work on the subject, points out that anæsthesia is not advisable during the operation, but in the article, "Atmocausis," we find it stated that anæsthesia should be pushed to the full surgical degree. Again, we learn from Dr. Pincus that whenever possible, the operation should never follow curettage, but here we find it recommended to curette the uterus previously, if we find it necessary; no indications are given. It would be interesting to know upon what these differences are based.

Schultze's diagrams illustrate the bi-manual method of reposing a retro-flexed uterus, a tribute to that great authority which is paid by nearly every writer on the subject. Fig. 65 compares very unfavourably with them, being wretchedly drawn and conveying quite a wrong impression as to the position of the uterus maintained by a pessary. In addition to the bi-manual, reposition by means of the sound is described and figured, no mention being made of that simpler and far less dangerous procedure of replacing a retro-verted uterus by means of a bullet forceps on the anterior lip of the cervix and a finger introduced into either the rectum or vagina.

Having replaced the uterus, we are told that should the vaginal pessary prove an insufficient means of support, by the cautious introduction of an intra-uterine stem benefit will be obtained. Has the stem pessary any place in modern gynæcology?

Many of the articles are fully written and well illustrated, the one on "Chorionepithelioma" being of great interest, and the illustrations of the pathological sections clearly reproduced. In spite of the fact that it used to be performed ten years ago, it is doubtful if any advantage is to be gained by the description of the supra-vaginal amputation of the uterus with extra-peritoneal treatment of the stump.

The volume is well bound and printed, and of a very convenient size, and, needless to say, contains much valuable information upon recent developments in gynæcology.

WORKS ON REFRACTION OF THE EYE.

We welcome a new edition, the seventh, of Morton's excellent little manual (*a*). The popularity which the work has gained is well deserved, inasmuch as it places before the student in refraction all the essentials of the subject, in plain and concise terms, without the padding of unnecessary details. In this new edition the work has been revised and largely rewritten, while a useful chapter has been added dealing with the applicability of prisms to the treatment of refraction cases.

Mr. Hartridge has carefully revised his work in the new edition (*b*), which has become so popular. But little need be said in the way of criticism of a manual of which twenty-eight thousand copies have been sold. The fact of its popularity speaks for itself for, despite the large number of works published upon the subject of refraction, this volume still maintains the position it established as long ago as 1884. We congratulate the author upon his success—a success, which, nevertheless, is deserved—inasmuch as his book is well written, plainly expressed, and deals in an eminently practical manner with the mass of detail inseparable from the work of a refractionist.

PULMONARY PHTHISIS (*c*).

The early diagnosis and prompt treatment of incipient phthisis are so important that we welcome every attempt to facilitate recognition of what may, for clinical purposes, be called the præ-tuberculous stage of the disease. In the sense in which we use this term we mean merely that the tuberculous lesions, though possibly present, are not as yet manifest. The author's attitude is in favour of erring on the right side and instituting appropriate treatment whenever we are in presence of a departure from health not explained by obvious disease. The author devotes much attention to the question of prognosis in phthisis, and some useful hints are given as to the interpretation to be placed on physical signs for this purpose. With regard to the treatment of phthisis the author, of course, has nothing very new to say. He, however, gives good practical advice on general hygiene and medicinal measures, but he speaks hesitatingly about the employment of the various tuberculins and serums—not without just cause. His remarks on the application of the opsonic index are rather scanty considering the importance of this discovery. Is he not in error in conveying the idea that it is possible by injection of tuberculin, controlled by the opsonic index, to redetermine a "high and continuous level of tissue resistance"? There is now sufficient material on hand to justify a more elaborate description of the method and its bearings. It is, however, a sound essay, which will be found of service by general practitioners who have to bear the brunt of the battle against tuberculosis, and need every assistance in so doing that their experienced brethren can afford.

(*a*) "A System of Gynæcology by many Authors." Edited by Thomas Clifford Allbutt, M.A., M.D., F.R.S., &c., Regius Professor of Physic in the University of Cambridge; W. S. Playfair, M.D. LL.D., F.R.C.P., Professor of Obstetric Medicine in King's College; Thomas W. Eden, M.D.Edin., F.R.C.P., Assistant Obstetric Physician, Charing Cross Hospital. London: Macmillan and Co., Ltd.

(*a*) "Refraction of the Eye: Its Diagnosis and the Correction of its Errors, with a Chapter on the Use of Prisms." By A. Stanford Morton, M.B., F.R.C.S.Eng. Seventh Edition. London: H. K Lewis. 1906.

(*b*) "The Refraction of the Eye: A Manual for Students." By Gustavus Hartridge, F.R.C.S., with One Hundred and Nine Illustrations. Fourteenth Edition. London: J. and A. Churchill. 1907.

(*c*) "Pulmonary Phthisis: its Diagnosis, Prognosis and Treatment." By H. Hyslop Thomson, M.D., Visiting Physician to the Consumption Sanatorium of Scotland. London: John Bale, Sons and Danielsson Ltd.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Adenoma of Langerhan's Islands. — Helmholz points out (*Johns Hopkins Hospital Bulletin*, May, 1907) that tumours of the pancreas of epithelial origin may arise: (1) from the duct epithelium, (2) from the pancreatic cells proper, and (3) from the cells of the Langerhan's islands. Tumours arising from the first two sources are common, but those from the third source are rare. The present specimen was found by chance, in a block of tissue removed for microscopical examination. It measured 5 by 3 by 5 mm., and was visible in section as a dull grey finely granular area, sharply circumscribed on all sides by a thin capsule. The structure of the tumour presented a stroma of connective tissue carrying blood vessels; the connective tissue network presented large delicate meshes in which lay solid hollowed out anastomosing masses of epithelial cells. The cells are polyhedral in outline, with coarsely granular protoplasm presenting clearly defined nuclei. The origin of the tumour from Langerhan's islets was suggested by the following points: (1) The anastomosing arrangement of the acini; (2) the intimate relation of the capillaries to the epithelium; (3) the general characters of the tumour cells which closely resemble those of the cells in the pancreatic cell islets. M.

Suture of Blood Vessels and Transplantation of Organs. — Watts contributes an important paper on the above subject to the *Johns Hopkins Hospital Bulletin* for May, 1907. After an exhaustive historical survey of the subject of blood vessel suturing, he reports the results he has himself obtained. He cut and then sutured the common carotid artery thirteen times, and in each case with a successful result; thirteen sutures of the external jugular vein gave ten successes, while two sutures of the femoral artery were both failures. Microscopical examination of the arterial sutures from 28-82 days after operation shows a gradual restoration of the entire arterial wall, except the elastic lamina. The common carotid artery was sutured to the external jugular vein four times, all being successful. Examination of the veins from 1-3 months later showed dilatation of these vessels with thickening of their walls and increase of elastic tissue in places. In four animals a lateral anastomosis of the femoral artery and vein was made; but in only one animal did the opening remain patent. In one other a thrill and murmur persisted for four weeks, and then disappeared, due, as the autopsy showed, to healing of the opening while both vessels remained patent. Excision and replantation of a portion of the femoral artery was done once but failed owing to thrombosis; on the other hand, a section of the external jugular vein was transplanted into the common carotid artery with complete success. Transplantation of the thyroid gland was done six times, but in no case successfully. The writer is, however, inclined to attribute this want of success to the small size of the inferior thyroid vein, and to the fact that the work was undertaken before he had himself gained skill with vascular suturing. He claims that his results show conclusively that completely divided vessels can be sutured with almost uniform success, when the aseptic technic is good. The intima can be included in the suture with impunity, the application of the suture being thus greatly facilitated. M.

Bier's Treatment by Hyperæmia.—Barcroft (*Edinburgh Medical Journal*, June, 1907) publishes a much needed description of the treatment of acute inflammatory disorders by Bier's method of inducing hyperæmia. Hitherto references to the subject in English have been few and partial. As regards theory, Bi treatment starts from two obvious physiological fa (1) Every organ during functional activity is hy æmic. (2) All growth and repair is evidenced hyperæmia, which is in proportion to the energ the process. As regards practice, Bier can point wide experience of several years' duration in sup of his method. There are few acute inflamma disorders which he has not treated successf Where possible, active hyperæmia is induced; commonly one has to be content with passive hy æmia. The former may be induced by stimulati the part by rubefacients, by massage, by electri or by heat. Heat is the method of choice, and attains his end by means of the hot-air bath. mode of treatment has the additional advantage it gives great relief to pain. Passive hyperæmia the other hand, is produced over small areas by cupping-glass, over larger areas by the suction ap ratus, and in the limbs by means of the elastic band In acute inflammations he applies the chosen ment for some twenty hours of the twenty-four intervening periods being used to reduce the œde Barcroft gives details of the methods of applica of the treatment to various clinical conditions. R

Carcinoma in Animals. — Loeb (*University Pennsylvania Medical Bulletin*, March-April, publishes an account of his recent investigation the endemic occurrence of carcinoma in animals on the inoculability of tumours. Some of his c clusions may be summarised as follows: (1) Heredita transmission of certain predisposing conditions fr parents to offspring is one of the factors causing demic occurrence of cancer among animals. Various kinds of tumours grow better when inocu into the animal in which the tumour had deve originally, or into an animal affected with the s kind of tumour, than when inoculated into animals of the same species. (3) There is no paral between the tendency of tumours to become ma and their inoculability. (4) Metastases into lymph glands were never found. (5) Microscopic stases could be found in the lung in a certain nu of cases when macroscopically no metastases evident. R

Splenomegalic Polycythæmia. — Saundby *Med. Journ.*, May 18th, 1907) reports two cas this rare condition, collects other reported cases puts forward a suggestion as to its pathology. discusses the question whether the polycythæmi apparent or real, and inclines to the opinion that only apparent. He quotes the observation of gra that when the vasomotor nerves are stimulate cold, the specific gravity of the blood is incre Under other conditions of high arterial tension number of corpuscles per cubic millimetre of the is increased. These changes are of course due to fact that with a general contraction of the ve walls, and a consequent decrease of their capa fluid is squeezed in excess into the tissues, leavi fluid richer in corpuscles in the vessels. Saun also adduces arguments to show that the diseas not a primary disease of the bone marrow or sple He believes then that the condition is due to narrow of the middle-sized arteries and arterioles, due in turn to a vasomotor spasm which has become org by thickening of the coats of the vessels. The va motor derangement may be part of a general neur thenia, caused at any rate in some cases by an atta of influenza. The resultant engagement of the ven and capillary systems also manifests itself in perplasia of the hair and spleen, while other symp- ms of the neurasthenia are muscular weakness, ss of knee-jerks, and mental impairment, such as owsiness, apathy and loss of memory. R.

The Physiology of the Parathyroids in Man.—orsyth (*Brit. Med. Journ.*, May 18th, 1907) pub- shes the results of an investigation into the structure d secretion of the parathyroid glands in man. He ncludes: (1) The parathyroid gland, like other ands, presents histological variations of activity d rest. The so-called oxyphil cells are the cells stended with granular secretion, and the so-called incipal cells represent the exhausted stage. Inter- ediate forms are common. (2) The secretion of the lls is extended into the surrounding lymphatic spaces, d the product of many cells may run together to rm a drop. The secretion is gradually drained away the lymphatics. (3) The secretion of the para- yroid, both in its physical and micro-chemical aracters, is indistinguishable from the colloid of e thyroid. (4) During the first few months of life e parathyroid glands show few, if any, signs of tivity. By the end of the third month colloid cretion is usually found. R.

The Blood in Rheumatoid Arthritis. — Bull- ore and Waterhouse (*Edin. Med. Journ.*, June, 907) publishes the results of an investigation into e condition of the blood in a series of forty-two ases of rheumatoid arthritis. They remark that ey have been unable to find any detailed description ublished hitherto. (*a*) *Hæmoglobin.* In only one ase was the percentage of hæmoglobin 100. In eight, was between 90 and 100, in twelve between 80 and 0, in eleven between 70 and 80, in four between 0 and 70, and in one 30. (*b*) *Red blood cells.* In ll but nine cases the number of red cells was below ,000,000 per cmm., in twenty it was between 4,000,000 nd 5,000,000, in ten between 3,000,000 and 4,000,000, nd in one only 2,890,000. The microscopical appear- nces were those of a secondary anæmia of greater r lesser degree. The colour index varied from 0.72 slightly over normal. The constancy in the number f white corpuscles was remarkable; in all but six stances they were between 5,000 and 10,000. Except one case, the differential leucocyte count showed hysiological proportions between the various forms. yclocytes were present in a few cases. R.

Ovarian Grafting.—Carmichael (*Journal of Ob- tetrics and Gynæcology of the British Empire*, March, 907) has added some facts to our knowledge of the ossibility of grafting ovarian tissue. He performed number of experiments on rabbits, and in fifteen out f twenty-one attempts some measure of success was ttained. In the majority of cases (about 80 per cent.) here was partial degeneration of the transplanted issue, the degeneration being either fibrous or cystic. he Granpian follicles and ova persisted and matured or some months after grafting, but ultimately tended o become cystic. The germinal epithelium persisted a small proportion of the cases. As regards the ossibility of grafting in the human subject, he oncludes: (1) It is unlikely that the whole human vary can be transplanted with success. (2) Part f the ovary may ovulate and preserve its function f internal secretion. (3) Grafting of a part, *e.g.*, f the cortex of the organ, is more likely to succeed han of the whole. R.

Action of Wine on the Typhoid Bacillus.—The ossibility of the carriage of typhoid infection by ther means than drinking water should not be over- ooked. In countries where cheap wine is a common rticle of diet, it is of importance to know whether ine may be the infected vehicle. Labrayes and arcaudin have therefore done a valuable piece f work in testing the bactericidal powers of various ines toward the typhoid bacillus (*Annales de l'In- titut Pasteur*, April 25th, 1907). They find that ines which have been long bottled are sterile, while red wines from the wood have a rich bacterial flora. Pure wines exercise a powerful bactericidal action on the typhoid bacillus, but this action varies in intensity with the nature and quality of the wines. White wines were found to be more active than red, and sour wines than sweet. The proportion of alcohol present has little effect on the bactericidal power, but various other bodies—glycerin, ethers, amylic alcohol—in all probability are of greater importance. Dilution weakens considerably the antiseptic action of wine. R.

Pathology of Chronic Metritis.—Chronic metritis has recently been the subject of much investigation. Donald and Shaw publish (*Journal Obstetrics and Gynæcology of the British Empire*, February, 1907) separate papers on the subject. Donald devotes himself chiefly to the clinical aspects of the condition, and Shaw to the pathological. The latter gives some good micro-photographs, and comes to the following conclusions: (1) Chronic metritis is a simple hypertrophy of the meso-metrium, and is not a connective tissue hyperplasia. By "meso-metrium" is meant the muscular coat of the uterus. The word is ambiguous and should be avoided. The proportion of connective tissue varies considerably, but many normal uteri possess as much or more. The vessel changes are variable, and similar affections are found in normal uteri. There is no evidence of active inflammation, as shown by small celled infiltration or cicatricial tissue. (2) Chronic metritis is a progressive affection. (3) It is never primary, but usually consequent on a chronic endo-metritis. It may however, be due to other uterine disease leading to increased uterine contraction or vascularity, *e.g.*, fibroids, tubo-ovarian inflammation, carcinoma, prolapse. R.

A Rare Tumour of the Vagina.—Doran (*Journal of Obstetrics and Gynæcology of the British Empire*, June, 1907) reports an interesting case of hypernephroma with a secondary growth in the vagina. Incidentally he analyses the literature of tumours of the vagina. In the case reported the right kidney was the seat of a tumour, 4½ inches by 2½ inches by 2¼ inches, which microscopically showed resemblance to the zona fasciculata of the adamal body; the growth was separated from the cortex of the kidney by a thin but quite distinct sheet of fibrous tissue. The vaginal growth was polypoid in character, and was at first taken for a sarcoma. Microscopically it showed close resemblance to the growth in the kidney. Doran emphasises the necessity of looking for primary facies in all cases of malignant tumour of the vagina. R.

Society of Apothecaries of London.

The Society of Apothecaries of London Bill was read a third time in the House of Commons last week, having previously passed through all its stages in the House of Lords; it now requires only the Royal Assent to make it law. Under the first Act of Parliament, the Apothecaries Act, 1815, the Society was enabled to grant to persons passing the necessary examination a certificate of their qualification to practise as an apothecary. The designation of such person was "Licentiate of the Society of Apothecaries." In 1887, in accordance with the Medical Act of the previous year, candidates for the Society's diploma were required to pass an examination, not only in medicine, but in surgery and midwifery, though no alteration was made in the title. The new Bill is designed to remedy this omission, and provide that all persons who have passed the examination since 1887, and shall hereafter pass it, shall be styled "Licentiates in Medicine and Surgery of the Society of Apothecaries, London," thus clearly indicating that the owner of the diploma possesses a qualification both in medicine and in surgery. The Bill also authorises the General Medical Council to enter the new title upon the Medical Register.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons in Ireland.

AT a meeting of the College, held on Monday, June 3rd, the following were elected president, vice-president and Council:—President, Henry R. Swanzy; vice-president, John Lentaigne; hon. secretary, Sir Charles A. Cameron; Council—William Stoker, Sir Charles A. Cameron, John B. Story, Sir Charles B. Ball, Sir Thomas Myles, Sir Arthur Chance, Richard D. Purefoy, Sir Lambert H. Ormsby, Henry G. Sherlock, R. Bolton M'Causland, John S. M'Ardle, Robert H. Woods, R. Lane-Joynt, Thomas Donnelly, William Taylor, Edward H. Taylor, R. Charles B, Maunsell, Wm. Ireland Wheeler and D. Edgar Flinn.

Royal Medical Benevolent Fund.

LAST week the annual meeting of the Royal Medical Benevolent Fund Society of Ireland was held in the College of Physicians, Dublin. The chair was occupied by the President of the Royal College of Physicians of Ireland.

During the present year eleven applications for grants were considered in anticipation of the regular annual distribution—five coming from new applicants. Of the eleven applications one was refused, two were postponed to the annual distribution, and the remaining eight being all pressing, grants, amounting to £79, were made. The total amount of the grants recommended since last distribution is £1,114. The total number of applicants considered during the year was eighty-four. Of these seventy-five were from widows of medical men; five from, or on behalf of, their orphans; and four from medical men themselves. The number of applicants this year has been even larger than usual, and the amount given in grants has strained the resources of the Society to the utmost, though the aid given to many of the recipients has fallen far short of their claims and of their urgent necessities.

Deputy Surgeon-General C. Joynt, M.D., read the treasurer's report. It stated: During the year 1906–7 the grants awarded by the Central Committee amounted to £1,097 10s., or £24 less than in the preceding year. The grants awarded for the last eight years averaged £1,182. Dividends on stock realised £690 3s. 2d., including a refund of £33 15s. 5d. income-tax. This shows an increase of £11 2s. 3d. The amount paid through the Central Treasurer was £221 19s., as compared with £196 6s. in the preceding year. Miscellaneous receipts realised £15 14s 6d. The subscriptions forwarded by the Branch Treasurers amounted to £343 0s. 6d., as compared with £323 4s. 8d. the preceding year. The Belfast and County Antrim Branch contributed £149 14s. (including £7 18s. received late for audit the preceding year), an advance on any former year. The County Armagh Branch contributed £22 16s. 6d., the next largest contribution from any of the County Branches. Of the £343 received from County Branches, £154 should have appeared in last year's account, but was only received after that account was audited.

Among those who took part in the proceedings were the President of the Royal College of Physicians, Sir John Moore, Drs. Andrew Horne, Edward Taylor, Travers Smith, Donneley, Purser, Craig, and Benson.

Irish Medical Association.

THE annual meeting of the Irish Medical Association was held on Wednesday, the 5th inst., at Portrush, the President, Mr. J. S. McArdle, in the chair; there was a large attendance of members.

The Secretary submitted the annual report, in which particulars were given of the various legal cases undertaken during the year.

The question of the appointment of a *locum tenens* for a medical officer going on vacation had been considered, and cases referred to in which conditions were laid down by the Boards of Guardians mak it difficult, if not impossible, for the medical offic to go on vacation. The Local Government Boa expressed their sympathy with the doctors in t matter, and stated that circular letters had been issu to Boards of Guardians advising them to appoint substitutes, wherever possible, those recommended the medical officer.

In the matter of remuneration offered by the Po master-General for attendance on rural post-offi officials, letters were addressed to the British Post Medical Association, and also to the Postmaste General. The British Postal Medical Associati replied that they did not consider it necessary to ta any action at present. The Postmaster-General wro stating that in his opinion the capitation fee of 8s. allowed to medical officers to the Post Office is adequa in amount, and that it compared favourably w that accorded to the medical officers of friend societies and to police surgeons; that with regard the age limit, while the efficiency of medical offic over sixty years of age is reviewed annually, no medic officer is called upon to resign until he is 90 years age. The Association had lost no opportunity pressing home the need of superannuation and, a temporary expedient, have endeavoured to get secti 118 of the Local Government Act, 1898, amended, as to include all existing officers.

The records of the Re-organisation Committee, t Finance Committee, and the statement of audit accounts were considered.

The election of officers, which was by ballot result as follows:—President—Dr. John S. McArdle. Merrion Square, Dublin (re-elected); Vice-Presiden —Ulster, Dr. Leonard Kidd, West Bridg Enniskillen; Munster, Dr. W. MacSweeny, Pa Place, Killarney; Leinster, Dr. F. W. Kidd, 17, Low Fitzwilliam Street, Dublin; Connaught, Dr. R. Kinkead, Foster House, Galway; Hon. Sec., Dr. Donnelly, 14, Rutland Square, Dublin; Hon. Treasur Dr. W. J. Thompson, 59, Fitzwilliam Square, Dublin.

The President then delivered his address, and variou matters of business were discussed.

In the evening a dinner was held at the Norther Counties Hotel.

St. Thomas's Hospital.—House Appointments.

THE following gentlemen were selected as Hou Officers for the ensuing term:—Casualty Officer (Senior) A. B. Howitt, M.A., M.B., B.C.Cantab (Junior) W. O. Sankey, M.B., B.S.Lond. Reside House Physicians: E. V. Dunkley, M.B., B.S.Lon (extension); H. A. Philpot, B.A.Oxon, M.R.C.S. L.R.C.P. (extension); C. E. Whitehead, B.A.Canta M.R.C.S., L.R.C.P.; H. G. Bennett, M.B., B.S Lond. House Physicians to Out-Patients: G. G Butler, B.A.Cantab., M.R.C.S., L.R.C.P. (extension S. L. Walker, B.A., B.C.Cantab. (extension); W. H. R Sutton, B.A., B.C.Cantab.; S. Churchill, B.A., M.B. B.C. Cantab. Resident House Surgeons: C. M. Page M.B., B.S.Lond. (extension); S. G. MacDonald M.A., M.B., B.C.Cantab. (extension); H. B. White-house, M.B., B.S., Lond. (extension); R. L. Gamlen B.A.Cantab., M.R.C.S., L.R.C.P. (extension). Hou Surgeons to Out-Patients: H. J. Nightingale, M.B B.S.Lond. (extension); H. R. Unwin, M.B., B.C Cantab. (extension); G. M. Huggins, M.R.C.S L.R.C.P. (extension); F. M. Neild, M.B., B.S.Lon (extension). Obstetric House Physicians: (Senio A. C. D. Firth, M.A.Cantab., M.R.C.S., L.R.C.P (Junior) F. S. Hewett, B.A., M.B., B.C.Canta Ophthalmic House Surgeons: (Senior) W. C. A. War M.R.C.S., L.R.C.P. (extension), (Junior) A. S Burgess, M.A.Cantab., M.R.C.S., L.R.C.P.(extension

Throat: W. R. Bristow, M.R.C.S., L.R.C.P. (extension); R. E. Todd, M.B., B.S.Lond. Skin: A. J. S. Pinchin, M.B., B.S. Lond.; E. A. Sparrow, B.A.,Cantab., M.R.C.S., L.R.C.P. Ear: A. J. S. Pinchin, M.B., B.S. Lond; H. E. T. Dawes, B.A. Cantab., M.R.C.S., L.R.C.P. Children's Surgical: H. H. Carleton, B.A., M.B., B.Ch.Oxon. (extension); R. E. Todd, M.B., B.S.Lond. Electrical Dept. and X-Ray Dept.: A. J. H. Iles, M.R.C.S., L.R.C.P.

Opening of Cossham Memorial Hospital.

THE opening of the Cossham Memorial Hospital on June 1st excited considerable interest at Kingswood and Two-Mile Hill. Mr. Handel Cossham left the residue of his estate for this purpose, and his trustees eventually found themselves in possesion of about £120,000. They were thus in the fortunate position of being able to spend £30,000 on building and equipping a new hospital with fifty beds, and investing the balance as an endowment to enable the work to be maintained. A fine site on Lodge Hill was obtained for the hospital, and this being in Stapleton parish the new institution, since erected from the designs of Mr. Bligh Bond, stands within the boundary of the city of Bristol. At the opening ceremony Mr. W. Butler presided, and there were present the Lord Mayor and Lady Mayoress, the Right Hon. Augustine Birrell, the High Sheriff (Mr. Henry Daniel), the Right Hon. Lewis Fry, and many other well-known Bristol people.

City of London Hospital Dinner.

ALDERMAN AND SHERIFF CROSBY, M.D., in the absence of the Lord Mayor through indisposition, presided on June 4th at the festival dinner of the City of London Hospital for Diseases of the Chest, Victoria Park, and read the following telegram from the Duke of Connaught, president of the Hospital: "The Duke of Connaught sends you his best wishes, and trusts every success will attend the festival dinner this evening." In proposing the toast of the evening the Chairman said that large numbers of poor patients awaited admission, and if the thirty-two beds, now closed for want of funds, could be re-opened, two hundred more in-patients could be admitted annually.

The Secretary announced subscriptions to the amount of £2,415, which included ten guineas from his Excellency Wang Tahsieh, the Chinese Minister, who was present. The announcement of his gift was loudly cheered.

Brompton Consumption Hospital.

THE Lord Mayor presided, on May 31st, at the Mansion House at a meeting called to further the movement to secure an increased income for the Hospital for Consumption at Brompton.

His Lordship said that the institution was founded in 1841, and they now had a convalescent home at Frimley. When they reflected on what a terrible scourge consumption was they must appreciate the good work done by the hospital.

The Earl of Derby, in advocating the claims of the hospital, said that a letter which Lord Cheylesmore and himself sent out had been erroneously construed in some quarters as an attack on the King's Hospital Fund. What they desired to show was that through no fault of theirs the contributions to the hospital had fallen short, but there was not the slightest intention to reflect on the King's fund. In the treatment of consumption they now found that a great deal might be done in anticipating infection rather than in dealing with it when it occurred. Their treatment of patients at the Frimley Sanatorium, good as it was, had added to the calls on their funds. He believed it to be a source of England's strength that our charities were maintained as they were to-day.

Lord Cheylesmore said he endorsed the statement by Lord Derby that their appeal on behalf of Brompton was in no way intended as an attack on the King's Fund, or even as a criticism of the administration of that fund. They especially required funds for the support of their sanatorium, otherwise beds would have to be closed. As a former mayor of an important borough he must call attention to the way hospitals were rated. For instance, Brompton Hospital was situate in the boroughs of Kensington and Chelsea, and for each bed in the institution they had to pay £3 13s. 10d. in rates and taxes, which was an excessive amount. Then at Frimley, where the sanatorium was, £4 12s. 11d. went in rates and taxes for each bed. Lord Cheylesmore mentioned that ninety-three persons out of one hundred and ten who were treated in the sanatorium were now engaged in their ordinary pursuits. Regarding the suggestion that the hospital should be removed to the country, he pointed out that the eminent medical men who now gave freely their time and skill could not do so if the institution was taken further afield.

Sir R. Douglas Powell and other gentlemen also delivered addresses in support of the movement.

Guy's Hospital and the University of London.

THE following letter has been addressed by the treasurer of Guy's Hospital to the principal of the University of London:—

"Guy's Hospital, S.E., May 10th, 1907.

"Dear Sir,—As treasurer of Guy's Hospital I have to bring to your notice the following resolution, passed at a school meeting of the 7th inst., and approved by me:—'That, in view of the resolution of June, 1905, that the Medical School of Guy's Hospital is not committed to any particular line of action with regard to the concentration of preliminary and intermediate studies, the school now desires the treasurer to inform the Senate of the University of London that it is of the opinion that the proposed scheme of three centres for the teaching of such subjects at University College, King's College, and South Kensington, and the institution of internal examinations at these centres, would not be to the advantage of medical education in London, and that it does not propose to abandon the teaching of the preliminary and intermediate subjects under these circumstances.' I desire to add that this decision must not be construed as adverse to the principle of the concentration of the preliminary and intermediate medical studies in the University, but solely as directed against the particular proposals for concentration indicated in the resolution.—I am, dear Sir, yours faithfully,

H. COSMO O. BONSOR, Treasurer."

The Year's Sanitary Work at the Port of Manchester.

A FAVOURABLE report has just been presented by Mr. W. F. Dearden, the medical officer of health, to the members of the Port of Manchester Sanitary Authority. The total number of cases of sickness reported during the year was 174, the greatest annual number reported since the formation of the Port Sanitary Authority—owing, it is believed, to the arrival of ships from greater distances than formerly and to the fact that many of them have been heavier vessels.

Infant Mortality.

SPEAKING at the seventh annual general meeting of Virol, Limited, held at the Holborn Restaurant on Friday last, Mr. B. S. Straus, M.P., referred to the high rate of infant mortality in the country, and quoted from a statistical study of the question by Dr. Newsholme, Medical Officer of Health for Brighton, that out of every thousand born in England and Wales during the years 1901-4 only 141 succeeded in reaching their first anniversary, and that this rate of infant mortality had remained stationary during the last fifty years, although the death rate between the ages of 5 and 25 had been reduced by 50 per cent. in the same time. During the same period the birth rate has fallen 17 per cent. The causes of death enumerated by the Registrar-General as accountable for this appalling rate of mortality were, he remarked, the very conditions that the use of Virol was calculated to prevent. That this fact was appreciated by the medical profession was shown by its greatly increased use in hospitals and nursing homes.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

Concha.—The treatment of buzzing in the ears, after physical methods have failed, is a disheartening business truly. Have you tried valerianate of diethylamine (so-called valyl)? Knoff prescribes it in daily doses of 3 to 9 capsules of 125 centigrammes each. We have no experience of it ourselves.

ADDITIONS TO THE MEDICAL REGISTER IN 1906.

We are informed by the Registrar of the General Medical Council that the actual numbers of new names added last year were: In England 612, in Scotland 415, in Ireland 170, making a total of 1,197.

Dr. L. S. R.—Mrs. Honor Coleman, who resides in a cottage at Cleeve, Somerset, is generally considered the oldest woman in England. She has recently attained the remarkable age of 107, with her faculties only slightly impaired. Her mother was a centenarian, her grandmother lived to be 101, while her daughter, who lives in the same cottage, is nearly 80.

Thix.—Mr. Halliwell Sutcliffe writes to warn editors, authors, and doctors, both in London and the provinces, against "a remarkably clever and unscrupulous scoundrel who is going about collecting charity on false pretences. I sent him money two years ago, when he wrote to me from a hospital, under the plea of destitution and of the profession we shared in common. Later he called on me, and my suspicions were aroused. Since then, I find, he has been assuming my name whenever he thought it safe. Heart failure, artificially produced, is his favourite method of admission to hospitals, where he usually contrives to enlist the sympathy of those who come in touch with him. Then he borrows money from the matron, nurses, or medical staff."

Meetings of the Societies. Lectures, &c.

Wednesday, June 12th.

Dermatological Society of London (11 Chandos Street, Cavendish Square, W.).—4.30 p.m.: Special General Meeting for the purpose of dissolving the Society and Merging it into the Royal Society of Medicine.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. C. Ryall: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. L. Cheatle: Paget's Disease of the Nipple and its treatment (with lantern slides).

Thursday, June 13th.

Ophthalmological Society of the United Kingdom (11 Chandos Street, Cavendish Square, W.).—8 p.m.: Card Specimens, 8.30 p.m.: Papers:—Mr. Nettleship: A History of Night Blindness in Nine Consecutive Generations.—Mr. L. Werner: A Peculiar Case of Subretinal Cysticercus.—Mr. A. L. Whitehead: (1) A Metastatic Tumour of the Choroid; (2) Multiple Cysts of Retina.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Voelcker: Enlarged Abdomens.

Friday, June 14th.

Ophthalmological Society of the United Kingdom (11 Chandos Street, Cavendish Square, W.).—6 p.m.: Bowman Lecture: Prof. Sattler: The Pathology and Treatment of Myopia.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. C. A. Parker: Clinique. (Throat.)

Saturday,, June 15th.

Society for the Study of Disease in Children (County Hospital, Bedford).—3 p.m.: Discussion on Acute Rheumatism (opened by Dr. C. O. Hawthorne). Papers by Dr. E. Cautley and Mr. Tubby.

Monday, June 24th.

Odontological Society of Great Britain (20 Hanover Square, W.).—8 p.m.: Casual Communication:—Mr. Montagu F. Hopson, L.D.S.Eng., on "An Inverted Mandibular Third Molar."

Vacancies.

Abbeyleit Union.—Medical Officer. Salary £110 per annum: also to act as Medical Officer for Health at a salary of £20 per annum. Immediate application to James Finnegan, Clerk of Union. (See advt.)

Glamorgan County Asylum, Bridgend.—Junior Assistant Medical Officer. Salary £150 per year, with board, apartments, attendance, and washing. Applications to the Medical Superintendent.

Canterbury City Asylum.—Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, and laundry. Applications to the Medical Superintendent.

Oldham Union.—Resident Medical Officer. Salary £150 per annum, together with furnished residence, coal, gas, rations, washing, and attendance. Applications to Horace A. Quarmby, Clerk to the Guardians, Union Clerk's Office, Rochdale Road, Oldham.

Newcastle-upon-Tyne.—Assistant Medical Officer of Health, etc. Salary of £300 per annum, with board, lodging, etc. Applications to the Medical Officer of Health, Town Hall, Newcastle-upon-Tyne.

Egypt.—Sub-Inspector of Ophthalmic Hospitals. Salary £500 a year, with two months' salary in lieu of travelling expenses to and from England. Applications to the Director-General, Department Public Health, Cairo.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Anæsthetist. Applications to the Secretary.

West Bromwich District Hospital.—Senior House Surgeon. Salary £110 per annum, with board, residence, and laundry. Applications to T. Foley Bache, Esq., Churchill House, West Bromwich.

Rotherham Hospital and Dispensary.—Senior House Surgeon. Salary £110 per annum, with rooms, commons, and washing. Applications to the Secretary, H. Kelson, Masonic Buildings, High Street, Rotherham.

London County Asylum, Bexley, Kent.—Junior Assistant Medical Officer. Salary £150 per year, with board, furnished apartments and washing. Applications to H. F. Keene, Clerk to the Asylums Committee, Asylums Committee Office, 6 Waterloo Place, S.W.

Appointments.

Coutie, W. H., M.B., Ch.M.Melb., Medical Officer to the Callan Park Hospital, Balmain, New South Wales

Hayward, W. T., M.R.C.S., L.K.Q.C.P.Irel., Member of the Board of Management of the Adelaide Hospital, Australia.

Hill, A. W., M.D.Brux., Member of the Board of Management of the Adelaide Hospital, Australia.

Hodgson, George James, L.R.C.S., L.K.Q.C.P.Irel., Member of the Medical Board of Victoria, Australia.

Melville, Stanley, M.D.Brux., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Chelsea Hospital for Women.

Mort, George Cecil, M.B., Ch.B.Vict., Resident Medical Officer at the Handel Cossham Memorial Hospital, Kingswood, near Bristol.

Murphy, Thomas, M.D., M.S.Melb., Surgeon to the Out-patients at St. Vincent's Hospital and Honorary Surgeon to In-patients in the Gynæcological Department, Victoria, Australia.

Purdy, J. S., M.D., C.M.Aber., D.P.H.Camb., District Health Officer, Auckland, New Zealand.

Rogers, R. S., M.D., Ch.M.Edin. and Adel., Member of the Board of Management of the Adelaide Hospital, Australia.

Wright, Garnett, M.B., Ch.B.Edin., F.R.C.S.Eng., Honorary Surgeon to the Ancoats Hospital, Manchester.

Dawson, George W., F.R.C.S.I., D.P.H., Surgeon to St. John's Hospital for Diseases of the Skin, Leicester Square, W.C.

Field, F. E., M.B., Ch.B.Edin., Clinical Assistant at St. John's Hospital for Diseases of the Skin, Leicester Square, W.C.

Hare, T. G., M.D., Freib., Pathologist and Bacteriologist to St. John's Hospital for Diseases of the Skin, Leicester Square, W.C., vice R. W. Brimacombe, M.D., resigned.

Births.

Dent.—On June 1st, at 20 Royal Parade, Cheltenham, the wife of Ernest A. Dent, M.B., C.M., of a daughter.

Haward.—On June 5th, at 55 Priory Road, London, the wife of Walter Haward, M.B., B.S., of a daughter.

Lloyd.—On June 4th, at Mackay, Queensland, the wife of George Tyndale Lloyd, M.B., J.P., of a son. (By cable.)

Marriages.

Herron—Brice.—On June 5th, at St. Michael's Parish Church, North Kensington, London, W., Robert T. Crosthwaite Herron, M.D., M.R.C.P.E., of 6 Victoria Street, Armagh, to Evelyn Maud, fifth daughter of the late Frederick Augustus Brice, M.D., Deputy Inspector-General of Hospitals and Fleets, R.N., and granddaughter of the late Lieutenant William Henry Goddard, R.N.

Braddon—Josling.—On June 6th, at Holy Trinity Church, Upper Tooting, William Vaudrey Braddon, M.B.Cantab., of London Road, Thornton Heath, to Beatrice, second daughter of the late George Frederick Josling, Suffolk, and Mrs. Josling, Tooting.

Bywater-Ward—Lawford.—On June 6th, at St. Luke's Church, Thurnby, Leicester, Lieutenant John R. Bywater-Ward, R.N., younger son of the late John Bywater-Ward, M.D., and Mrs. Bywater-Ward, of St. Giles', Oxford, to Winifred Fisher, daughter of Mr. and Mrs. James Lawford, of Bushby, Leicester.

Corley—Watson.—On June 4th, at St. Matthias' Church, Adelaide Road, Dublin, Henry Hagarty Corley, second son of the late Anthony H. Corley, M.D., F.R.C.S.I., of 16 Merrion Square, to Janet Agnes Violet, only daughter of Sir William Watson, D.L., of Fitzwilliam Place, Dublin.

Hunt—Whiteley.—On June 5th, at Ockbrook, Derbyshire, Sydney Hunt, M.R.C.S.Eng., L.R.C.P.Lond., of Spondon, Derbyshire, son of Richard Hunt, of Woking, to Mabel Mary, elder daughter of W. A. Whiteley, of Borrowash.

Deaths.

Bromley.—On May 31st, at Nottingham, Emma, widow of Charles Nelson Bromley, M.R.C.S., formerly of Stafford, in her 89th year.

Lascelles.—On June 5th, at Eatons, Haywards Heath, the wife of J. Eaton Lascelles, Esq., M.R.C.S., L.R.C.P., prematurely, of a son, stillborn.

Moir.—On June 5th, at Calcutta, Major David Macbeth Moir, M.A., M.D., I.M.S., Professor of Anatomy, Medical College, Calcutta, eldest son of the late Dr. Moir, St. Andrews.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, JUNE 19, 1907. No. 25

NOTES AND COMMENTS.

Lord Howard de Walden and Mr. Eastes.

LAST week, in the Chancery Division, an action was brought by Lord Howard de Walden against Mr. Leslie Eastes, M.B., B.Sc., the well-known clinical pathologist, to restrain him from using No. 62, Queen Anne Street, as a laboratory of pathology. It seems that when Mr. Eastes started practice in his special line in 1901, he took a sub-lease of part of these premises from the then tenants, who were under covenant with Lord Howard de Walden's agent not to allow or suffer any trade or business to be carried on in them, though they might sub-let the house for professional chambers or offices. When it came to the agent's ears that Mr. Eastes was using his chambers or offices for the purpose of examining pathological material instead of pathological persons, there was a great to-do, and he was only spared eviction through the good offices of Sir Alfred Fripp, who by personal influence obtained for him a license to "carry on microscopical tests of fluids of the human body in the basement portion of the said premises and to affix one name-plate outside the premises." There were numerous conditions attached as to not annoying or causing a nuisance to the noble lord, his heirs, assigns, and so on, and a grossly arbitrary clause enabling the license to be revoked at three months' notice, apparently entirely at the pleasure of Lord Howard de Walden. Last year the tenant of the premises died, and the wife assigned the whole house to Mr. Eastes, who thereupon equipped it more completely for his work, and adapted some of the ground-floor rooms for laboratory work. He also—heinous offence!—put up another name-plate on the door. On the ground of these alterations and the name-plate, and also because investigations by other than "microscopical" methods, and on other objects than the "fluids of the human body," were carried on, the license was revoked by Lord Howard de Walden.

Microscopical Tests and Macroscopical Prejudice.

Now, considering that Mr. Eastes, by his foresight in choosing his position, together with his care and accuracy in examinations and reports had built up a large connection among medical men, suddenly to turn him neck and crop out of his premises because he technically violated the arbitrary conditions of his lease, strikes us as a piece of high-handedness of the most tyrannical order. There is no suggestion, in the *Times'* report of the trial, that he annoyed anybody except Lord Howard de Walden, and Mr. Justice Swinfen Eady, in deciding that the notice was within the terms of the contract and therefore technically valid, spoke in high terms of the useful and skilful work Mr. Eastes was doing, and in granting the injunction, as he had no option but to do, gave him three months' special grace in which to make fresh arrangements. While congratulating Mr. Eastes on having drawn such high praise from the judge, we offer him our sincere condolences on his treatment by Lord Howard de Walden. The prejudice that exists in noble bosoms against scientific work is usually on a par with the ignorance of its character that exists in noble brains, and we should be interested to learn what "microscopical tests of fluids of the human body" the haughty peer and his advisers contemplated being made, for to no one outside the House of Lords does the sentence convey much meaning. But no amount of ignorance or prejudice will prevent the average West-end noble landlord getting his pound of flesh out of the tenants he "inherits," and we presume that Lord Howard de Walden is satisfied now that he has succeeded in giving Mr. Eastes a blow from which, unless his clients stick closely to him, he may never recover. The name Lord Howard de Walden had none too sweet a savour in the public nostrils during its tenure by the late holder, and the present peer will hardly bring it back into good odour by this magnificent vindication of the rights of British property against the industry, skill, and scientific advance of the British citizen.

The G.M.C. and Dental Partnerships.

WE are thankful to be able to record that in the Appeal Court last week, before the Master of the Rolls, Sir Gorell Barnes, and Lord Justice Buckley, the important case, Hill *v.* Clifford, was settled in diametrically opposite fashion to that in which it was decided in the Court below. It may be remembered that Dr. H. F. Hill was partner in a dental practice, with Messrs. Ruby and Isidore Clifford, and that the two latter were struck off the Register by the General Medical Council, after being charged with employing unregistered assistants and issuing improper advertisements. Dr. Hill then determined his partnership on the ground that he had a clause in his agreement enabling him to do so if either party were found guilty of professional misconduct. Mr. Justice Warrington, who tried the case in the first instance, with penetrating acumen argued that the proceedings before the General Medical Council were not admissible as evidence, and that, therefore, he had no evidence before him on which to find professional misconduct; consequently, he found for the Cliffords, and left Dr. Hill in the anomalous position of not being able to separate himself from his partners, and yet being amenable to the General Medical Council for not doing so. This truly lawyer-like *impasse* was cleared up by the Appeal Court last week, and Dr. Hill is free to do as he wishes with regard to leaving his partners. It is hardly possible for an educated man not a lawyer to understand the puerile, or rather ostrich-like, attitude, of Mr. Justice Warrington in refusing to recognise patent facts when, by his refusal, he brought about a ridiculous miscarriage of justice; but, happily for the credit of our legal system, it has been shown that there is a way of reducing such farces to their proper level.

Livingstone College.

We have received the last annual Report of Livingstone College, with a request that we may say a few words about it. The College, as many readers doubtless know, is one for giving a certain medical training to men who are going out as missionaries to the heathen (abroad). The full course of this training extends over nine months, but students can enter for one or two terms if they wish, though the management naturally prefer them to take the whole course. It seems that though the College has done a good deal in the way of training missionaries, it is still not completely paying its way, and more students are wanted. Though we have no doubt that it is an excellent thing for missionaries to know how to treat a simple wound antiseptically, and what quantity of quinine to take as a prophylactic for malaria, we confess that we see many dangers and temptations in placing a little medical knowledge in the possession of men who are going to districts where they will frequently be the only Europeans. We see too much of the attractions of amateur doctoring in a civilised country not to fear that the novitiate cast on his own resources may be tempted to indulge in experiments, which may bring the white man's medical skill into disrepute with the natives. Surely, if medicine is worth studying, it is worth studying well, and there certainly is no civilising and humanising agency to compare with skilled medical practice. For our own part, we find it difficult to recommend a system of unqualified practice among natives which we would condemn if pursued at home, and we notice from the report that some of the Livingstone alumni seem to practise quite extensively. There are doubtless many difficulties surrounding the subject, but we cannot but remember that Livingstone himself was a qualified and skilful medical practitioner, as well as a missionary and explorer.

A Confusion of "Doctors."

There were certain disclosures at an inquest at Liverpool on June 10th, which seem to call for the investigation of the medical protection societies. The subject of the inquest was the infant child of a labourer, whose wife was attended at her confinement by a midwife. The child was born prematurely, and as it was very puny the midwife suggested that a medical man should be called in. After some discussion, a "Dr. Hamilton Williams Jolly" came and from the midwife's evidence there seemed to be some confusion between him and a "Dr. Fitzgerald." At the inquest, Mr. Jolly said he had a certificate from America and that he was conducting the business which used to be carried on by his brother-in-law, Dr. Fitzgerald. He also confessed that he had given certificates in the name of Fitzgerald, and had been fined for doing so. The curious part of the case was that a certificate signed "J. Fitzgerald, physician and surgeon," was then read by the Coroner, in which it was stated that the child was born prematurely and died from debility. Dr. Fitzgerald was then called, and said that he knew Jolly had been carrying on business in his (Dr. Fitzgerald's) name a year before, and had been fined for doing so but that "it was past and gone." Further, he said that he had been called in to the present case by Mr. Jolly, but did not charge anything. If Dr. Fitzgerald is Jolly's brother-in-law, it must be difficult to avoid him altogether, but if he even appears to have any dealings with an unqualified practitioner, he not only compromises the practice of medicine, but is apt to compromise himself. It is impossible to be too discreet in any dealings with an unregistered practitioner.

LEADING ARTICLES.

THE MONOPOLY OF HOSPITAL APPOINTMENTS.

In our correspondence columns appears a letter from the President of the Association of Medical Diplomates of Scotland, calling attention to the exclusion of Scotch and Irish diplomates from the majority of London hospital appointments. The grievance is one of long standing, and applies not only to the Metropolis, but to many of the large provincial medical charities in addition. The fact that both in Scotland and in Ireland various similar posts are restricted to those holding such qualifications is no adequate answer to the complaint. First of all, we believe that such restriction is only limited in extent, and that its existence is not likely to injure materially the few Englishmen who may wish to settle in Scotland or in Ireland. Moreover, in some at least of the leading hospitals and infirmaries of Scotland the possession of one of the higher English qualifications is made a *sine qua non*. The case of the holders of Scotch and Irish qualifications residing in England, however, assumes an entirely different aspect. There are many thousands of men practising under such conditions in English urban and rural districts, and their exclusion from the majority of hospital appointments constitutes a standing injustice to themselves and an insult to the Scotch and Irish Corporations from whom they have obtained their diplomas. For many years past the Irish Graduates' Society have protested against this unfair exclusion, and in not a few instances have succeeded in securing its removal from the rules of provincial hospitals. The Scotch diplomates have now followed suit with an energy that augurs well for the future. Under present circumstances the rules of practically all the great hospitals and infirmaries in London and the provinces make the holding of one of the higher English qualifications an essential condition for posts on the honorary medical and surgical staffs. The result is to place a valuable monopoly in the hands of the English colleges and the English diplomates at the expense of the holders of Scotch and Irish qualifications. In most cases the rules have probably come into existence without the attention of governors having been called to the existence of any condition of the kind. So obviously unfair is the proceeding that in several provincial towns it has only been necessary to inform the local supporters of a charity of the fact to secure its immediate repeal. The whole matter, indeed, appears to have drifted into the position of an old-fashioned anomaly which, however unjust, has become sanctioned by usage. It seemed unlikely that fresh institutions would be called into being and endowed with so obnoxious a condition. Yet that is precisely what appears to have happened in the case of the amalgamated London Orthopædic Hospital. Three hospitals were united into one institution. Of these, two admitted Scotch and Irish diplomates; the other did not. Incredible as it may seem, the charter of the amalgamated hospital excludes any but holders of the higher English qualifications. Worst of all, the Hospital Sunday and the King Edward's Funds, who pressed forward the amalgamation scheme by every means in their power, seem to have sanctioned this grossly unfair exclusion. They cannot plead ignorance, for attention has been repeatedly drawn to the point in the columns of The Medical Press and Circular. On January 18th, 1905, in a leading article, we appealed to both the Funds mentioned "to examine the whole of the circumstances attending the sale of the site and the amalgamation of the Royal Orthopædic Hospital." The wisdom of the sale of that valuable freehold, the sole birthright of that particular institution, under the chairmanship of Mr. H. H. Marks, was, in our opinion, open to grave question. We have no evidence that either of the Funds that pressed for amalgamation took either the financial aspect or the possible exclusion of Scotch and Irish diplomates into consideration. The irresponsibility of the Funds under present circumstances renders remonstrance and inquiry of no avail. They are autocratic and unrepresentative, and so long as they rest on such a constitution, so long will they fail to secure the full confidence of the public. We feel, however, that the time has now arrived when the Hospital Funds and the public that support the hospitals should be fully informed of the fact that an honourable body of men are excluded from the great majority of English hospital appointments simply because their medical qualifications were obtained in Scotland or in Ireland. The present state of affairs forms a strong argument in favour of the one-portal system. A single qualification is good enough for law and lawyers, but medicine is reached through many qualifying approaches. When medical men follow the example of the legal profession and sink all individual rivalry in the wiser policy of collective protection, then unjust competition and privilege of all kinds, whether within or without the camp, will have to hide their diminished heads.

PUBLIC CHARITY AND UNQUALIFIED MEDICAL PRACTICE.

Medical men generally have themselves to thank for much of the encroachments upon their legitimate field of practice by unqualified pretenders. They are not sufficiently alive to the necessity of educating the public of the precise dangers they are incurring by the use of quack medicines and by resorting to quack practitioners. Nor have they yet come to recognise that the proper way to render their own position one of security is to abandon internal squabbles and insist upon the absolute need of the consolidation of the laws affecting the medical profession. One of the first requisites is to amend the constitution of the General Medical Council, so as to make it representative of the medical profession, and to endow that body with powers of prosecuting unqualified practitioners akin to those possessed by the Incorporated Law Society. The next step should be the passing of a new medical Act rendering the performance of medical acts generally by unqualified persons a punishable offence. Possibly, or probably, the best way of opening up a vigorous campaign would be the appointment of a Royal Commission of Inquiry, a step that has repeatedly been advocated in our editorial and correspondence columns. Meanwhile, the necessity of unceasing vigilance is being emphasised from all sides. Only last week, the secretary of a body described as the Incorporated Society of Extractors and Adaptors of Teeth, appeared before the Select Committee of the House of Lords sitting to examine the bills prohibiting medical practice and restricting dental practice by companies. He advanced the specious plea that in 1,750 towns and villages in Great Brtiain there is no registered dentist, and the members of his society accordingly meet a great public want in those places. How would the Incorporated Law Society deal with an appeal to permit legal work to be conducted by unqualified persons in towns and villages unblessed by a resident solicitor? Medicine, no less than law, should be vigorously protected by the State against the encroachments of ignorant and unqualified pretenders. So insidious is the evil that some classes of quack are taken under the protection of fashionable society. A whisper has even been raised that the Lord Mayor of London has in contemplation the services of expert but unqualified help as regards the cripples whose cause he has so strenuously and successfully advocated. It is impossible to believe for a single moment that a man of the tact and experience of Sir William Treloar would be betrayed into such an indiscretion. We are constantly reminded, however, that philanthropy and wisdom do not usually go hand in hand. Especially is it wise for the medical men connected with the administration of the medical charities, to keep a watchful eye upon the vagaries of executive and administrative bodies. In that way alone may it be hoped to protect the public as well as medical practitioners against the great evil of irregular medical practice.

CURRENT TOPICS

The Discussion upon Cancer in the Lay Press.

Since the latter end of last year, when a Dr. Saleeby contributed a series of flamboyant articles to the *Pall Mall Gazette*, entitled the "Conquest of Cancer," which forsooth must have caused a sad smile of compassion for the writer from his medical readers, the lay press has periodically published various contributions upon cancer. But the past two weeks have seen a violent recrudescence of this effort to inform the public regarding this disease. The *Daily Mail* has distinguished itself by publishing a series of articles entitled "The War Against Cancer." When the "Conquest of Cancer" article appeared we were led to infer that there was nothing more to conquer, and that the war with the disease had come to an end. But it now seems from the *Daily Mail* that the war is still going on; indeed, if our judgment be sound, that hostilities are in a very active state. We confess to a great deal of disappointment at having had to arrive at this conclusion; a disappointment which, no doubt, has also visibly impressed itself upon the public generally. There is so much difference between war and peace that even to the most insignificant person no difficulty is caused in distinguishing between the two. Nevertheless, having had our best hopes ruthlessly shattered by this renewal of hostilities, we can only conclude that something must have gone wrong with the article announcing the "Conquest of Cancer," despite the all-pervading self-assertiveness in which the writer conveyed his convictions. So far, however, as the *Daily Mail* articles are concerned, we could not presume to criticise them; they are beyond criticism. The writer has evidently powers of prescience and observation to which we cannot attain. With becoming modesty we still feel disposed to describe ourselves as ordinary mortals to whom our sublunary abode is at present a matter of necessity. As it is we are quite incapable of following the writer into that phlogistic realm of fancy which confers the power upon a surgeon of saying when a cancerous growth is dead as the result of the administration of trypsin. We gather, however, from the writer that when the surgeon has diagnosed the dead growth, whose melancholy decease has thus been brought about, he must at once administer amylopsin, which acts as a sort of family besom, and sweeps all the dead cancer away. After that the patient is cured. All this is most impressive. We are now able to grasp how easy a matter the subject of cancer really is.

The Medical Manifesto.

The manifesto recently issued in favour of alcohol is being circulated under conditions that must be somewhat distasteful if known to the signatories. It is being circulated broadcast presumably in the interests of the wine and spirit trade. Moreover, we are informed by one correspondent that he has seen it posted in public-house windows. In any case the issue of such a manifesto illustrates the unwisdom of any medical declarations that may be made use of by trade capitalists or by interested politicians. The names of the signatories are about the last that medical men would expect to see appended to unwise public documents. *Nemo omnibus horis sapit.*

The Coventry Dispute.

The Coventry fight has entered a new phase. We regret to say that the Dispensary Committee have succeeded in getting candidates for the posts on the medical staff which were recently vacated by the local medical men, and three qualified men—Messrs. I. Inman-Langley, A. P. Blanchard Ellis, and A. St. Laurence-Burke—have been elected medical officers to the institution. There seems to be no misunderstanding on the part of these gentlemen as to the state of affairs prevailing at Coventry, and they presumably are aware that they are stepping into the shoes of medical men who resigned their appointments on questions of principle. What the consequences will be with regard to the support accorded by the patients remains to be seen, but if the new members find themselves in a position even more uncomfortable than their predecessors they will hardly expect much sympathy from their colleagues. At the annual meeting of the Dispensary there was a great deal of blarney and bluster on the part of the chairman and members of the committee, appeals not to "desert the old ship," and so on, but reading between the lines it looks as though there was not so much confidence in the success of their cause after all, especially as in the chairman's speech he intimated that there was a possibility of the Coventry Hospital not recognising patients sent to it by the dispensary authorities. The battle, he said, would begin on June 24th, and its issue we shall watch with keen interest, and the fervent hope that right and justice may triumph.

Dirty Milk and Infantile Mortality.

The problem of infantile mortality is one of the most serious problems with which the health authorities of all large cities have at present to deal. In Dublin, for instance, it was stated by the medical officer of health the other day that the death rate among children is the same as the average in seventy-six great towns of England. This is a very bad record when it is remembered, as Sir Charles Cameron added, that babies in Dublin are almost entirely breast fed. Probably in no city in the kingdom are there so few mothers employed in industrial work. In the causation of disease among older children there is little doubt that dirty milk plays an important part. Sir Charles Cameron made an urgent plea that the Department of Agriculture should take on the duty of supervising at its source the milk supply of Dublin. This, however, would seem to be the duty of the Dublin Corporation, and only a few weeks ago we had to chronicle the refusal of the Corporation to take any steps to obtain greater powers over the milk supply of the city. Though the Corporation has no power to inspect dairy-yards outside the city, it has ample power to deal with milk exposed for sale which is adulterated or unfit for food, and we fail to see any justification for the attempt to shuffle responsibility on to the Department of Agriculture.

The British Medical Association and its Charter.

After the discussion at the special Representative Meeting of the British Medical Association a week or two ago, it is not likely that the movement in demand of a charter will proceed much further for the present. The Dublin Division, while approving of a charter in the abstract, moved that the consideration of it be postponed to allow of fuller discussion of its terms. The Glasgow division wished to go further, and expunge any expression of approval. It is obvious that the demand has no chance of success unless it be practically unanimous on behalf of the Association, and the support given to the Dublin proposal shows that there is little prospect of any unanimity at present. On a vote, the proposal was lost by 81 votes to 34, showing that a minority of nearly one-third of the Association is opposed to the present demand. In this minority are to be numbered, in addition to the divisions mentioned, such important constituencies as Lancashire and Cheshire, Liverpool, and the Northern Counties of Scotland. As Dr. Bradshaw pointed out, the demand for a charter, if it is pressed, will be in the teeth of a determined opposition, so that it is hardly likely that those in its favour will engage themselves in a hopeless fight, and embarrass the Association with heavy and fruitless expenses.

PERSONAL.

It has been arranged that the ceremony of presenting the Freedom of the City of London to Lord Lister shall take place at the Guildhall on the 28th inst. at 11.30 a.m.

Sir William Church has been elected first President of the Royal Society of Medicine.

Dr. Dearden, the medical officer of health for Douglas, has resigned the position through ill-health, and the Douglas Town Council have passed a motion of regret, and decided to advertise for a successor.

Dr. E. Hooper May, one of the honorary surgeons at the Prince of Wales' General Hospital, was presented with a gold sovereign purse and match-case in connection with the celebration of his golden wedding on Thursday last.

Dr. Charles W. Chapman, took the chair at the annual dinner of the Durham University Medical Graduates Association.

Dr. Joseph Smith has received the King's permission to wear the Order of the Lion and the Sun (Second Class) conferred on him by the Shah of Persia for medical distinction.

Sir Thomas Barlow, Bart., took the chair at the meeting at Queen's Hall, organised by the *Tribune*, to urge on the Government the duty of excluding children from public houses by legislation.

Dr. C. W. Newton, who has twice been Mayor of Newcastle, was presented on June 6th with an illuminated address by the trades and friendly societies of the City to commemorate his forty years' work on the Corporation.

In honour of the memory of Mr. James Smith Turner, a "Smith Turner Scholarship in Dental Mechanics" has been founded for deserving students. The first examination will be held at the Royal Dental Hospital, London, on April 8th, 1908.

Dr. A. F. R. Wollaston, who was sent out by the British Museum last year to explore the Ruwenzori region of Africa, has lately returned safely home.

Sir Richard Douglas Powell, and Professor Watson Cheyne are to be the recipients of the Honorary D.Sc. at Oxford at the next Encoenia.

Dr. W. A. Densham, of the East African and Uganda Medical Service, has, we regret to learn, been killed by a buffalo, while out shooting.

In conferring the honorary degree of Doctor of Science of Cambridge upon Sir Thomas Fraser, the Public Orator referred to his famous dissertation, published nearly forty years ago, upon the Ordeal Bean of Old Calabar, and remarked that it won him early distinction as Laureate of the Institute of France.

Mr. T. H. S. Pullin, of Sidmouth, was recently presented with a silver salver and an address by past and present members of the Honiton Board of Guardians, in recognition of fifty-seven years of public work.

Professor J. J. Charles, M.D., has been presented by the medical students of Queen's College, Cork, with an address and a handsomely-illuminated album on the occasion of his resignation of the Chair of Anatomy and Physiology.

Cerebro-spinal-Meningitis has already made a victim in the medical profession, namely, Signor Lampagnani, of Rome.

Mrs. Mary Scharlieb, M.D., M.S., will open a discussion on "Alcohol, and the Children of the Nation" at the next meeting of the Society for the Study of Inebriety, at the Rooms of the Medical Society of London, on Tuesday, July 9th, at 4 p.m.

The late Mr. John W. Taylor has left £100 each to the Sheffield Royal Hospital, the Jessop Hospital for Women, Sheffield, and the Sheffield General Infirmary.

At a meeting of the Board of Cardiff Infirmary on June 12th a letter from Dr. Tatham Thompson was read, in which he stated that he had completed his service of twenty years as an ophthalmic surgeon, and, consequently, his office as an acting member of the staff terminated. On the motion of the Chairman, seconded by Dr. Wallace, Dr. Tatham Thompson was appointed consulting ophthalmic surgeon, and the meeting recorded its great appreciation of the valuable services he had rendered to the institution.

A Clinical Lecture

ON

DISORDERS OF MICTURITION IN WOMEN (a).

By PETER HORROCKS, M.D.Lond., F.R.C.P.,

Senior Obstetric Physician, Guy's Hospital, Lecturer on Obstetrics and Diseases of Women, Guy's Hospital Medical School, &c.

Gentlemen,—The frequency with which women complain in regard to trouble of one kind or another in micturition, makes it certain that when you get into practice you will often be consulted for the relief of such suffering. In order to be able to give relief, and in order to understand the varied causes of micturition troubles, you should know the anatomy of the parts, how they differ from those in the male, and how they are apt to be disturbed by causes which never act in the male. The bladder of a woman is said to be rather more capacious than that of a man, and this is said to be due to her habit for countless generations of holding her water a longer time than men do, for reasons of modesty and lack of conveniences. Again the urethra in women is a short and comparatively wide tube, a fact which explains some of the differences between women and men in regard to micturition troubles.

Also, you should understand the physiology of the act of micturition. Is it voluntary or reflex ? It is certainly a reflex act, but it is largely under the influence of the will.

The stimulus arises when the bladder contains a certain amount of urine, and grows in intensity up to a limited extent, with the increase of the amount. The afferent impulses are conveyed to a centre in the spinal cord but the Will can, up to a certain point inhibit the effect of these afferent impulses passing down to the micturition apparatus. When it is convenient the will power can set the apparatus in motion,

The detrusor fibres of the bladder are set in motion by the efferent impulses, and at the same time the sphincter vesicæ is relaxed and so the urine is voided. Normally the abdominal walls are not required to assist, but they can be made to do so either to increase the speed or to overcome any obstacle.

The bladder can empty itself by a purely reflex act, as for example in children when they wet the bed during sleep, or in persons whose spinal cord is so injured above the micturition reflex centre as to cut off the influence of the will. A gamekeeper generally squeezes out the contents of the bladder of a recently killed rabbit, before putting it in his pocket because he knows what would happen if he did not.

When the bladder is empty its walls are more or less in contact. In other words it contains a potential and not a real cavity. In this condition it measures from the meatus externus five inches, of which an inch and a half belong to the urethra. As the urine gradually accumulates the walls are separated, and it can contain a pint without its length being increased. It may be considered to be quite full when it contains a pint, and over-distended when it contains more than a pint. Its walls are thinner when it is full (still thinner when over-distended) and thicker when it is empty. When it is filling the walls are gradually stretched and so the muscular fibres are elongated. which places them in a position not only to actively contract, but also to shorten When the act of micturition is finished and the bladder is empty, the muscular walls of the bladder are in a state of retraction, the muscular fibres of the bladder, like those of the rest of the body cannot elongate themselves, and they have no muscular opponent (like most muscles have) to do this. But the *rôle* of opponent is performed by the accumulating urine.

RETENTION OF URINE.

The most frequent trouble and the most important in women in regard to micturition is retention. Owing to the short wide urethra, retention would be far less common in women than in men were it not for one important cause, namely *parturition*. When the child's head descends into the pelvis the neck of the bladder and the urethra are compressed more or less, and, as all doctors and midwives know, it not infrequently happens that a woman cannot pass her water properly for a day or two after labour. It is this most important cause which renders retention of urine as common in women as in men, and you should always give it as the first cause if ever you are asked the question at an examination. When you get into practice you will learn it by experience and sometimes by very unpleasant experience, If a woman passes no urine after labour attention is at once drawn to the fact and she is relieved by some method of getting her to pass water, or by catheterism. But you may come to grief with women who pass *some* urine, but who do not empty the bladder which gradually gets more and more distended. In such a case the nurse may tell you,. and honestly believe it, that the lady is passing her urine all right. If you accept the nurse's statement you ought to accept the responsibility. I remember a medical man fetching me to his wife, who, he feared, had puerperal fever. It was the fourth day after labour, she had had a rigor and her abdomen was distended and she was in great pain. On arrival at the house the patient certainly looked ill, and in distress, but on examining the abdomen it was obviously an enormously distended bladder which caused the abdomen to be enlarged, for it was dull in front, resonant at the sides, fluctuating and of the peculiar pyriform shape which the bladder assumes. A catheter was passed, over six pints of urine withdrawn, and the patient's distress was immediately relieved. The doctor was very angry with the nurse because he said she had assured him that his wife had passed her water all right. This is only one of many cases which I could relate to you, where a lady has apparently passed her water all right, and in the opinion of the nurse, in sufficient quantities, and yet where the bladder has gradually become distended. Let me advise you therefore, not to accept the nurse's word without confirming it by feeling the abdomen in the region of the bladder particularly if there be any distress, or by passing a catheter if need be, in case you are in doubt.

(a) Two Clinical Lectures delivered at Guy's Hospital, October, 1906, and January, 1907.

After abdominal section, if a catheter is not used, and the patient is supposed to pass water herself, you may get this gradual filling of the bladder, causing distress and simulating distention from peritonitis.

The next great cause of retention of urine is a *retroverted gravid uterus.* The uterus may be retroverted before pregnancy, or it may become so after it has become pregnant. In either case as it gradually enlarges it fills the pelvic cavity and the cervix uteri, presses against the urethra, and the neck of the bladder. As a rule, it is during the fourth month of pregnancy that the pressure becomes so great as to prevent the emptying of the bladder. Again, the woman may not complain of retention of urine, because she may be passing *some*, though it does not strike her that she is passing too little. For the same reason the nurse may, in answer to a direct question, reply that the urine is voided all right. Of course, if the patient cannot pass water at all, your attention is drawn to it but in other cases you may be called in on account of pain and swelling of the abdomen.

A medical man once asked me to see a case with him, and on the way he told me that the patient said she was only four months pregnant, but that he considered her to be six months at least.

On examination a four-months' retroverted gravid uterus was found in the pelvis, and an enormously distended bladder, rising above the umbilicus in the abdomen. We drew off nearly eight pints of urine and then restored the uterus to a normal position by means of digital pressure and she went on to term afterwards.

As we came away he said: "That confounded nurse told me that she was passing her water all right or I should never have made such a mistake."

So let me impress it as forcibly as I can upon your minds that a woman may be suffering from retention of urine, even when you are told that she is passing urine all right. Keep it in your mind, and if you find a suspicion of distention of the bladder, or if you are unable otherwise to eliminate the possibility, by all means pass a catheter to make sure.

In the case of retention from a gravid retroverted uterus you get a vicious circle. For the pressure against the urethra causes retention, and the distended bladder prevents restoration of the uterus.

A third cause of retention of urine in women is *hysteria*, and is met with chiefly in unmarried young women. Do not mistake hysteria for malingering and *vice versa*, and remember that you may have both at the same time in the same patient.

Retention is apt to follow operations on the vulva, vagina, uterus, peritoneum, bladder, rectum, abdominal walls, hernia, and even after operations on parts more removed from the bladder than those already enumerated. After an abdominal section a patient may be unable to pass any urine, or she may be able only to partially empty the bladder. Often enough urine is withdrawn by means of a catheter every six or eight hours for a day or two chiefly in order to keep her quiet and to subject her to no effort at all of her own. Where this is not done, it sometimes happens that the bladder gradually distends, and if some urine is voided, and so attention is not directed to the bladder, it may be mistaken for peritonitis, I could tell you of many instances illustrating this, but I will content myself with drawing your attention to it, in order that you may be on the *qui vive* for such a condition.

Pressure from tumours may cause retention. You will find this is by no means a frequent cause. For example, fibroid tumours of the uterus are extremely common, and yet retention due to such growths is very rare. Probably the reason of this is that they are slow growing things, and so the parts are able to accommodate themselves *pari passu.* I have certainly seen retention caused by a fibroid, but it was due to an accident or to straining. A young lady out hunting was thrown from her horse whilst leaping a ditch. She came down to the ground very forcibly, but fortunately without being much injured. Nevertheless when she got home she was unable to pass urine. Her doctor passed a catheter and on rectal examination (as she was single) he felt a large tumour in the pelvis. On seeing her with the doctor, I recommended an operation, and we removed a fibroid tumour as large almost as a fœtal head. It was of the sub-peritoneal variety, attached to the uterus by a thick pedicle. Its presence had not been even suspected before the accident, and what had most likely been the case was that it lay chiefly above the pelvic brim so causing no trouble, but that the sudden concussion when she was thrown, forced it down into the pelvic cavity, and so produced sufficient pressure to cause retention. It was removed without removing the uterus, and later on she married and had children.

Again, cystic tumours are common, but they seldom cause retention. Curiously enough small tumours are more prone to do so than large ones. That this is so may be due to the fact that small ones are often held down in the pelvis by some anatomical or pathological bands. Thus broad ligament cysts are held down by the layers of which that ligament is composed. But cystic tumours even when they grow rapidly accommodate themselves to the surrounding parts owing to their mobile fluid contents. Hence the rarity of retention of urine caused by such tumours.

Cancer in the urethra or vagina or cervix uteri may block the urethra and so cause retention. But it is only rarely that cancer does this. Far more frequently it causes incontinence by producing a fistula.

Inflammation in the neighbourhood of the bladder, pelvic peritonitis, either local or as part of a general peritonitis, perimetritis, parametritis, especially when in front or between the uterus and the bladder, all these may cause retention.

Certain *nerve diseases*, of the spinal cord, or brain, and certain mental affections, cause, or are at all events accompanied by retention of urine. Rarely it is seen in locomotor ataxia, and in some forms of paraplegia.

Similarly it is occasionally met with in the *continued specific fevers.*

Calculus as a cause of retention is almost unknown in women. The urethra is so short and wide that small calculi are easily passed, and only very rarely stick fast in, and block up the passage. Large calculi, are rare in women and when they do occur cannot get into the urethra.

Stricture of the urethra is almost unknown in women. I have never seen a case following upon gonorrhœa, as is so commonly the case in men. Theoretically it might occur, and you may have stricture following upon ulceration, injuries, operations caustics, or they may be congenital. Still you may go through a long life of busy practice and never meet with a case.

Lupus maximus may block the urethral orifice, and so cause retention Lupus minimus produces painful micturition so causing a woman to hold her water a long time.

Syphilitic adhesions might block the meatus, and also *elephantiasis*.

It is remarkable that in cystocele patients rarely find any difficulty in emptying the bladder. The detrusor fibres can expel the urine, although the bladder is upside down and out of the reach of the pressure exerted by the abdominal muscles for the most part at any rate.

TREATMENT.

After parturition not only see that the patient is passing enough urine by asking the nurse to tell you as near as she can the amount, but also palpate and percuss over the bladder whenever you suspect retention, and if you find it, or if the patient is not well, and you don't find it, pass a catheter. In some cases you may have to pass it every six or eight hours. As a rule the bladder and urethra recover their lost tone and micturition. becomes normal in a few days. If they do not you must continue to use the catheter, or still better drain the bladder by means of a self-containing catheter, the sigmoid shape being the best.

In retroverted gravid uterus draw off the urine with a catheter, restore the womb to its normal position and fit her with a suitable pessary to prevent remalposition, and let her wear it until the end of the fourth month of gestation after which the uterus is too large to be retroverted. As a rule it is not necessary to repeat catheterism if the uterus can be restored. If it cannot then you should keep the bladder emptied by a catheter until the trouble is overcome. It would take me beyond the limits of this lecture to deal with irreducible retroverted gravid uterus.

In hysterical retention you should draw off the urine with a catheter and satisfy yourself that there is no organic lesion, and then if the retention recurs let the catheter be used only as a last resource, and even then by the nurse or female relative or friend. The condition is soon cured in this way.

After operations the bladder soon recovers itself if kept from over-distention by means of catheterism. When due to the pressure of tumours of course these must be removed if possible by operation. Sometimes it is possible to relieve the pressure by pushing them into a different position. Inflammatory products must be absorbed or let out, relieving the bladder by catheterism in the meantime. In cases of nerve disorder and of insanity, where retention is present it is important to prevent over-distention by passing a catheter regularly, or by fixing a self-retaining catheter. A calculus must be removed, and anything blocking the urethra at the meatus urinarius must also be removed. A cystocele can usually be restored wholly or partially and kept in position by means of a suitable pessary or by operation.

Retention of urine in the ureters and kidneys may be caused by the pressure of tumours in the pelvis and abdomen and by collections of blood (hæmatocele) pus, or other fluids. A calculus more often met with in the ureter than in t urethra, but is as a rule on one side only.

NOTE.—*A Clinical Lecture by a well-known tea appears in each number of this journal. The lect for next week will be by Peter Horrocks, M.D.Lon F.R.C.P., Senior Obstetric Physician, Guy's Hospi Lecturer on Obstetrics and Diseases of Women in Gu Hospital Medical School, etc. Subject : "Disorders Micturition in Women." (Being the second of t lectures delivered at Guy's Hospital.)*

ORIGINAL PAPERS.

CEREBRO-SPINAL FEVER (*a*).

By F. M. SANDWITH, M.D., F.R.C.P.Lond.

Consulting Physician to Kasr el Ainy Hospital, Cairo, and Lect at the London School of Tropical Medicine.

SOME statistics from the British Isles durin the first three months of 1907 were given to sho the present prevalence of the disease. As man as 312 deaths occurred in Glasgow from th cause during the quarter, 179 of them havin been recorded in March. This represents higher death rate than from any other acut infectious disease in Scotland.

The history and geographical distribution the disease during the last hundred years we briefly traced. Mention was made of the exis ence of the disease in Nigeria, Egypt, and th Sudan, where the Mahdi is believed to have die of it. But the United States have really bee its headquarters, both as regards extent of pre valence and severity of the disease, for the are for several years has extended from Canada t Mexico and from the Atlantic Ocean to Minnesot and Iowa. It was noticed that new district are constantly being attacked, but that there wa no reason for anxiety with regard to the presen outbreaks in the United Kingdom. The curious irregular type of epidemics, both as to space an time, distinguish this disease ; a local epidemi may smoulder on for months, and may recur a irregular intervals in the same district, showin that the infection is endemic for the time bein in that particular spot, from which it is argued that the poison of the disease can exist for a short time outside the human body.

Though prisoners and soldiers in barracks are specially liable in endemic centres, in ordinar civil life it is children and young adults who ar the most susceptible. Infants of five months have been known to recover, though many babies under one year have succumbed in New York Speaking generally, the older the child the bette are its chances of recovery.

The arguments for and against personal contagion were considered, and the disease was compared to certain outbreaks of pneumonia whic at times in a family or a school may present a high degree of malignant infection. The lecture gave his personal experiences at Boston an New York in the spring of 1905, when he ha the opportunity of seeing dozens of cases by the courtesy of various hospital physicians. In the Boston City Hospital the house physicians an nurses were instructed to wear a gauze muzzl

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(*a*) Abstract of a Lecture delivered at the Medical Graduates' Coll and Polyclinic.

covering the nose and mouth because the avenue of infection was thought to be through the nasal passages, and the same general instructions were issued that obtain in that hospital in the general management of infectious cases. On the other hand, in New York he found that no great precautions were taken beyond isolating the patients in special wards. Attention was drawn to the fact that the diplococcus is often found in the nose and throat of attendants on patients suffering from cerebro-spinal fever, and in such cases the nose and throat should be carefully disinfected.

Flexner's experiments on monkeys in New York were mentioned. During 1905, in New York city alone, no less than 2,755 cases of this fever were reported, besides, probably, many mild cases which were not notified. Of the number reported 1,511 died, giving a mortality of about 55 per cent. The duration of the cases varied extremely, from nine hours to several months. The incubation period is short, from one to five days. The *diplococcus intracellularis meningitidis* is found in the mucus of the nose in at least half the patients during their first week; it is of feeble vitality, being rapidly killed by drying and on exposure to sunlight, which makes the probability of infection by dust very unlikely.

The cases of posterior basic meningitis, well-known in this country, are due to the same organism, and are therefore only sporadic forms of the disease. Among the differences between cerebro-spinal fever and tubercular meningitis is the fact that in the former the spinal cord is much more involved than in the latter, where the membranes of the brain are chiefly attacked; this is shown by stiffness of the neck, rigidity of muscles, sensitiveness of the skin, great retraction of the head and sometimes opisthotonos. In various cerebro-spinal epidemics the number of recoveries varies from 20 to 50 per cent., whereas in other forms of meningitis recovery is almost unknown. Other points in favour of this fever are the abrupt onset, Kernig's sign (though this is of very little value in children under two years of age), hyperæsthesia, mental irritability, the peculiar skin eruption and herpes on the lips.

The absolute diagnosis is made by the detection of the diplococcus in the cerebro-spinal fluid after lumbar puncture, but it must not be forgotten that the diplococcus may not be found after the first ten days of the illness, and that it is necessary always to use the fluid as fresh as possible.

Cases were reported where the disease had been mistaken for sunstroke, typhoid fever, pneumonia, influenza, typhus, and even nervous symptoms produced by the presence of ascarides.

Several patients in the United States during the last epidemic there were empirically treated with large doses (up to 30,000 or 40,000 units) of diphtheria antitoxin, usually administered intra-muscularly, but sometimes intra-spinally. This treatment was of no avail, and no drug has yet been found as a specific. Repeated lumbar punctures undoubtedly often help to allay the fever, headache, delirium and general irritability of the patient, and the operation has not been followed by ill results, though occasionally there is a little hæmorrhage. Flexner's serum from artificially-infected monkeys holds out hopes of future prophylactic and even curative value.

THE USE OF MASSAGE AND MOVEMENT IN THE TREATMENT OF FRACTURES (*a*).

By C. W. CATHCART, M.B., F.R.C.S.,
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In recent years there have been improved methods of diagnosis of fractures—Röntgen rays, antiseptic incision, as well as improved methods of treatment—Championiere's use of massage and movement, and in a few cases, operation under antiseptic precautions. Our views as to the treatment of fractures have changed greatly, due, to a large extent, to the pioneer work of Lucas Championiere. The old principle in dealing with a broken bone was to secure absolute immobility by fixing the joints above and below with some form of retentive apparatus. It is now known that absolute immobility, instead of being necessary for bony union, is a hindrance to it, and may lead to secondary functional disability, sometimes permanent. On the other hand, massage and movement for a few minutes daily, combined with fixation, hastens bony union, maintains the functional power of the muscles, and minimises adhesions. Many forms of retentive apparatus which were formerly valued can now be dispensed with; those still employed are simpler than before, leave the joints more free, and are taken off sooner. The objects to be attained by massage are the removal of deformity, of swelling, of spasm, and of pain, and the promotion of absorption of effusion into muscles, and about tendons and ligaments. At first passive and then active movement should be practised. There is one rule in both massage and movement, and that is that pain should never be caused. Passive movement ought to precede active movement; the object of the former is to prevent adhesions, while the place of the latter is that of promoting the return of functional integrity. Splints are still needed in the treatment of fractures to prevent deformity in fractures of unsupported shafts of long bones, when the neighbouring joints may be supported but not immobilized, or in some fractures near joints where the long fragment has to be brought into line with the short one. They may also be needed for the purpose of supporting and steadying a recently broken bone because of muscular spasm and pain on movement. Extension is also still necessary to diminish overriding and relieve muscular spasm in certain fractures of the lower limb, but it can generally be dispensed with in from two to four weeks. By the use of massage and movement retentive apparatus is greatly simplified. Taking the case of fracture of the clavicle, all pads in the axilla, &c., can be dispensed with; and if the arm is supported by a bandage, nothing more is needed. Even strapping is, to a certain extent, objectionable. The same applies to fracture of the surgical neck of the humerus; no splints are needed. It is enough to support the arm, and to give early massage and movement. In fracture of the olecranon it is no longer essential to keep the arm extended in an anterior splint; a piece of plaster is applied to steady the fragments, and the arm is kept quiet. The same applies to fractures of the lower end of the radius, of the neck of the femur, of the patella, and of the lower end of the fibula. No particularly skilled massage is needed; a nurse becomes thoroughly competent after a few lessons.

(*a*) Abstract of Paper read at the Edinburgh Medico-Chirurgical Society, June 5th, 1907.

THE CAUSE OF THE HEART BEAT (*a*).

By G. A. GIBSON, M.D., F.R.C.P.Ed., F.R.S.Ed.,

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The literature which has already grown up in connection with the subject of the causation of the heart beat is enormous. It is quite impossible in the compass of a single lecture to do more than refer to the really important contributions yielding something more than mere destructive criticism. For an excellent summary of the whole question of the cause of the heart beat let me refer to the learned article of Langendorff in the *Ergebnisse der Physiologie*, and let me further add that while this oration was in course of preparation two interesting addresses have appeared on the subject by Wesley Mills and Alexander Morison.

Harvey made no attempt, even in that chapter which forms the most beautiful part of his immortal work, to explain the causes of the pulsation of the heart, and we have to pass on till a period a hundred and fifty years later before we encounter any attempt to define the problem. Cardiac movements were originally attributed by Albrecht von Haller to an inherent power of contraction belonging to the heart itself. It has been claimed that he regarded the automatic movements of the heart as due to an inherent faculty of the heart muscle. This, however, is not specifically stated, and, as the intimate nervous connections were then unknown, it is probable that the intrinsic nature of the movements did not particularly trouble the mind of that great observer. Senac also regarded the pulsation of the heart as due to special activities, but he laid greater stress upon external sources of interference. With these vague views pathologists, as well as physicians, were content until the middle of last century. The discovery of the ganglia at the junction of the sinus and of the auricle by Remak, of those between the auricle and the ventricle by Bidder, and of those between the two ventricles by Ludwig, necessarily opened up the possibility of some definite explanation, and the formal presentation of the views which resulted was given by Volkmann, who enunciated the theory that the pulsation of the heart was due to the automatic action of the intrinsic ganglia of the heart.

These views, however, were almost from the first modified in certain respects from time to time, by the investigations of several observers. It is only necessary to mention the experiments of Eckhard as well as of Foster and Dew Smith upon the apical region of the heart, and the further researches of Bowditch and of Merunowicz on the influence of different nutrient fluids upon the same part. The general result, however, was embodied in the theory, stated by Rosenthal, that impulses flowed from the ganglia in the sinus and produced the rhythmic action of the heart.

In the minds of those, nevertheless, most competent to form a judgment in respect of such facts, a considerable degree of doubt existed in regard to such an explanation. "In the sporadic ganglia," Foster says, "the evidence of automatic action seems more clear, and yet is by no means absolutely decisive. The beat of the heart is a typical automatic action; and, since the heart will continue to beat for some time when isolated from the rest of the body (that of a cold-blooded animal continuing to beat for hours, or even days), its automatism must lie in its own structures. When, however, we come to discuss the beat of the heart in detail, we shall find that it is still an open question whether the automatism is confined to the ganglia (either of the sinus venosus, auricles or auriculo-ventricular boundary), or shared in by the muscular tissue; whether, in fact, the automatism is a muscular automatism like that of a ciliated cell, or the automatism of a differentiated nerve-cell. And yet the heart is the case where the automatism of the ganglia seems clearest."

At this point we reach the parting of the ways. The long series of researches made by Gaskell and embodied in a valuable paper which has for well-nigh quarter of a century been a constant subject of study amongst all of us interested in the problem of the circulation may be regarded as the starting point of the myogenetic theory. In this admirable contribution the author enunciates two laws, as follows: "the power of independent rhythmical contraction decreases regularly as we pass from the sinus to the ventricule," so runs the first law. The second is, "the rhythmical power of each segment of the heart varies inversely as its distance from the sinus." These conclusions have never been controverted, and from an exoteric point of view there is practical unanimity regarding them. It is when we approach their esoteric consideration that we are struck by the fact that the phenomena are susceptible of explanation in two absolutely antagonistic ways. Gaskell concludes that the contractions are myogenetic and automatic, He bases his belief in the myogenetic origin of the contractions on the absence of special nerve structures, and on the fact that when the rhythm is once well established the strip can be cut into small pieces, each of which will still continue its rhythm for a long time. The origin of the movements must therefore, according to Gaskell, be either in the muscle cells or nerve fibres, as was suggested by Schiff in discussing the movements of the heart. It is to be noted that Gaskell does not deny nerve influence. By the method of its development Gaskell was led to the conclusion that the rhythm is due to some quality inherent in the muscle itself, *i.e.*, that it is automatic. He holds that nothing can be more striking than the nature of its development, the gradual recovery of conduction, the steady increase of the contraction, the uniform augmentation of excitability—all show a steady improvement in the activity of the processes upon which the various properties of the muscle depend, which is manifested by the outburst of automatic rhythmical contractions. It continues for many hours after the discontinuance of all stimulation. Gaskell points out that the ventricle contracts in due sequence with the auricle, and shows by experiment that this occurs only when such a contraction wave passes to the groove. He points out the special structure of the muscular fibres at the sino-auricular junction, forming a regular band or muscular ring from which the fibres of the auricle take their origin; and again at the auriculo-ventricular junction, where there is another well-defined ring of parallel muscular fibres from which, in part, the muscular fibres of the ventricle take their origin. The existence of these two muscular rings connecting the two muscular cavities of the heart is, according to Gaskell, amply sufficient to account for the passage of the contraction from the sinus to the auricle and from the auricle to the ventricle without the necessity of invoking the presence of ganglion cells. He next repeats the experiments of Eckhard and Marchand, which led them to conclude that the auriculo-ventricular ganglia are essential for the due sequence of the ventricular upon the auricular contractions in the frog, and he asserts that, after removing them, the sequence continues just as well as before. From a few observations upon the heart of the skate he concludes that it affords a good example of the peristaltic nature of the heart beat and also furnishes a new proof that the starting-point of the peristaltic contractions is determined by the nature of the muscular substance rather than by the presence or absence of ganglion cells.

Gaskell shows that the cardiac nerves are able to increase and diminish the conductivity of the muscular tissue of the auricle. He finds, however, and the fact is of great importance, that nervous action can remove a partial block, and that it does so because it expedites the recovery of the conduction power of the muscle. One of Gaskell's most important results is that by nervous influences there may be increase or diminution of the five different aspects of cardiac activity—

(*a*) [illegible] of the Oration delivered before the Medical Society of [illegible] 27th, 1907.

rhythmicity, excitability, conductivity, contractility, and tonicity.

The chief criticism to which the observations and deductions of Gaskell are open lies in the fact that there is in every case the presence of nerve tissue. Further, the changes in rhythmicity and the other functions which he describes as the result of experiments on the vagus seem to me strong arguments for a nervous origin of these functions.

The co-ordination of the cardiac movements and the conduction of the motor impulses is attributed by Engelmann to the muscular connections which have in recent years been described; and, to get over the difficulty of the almost instantaneous conduction of impulses through the auricles and through the ventricles while a comparatively long time elapses between their respective contractions, Engelmann ascribes with Gaskell a more restricted and embryonic power of conduction of motor stimuli to the muscular bridges. He points out that the facts of artificial stimulation in different parts of the heart show that the conduction may be reversed, and he regards this as being highly antagonistic to any theory based upon nerve conduction. Again, he points to the result of researches into the rapidity with which motor impulses pass through the heart, which are much slower than under similar circumstances in the motor and sensory nerves. From all these facts he holds that the theory of neurogenetic conduction and co-ordination is no longer tenable.

The arguments derived from the recent studies of the connections between the vein and the auricle, as well as those between the auricle and the ventricle, together with the wonderful ramifications of the Purkinje fibres, have often been claimed as strong evidence in favour of the myogenetic theory. The same is true of the clinical features of heart-block studied from the clinical point of view by a great army of physicians, and of the pathological investigation of morbid changes in the auriculo-ventricular bundle which have been described by Stengel, myself, Schmoll, Jellick, Cooper and Ophüls and Keith and Millar. But it has to be remembered that even the auriculo-ventricular bundle contains not only nerve fibres but ganglia as well, as has been shown by Tawara and Keith. That the conduction is by muscle cannot as yet be held as proved.

It is universally recognised that the seat of the causes of the rhythmic movements lies in the great veins entering the auricular sinus. From the days of Albrecht von Haller to the times of Lauder Brunton, MacWillian, Engelmann, Hering, Krehl, and Romberg, this fact has been received with general acceptance. But to what particular tissues is the function to be assigned? In one of the most beautiful researches of recent years Keith and Flack have attempted to answer this question. They describe the musculature of the sinus as being freely continuous with that of the auricular canal and auricle, and in their search for a well-differentiated system of fibres within the sinus. which might serve as a basis for the inception of the cardiac rhythm, they have been led to attach importance to a peculiar musculative surrounding the artery or arterial circle at the sino-auricular junction. The structure is described as being like that of the auriculo-ventricular bundle, consisting of an intimate network of pale undifferentiated fibres with well-marked nuclei. It is to be observed that Keith and Flack describe the presence of nerve cells and nerve fibres, and state that "although the mass by its connections is undoubtedly muscular, the nerves in the neighbourhood of the vena cava appear to come into very intimate connection with it, so that we feel justified in stating that a highly-differentiated neuro-muscular junction occurs at this point."

The occurrence of a block at the sinus, if the interpretation furnished by Hering and Wenckeback, as well as by Ritchie and myself is correct, seems to me strongly in favour of neurogenetic conduction. The muscle fibres are certainly not so much restricted as in the case of the auriculo-ventricular bundle according to Keith, and the recurrence of a block at this point is, therefore, more likely to be the result of disturbed nerve influence than of diminished muscular conductivity. This, in fact, is fully recognised in a valuable paper by Keith and Flack which appeared after these remarks had been written. They frankly acknowledge that a sino-auricular block cannot be due to any anatomical lesion of a narrow bridge of fibres, but must arise from the depression, probably of vagal origin, of the muscular tissue. We may well ask why muscular tissue?

With regard to the contractility and conductivity we must hold that as yet no evidence has been brought forward that differentiates between the muscular and the nervous fibres.

The occurrence of irregularity of the heart in early life seems to me to have an important bearing upon this subject. The long series of careful observations made by Mackenzie have led him to the conclusion that the irregularity of early life is commonly of nervous origin, and his conclusions entirely commend themselves to my judgment. This view necessarily leads to the probability that disturbances of the heart functions arising in such a way are more likely to be produced through changes in the intra-cardiac nervous system than the muscular. The irregularities of later life are undoubtedly produced very commonly by structural alterations in the muscular as well as the nervous tissues, and no argument from them can be deduced; but many of the toxic forms of arhythmia in patients suffering from gouty troubles are, like early irregularity, to be regarded as in favour of the neurogenetic theory.

The action of chemical substances has sometimes been invoked as an argument in favour of the myogenetic theory. It was shown by Biedermann more than five and twenty years ago that the skeletal muscles may show rhythmical contractions under the influence of alterations in the chemical composition of the fluid by which they are surrounded, and more recently Loeb has demonstrated that certain ions have the faculty of producing such phenomena. Here again, however, it is a pure assumption that such agents act on the purely muscular protoplasm. Seeing that the muscle cell is inextricably interwoven with nerve fibres, and that these nerve fibres, as Carlson has shown, are less subject to destructive changes than the muscle cells, the argument would seem to the unbiassed mind to lie in an entirely opposite direction.

The observations of Magnus and of Sollmann are of considerable importance in their bearing upon the question at issue. They have been able to prove that distension of the coronary arteries is able to start and to maintain the beat of the heart. It seems probable that Sollmann is correct in his conclusions that this fact is in favour of the neurogenetic theory, since it seems likely that the effect of distension is to stimulate the nerves in the walls of the vessels, whence the impulses are conveyed to the ganglia.

One most interesting fact has recently been ascertained regarding the peristalsis of the intestine in the embryo by Yanase, who has discovered that this function does not make its appearance until the development of the earliest nervous elements. Yanase concludes from his observations that the automatic movements of the fœtal intestine are neurogenetic in origin. There are undoubtedly some differences between the state of matters here and in the case of the embryonic heart, in so far as the heart beats before any nervous structures are apparent in it, while the first movements of the intestines are synchronous with the earliest development of nervous structures. The facts investigated by Yanase are, nevertheless, a powerful argument in favour of the neurogenesis of cardiac pulsations.

So far we have devoted attention to the observations and opinions in favour of the myogenetic hypothesis. It is time to turn for a space to facts and views which have been recently advanced in favour of the theory of Volkmann.

Observations upon invertebrates, even of lowly types, have been of great assistance in the elucidation of the problems connected with cardiac movements. A very large number of researches have been carried out in this field, of which it is only possible to refer to a limited number, from which the most important information has been obtained.

The obvious criticism of all investigations on the invertebrata is that the invertebrate type of heart cannot be regarded as homologous to that of the vertebrates. The organs undoubtedly differ widely in structure, and exact comparison is therefore impossible; it is, nevertheless, a striking fact that Carlson finds so many points of resemblance in the two types. It may be recalled, moreover, that Wenckebach admits there is no fundamental difference between striped and smooth muscle fibres, or between vertebrate and invertebrate muscle cells.

Amongst the opponents of the myogenetic theory Von Cyon stands prominently forward as one of the most formidable in destructive criticism. In his famous paper, "Myogen oder Neurogen," he furnishes one of the most acute examples of physiological polemics which our generation has witnessed. To this has more recently been added his work on the nerves of the heart, which also abounds in trenchant criticism. On this occasion it is impossible to follow the author through his analysis of the myogenetic hypothesis, but it may be said in a word that his opinion is strongly in favour of the views of Volkmann and his followers.

An important argument against myogenesis is to be derived from the fact that the heart may conduct impulses without manifesting contraction. Fredericq observed that the apex of the heart might be electro-negative to the base, or, in other words, that it contracted before the base. Waller and Reid found that the apex may either precede or follow the base in the manifestation of electro-negativity. Bayliss and Starling, on the other hand, found that in health the base always manifested electro-negative conditions before the apex, but that in hearts which had been damaged the apex might precede the base. Some light upon this subject has been thrown by the researches of Carlson on Limulus. He finds that the heart walls may conduct impulses without showing contraction. After soaking the heart until the condition of water-rigor appears, it is clear that the nerves can withstand the evil effects of the process better than the muscle cells, and after inducing that condition in Limulus he is able to prove that the conduction does not take place by muscle, but by nerve. He observes that analogous effects may be produced by heat, and that after the application of heat the muscle fails to respond, while the ganglion cells are still active.

After a long examination of the doctrines of Yandall Henderson, MacWilliam, Fredericq, and others, the lecturer quoted the quaint remarks of Burton on excessive mental effort as a cause of melancholy. "No labour in the world," he says, "like unto study."

The conclusion of the whole matter, so far as can be seen at present, lies in a question of probabilities. Five years ago my adhesion was almost given to the myogenetic hypothesis, but much clinical observation and pathological investigation, as well as laborious study of critical analysis of all the important contributions upon the subject, have led me to the conclusion that the view of Volkmann is still a more satisfactory explanation of the facts than any other which has yet been advanced.

Dealing with matters of such intricacy and complexity it must be frankly confessed that such proof as will satisfy the demands of a rational scepticism is still far from attainment. It is, indeed, difficult to see at the present moment whence such evidence is to be obtained.

"Causa latet, vis est notissima fontis."

Dr. Barritt, medical officer of health to the Spalding Urban District Council, in his annual report to that body, states that during the past year, out of a total number of 163 deaths, 18 had been due to cancer, as against 13 last year. This gave a percentage of 11.04 of all deaths registered.

THE OUT-PATIENTS' ROOM.

THE ROYAL EAR HOSPITAL.

(*Hereditary Syphilitic Labyrinthitis*).

By P. Macleod Yearsley, F.R.C.S.

Among the out patients was a young man, æt. 37, a clerk by occupation, who complained of deafness in both ears, with rushing and booming tinnitus. The right ear commenced to lose its function two years and a half ago, becoming deaf with moderate rapidity. The left ear became affected three months later, but not to the same extent. For the past ten days he had been totally deaf in the morning, and he stated that the hearing varied considerably during the day. Both deafness and tinnitus were always worse lying down. Fifteen years ago he had suffered for a long time with his eyes, requiring to be under treatment for some months. He had never had any vertigo.

On examination the right tympanic membrane appeared to be practically normal, the left was uniformly dull. There was no indrawing. No seriously abnormal condition was to be seen in the nose or throat, and the post-nasal space was free. The eyes showed old interstitial keratitis, the teeth were not typical.

On functional testing it was found that Rinne's test gave a positive reaction on both sides. There was loss of bone conduction for the C (128) tuning fork amounting to 29 seconds on the right side, and 24 seconds on the left. Galton's whistle registered 2.4 on the right side and 2.8 on the left, showing loss of perception for the notes in the upper scale. Owing to the noise in the Consulting Room the lower scale was not tested.

Mr. Macleod Yearsley said that the diagnosis was clearly that of hereditary syphilitic labyrinthitis. These cases were of very great interest from the pathological and otological points of view. They could be divided into two groups, both of which had their counterparts in the acquired disease. These two groups were:—

1. Deafness without vertigo.
2. Deafness with vertigo.

The first of these, in which the deafness came on with giddiness, and to which the case under consideration belonged, was by far the commoner variety. The history was usually that of a gradual onset, one ear being affected before the other, and usually the eye symptoms closely preceded the aural manifestations. As a rule, other signs of hereditary syphilis were well marked, making the diagnosis easy. It must not be forgotten, however, that the ears may become affected before the eyes. In such cases, where the congenital specific signs were ill-marked, the diagnosis must rest upon an insidious internal ear deafness coming on between the ages of 8 and 25 years, all other possible causes having been excluded.

It was to be noted that the age of the present patient was 37, and he had first shown signs of deafness at about 34 or 35. The condition had, therefore, appeared rather later than usual. Mr. Macleod Yearsley had, however, once seen it appear, in a private case, as late as 50 years of age.

Another interesting point, and one that it was, unfortunately, impossible to ascertain in this particular case, was the question of early treatment. It had been pointed out that hereditary syphilitic labyrinthine deafness only appeared in those persons in whom appropriate treatment had been neglected in infancy.

The pathology of this group of cases, in which deafness came on gradually and without vertigo, was that of a chronic osteitis, leading to a gradual and more or less complete occlusion of the cavities of the internal auditory meatus and bony labyrinth. The symptoms closely resembled those which occurred in one form of labyrinthine disease, due to tertiary, acquired syphilis, and Politzer pointed out, from published investigations, that an osseous growth from the periosteum takes place owing to chronic inflammation of the lining of the labyrinth.

Remembering that congenital syphilis may take on a typical tertiary form, as seen in the acquired disease, and as illustrated by the throat ulceration not infrequently seen in hereditary specific children, it was possible that the condition as presented in this group was a tertiary form.

The second group of cases, in which the onset of the deafness was with vertigo, was decidedly uncommon. There was one case of this variety attending the clinic, and Mr. Macleod Yearsley regretted that it was not there now for comparison. Kipp pointed out that a certain number of cases of hereditary syphilitic labyrinthitis occurred in which sudden deafness, vertigo, disturbances of equilibrium and tinnitus were complicated by interstitial keratitis and iritis. It had been suggested that an exudation into the labyrinth, corresponding to that which occurs in iritis, takes place, but this had never been proved. These cases ran an acute, subacute, or chronic course, involving the whole of the labyrinthine nerve endings, and in which the symptoms present were best accounted for by an increase of tension due to exudation, as in the eye. The resulting deafness was due, in the acute form, to an immediate destruction of the labyrinthine nerve endings by pressure, and in the subacute and chronic cases to a constantly recurring increase of tension, with changes in the exudation itself acting on the labyrinthine nerve endings. This second group had its counterpart in secondary acquired disease. As regards treatment the prognosis was a good one, provided the case was taken in hand at an early stage, as with those recurring cases in acquired syphilis; the treatment must be vigorous. Pilocarpine given by hypodermic injection was almost a specific, provided it was used sufficiently early, starting with one tenth or one-twelfth of a grain, and rapidly increasing it until one-fifth of a grain was used. It should be injected daily for a fortnight. Should it fail to bring about improvement in that period it was useless to try it further, and mercurial inunctions with large doses of iodide of Potassium and blistering over the mastoid should be employed instead. In a case recently published, Mr. Yearsley said, the latter treatment, after being persevered with for a year, succeeded in relieving the patient, who had been suffering for several months. The surgeon should not therefore despair in old standing cases until treatment has been tried for at least that period.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

Case of Cerebral Concussion.—Mr. Peyton Beale operated on a man, æt. about 20, who had been admitted to the hospital some eight hours previously having fallen from the top of a cart on to the road. On admission, there was a small hæmatoma just to the left of the occipital protuberance; the man's general condition was that of well-marked cerebral irritation. He was admitted and watched, and in three or four hours had all the symptoms of cerebral concussion. When Mr. Beale saw the patient his condition was the same, but symptoms of compression were evidently commencing, for his pulse-rate was getting much slower and he was gradually becoming comatose. There was well-marked paresis of the right side of the body, so, after the head had been shaved, a large scalp flap was turned up over the left Rolandic area. No fracture was visible, either immediately beneath the hæmatoma or at any other part of the exposed bone, so he was trephined over about the middle of the Rolandic area. The dura mater was exceedingly tense, and when incised the brain bulged up through it, the intra-cranial tension being evidently enormous. On passing a flat, narrow spatula in various directions between the brain and the dura mater, dark blood and clot were found in the temporal region and it seemed likely that there was a fracture of the base of the skull, which had involved the lateral sinus. There was not any active hæmorrhage progressing, so a drain was inserted between the brain and dura mater in a downward direction, and the wound dressed in the usual manner. Mr. Beale said that this was evidently one of those cases in which the fracture did not occur at the point struck; the old idea of fracture by *contre-coup* seemed now to be given up and the modern view was that the force from the point of impact was transmitted round the vault and base of the skull and, as the base was the weaker part, it was unable to withstand the strain and so fractured. It was, he thought, interesting to note that all the compression symptoms had passed off by the time the operation was completed, and when the patient recovered from the anæsthetic his symptoms were those of concussion only; in fact, he was in the same condition as he was three or four hours after admission. Mr. Beale assumed that concussion of the brain always implied more or less laceration of brain-substance; in cases which succumbed to symptoms of concussion alone there was practically always laceration of the brain found post-mortem.

GREAT NORTHERN HOSPITAL.

Extensive Fracture of the Skull.—Mr. Peyton Beale operated on a man, æt. about 30, who had been admitted in a comatose condition after a serious head injury. The patient had received a severe blow on the back of the skull from a heavy iron rail. There was a large hæmatoma occupying the whole of the back of the skull and some hæmorrhage from the back of the pharynx. He had typical symptoms of cerebral compression: respiration slow and laboured, occasionally Cheyne-Stokes's; pulse full and slow, about 20 beats to the minute; pupils dilated, the right reacting to light only slightly; paralysis of right arm and leg and complete anæsthesia. The man having been suitably prepared, a large curved incision with the convexity downwards was made on the left side of the skull and a flap of scalp about 7 ins. in length, turned up. Several fractures were at once apparent; one of them appeared as if it went right round the skull just above the level of the occipital protuberance; another passed vertically upwards over the Rolandic area. There was no depression of bone, but it could be easily levered up by means of an elevator. Cutting forceps were applied to the elevated edges, and three or four square inches of bone rapidly removed. There was no hæmorrhage between the bone and the dura mater, but on opening the latter a large amount of dark blood clot escaped. By inserting the finger, fully half a pint of this was scooped out, and it was then seen that there was very profuse hæmorrhage coming from the direction of the longitudinal sinus. Portions of the parietal bone were then freely cut away until the sinus was reached; it was then seen that the latter was torn right across, so pressure forceps were applied and gauze packed in firmly between and around them. The brain was found to be lacerated as far as it was exposed to view, and it was obvious that there was nothing more to be done, the pressure having been relieved and the hæmorrhage stopped. Mr. Beale said that in cases where the injury was so extensive the use of the trephine was too slow and tedious. A pair of cranial cutting forceps were of great service, but, of course, the best thing was an electrically driven saw. It was advisable, he thought, to remove a good deal of bone in order that the extent of the injury might be ascertained, and a ruptured sinus exposed to view, so that there might be a chance of applying pressure forceps to it. In the case he had just operated on, the laceration of the brain was so extensive that nothing beyond removing blood and clot and dealing with the ruptured sinus could be attempted.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Obstetrics.

President.—R. D. Purefoy, M.D., F.R.C.S.I.
Sectional Secretary.—H. Jellett, M.D., F.RC.P.I.

Meeting held May 24th, 1907.

Dr. R. D. Purefoy, President of the Section, in the Chair.

Dr. **Henry Jellett** exhibited the following specimens:—(*a*) Uterus and upper two-thirds of vagina removed by Werder's method for cancer of the vagina; (*b*) remainder of vagina and inguinal glands from the same case. They were, he thought, of interest from both the operative and pathological standpoint, as cancer of the vagina was a very rare condition. The specimen had been removed from a patient, æt. 39. She stated she had menstruated regularly up to the present time, but that there had been a certain amount of leucorrhœal discharge, which had been gradually increasing. She had not suffered in any way from hæmorrhage. Her general health was good, and she had not lost weight. On examination he found, first of all, that there was a condition of the cervix somewhat resembling an erosion. It was congested, and bled when touched. On the anterior vaginal wall there were several nodules about the size of a hazel nut, extending half way down the wall, and upwards almost to the cervix, and so close that for that and other reasons he believed the case to be one of intra-cervical cancer that had grown out on to the vagina. The case was a favourable one, and he decided to perform the operation described as Werder's operation. The operation went off better than he expected, there being practically no hæmorrhage. He removed the uterus, appendages, broad ligaments, and upper two-thirds of the vagina, but did not do a very extensive para-uterine dissection, as there seemed to be no indication for it. He separated the anterior vagina wall practically down to the urethral orifice, and the posterior wall half-way down. The patient made a favourable recovery. He sent the specimen to Dr. Rowlette, who reported as follows:—

"Specimens submitted by Dr. Jellett—(*a*) Uterus and appendages, with part of vagina; (*b*) remainder of vagina, with inguinal glands.

"(*a*) *Vagina* shows ulcerating patch, about one and a half inches in diameter, situated in anterior wall. *Microscopically* this patch shows proliferating masses of epithelioid cells. In parts the cells show considerable resemblance to gland tissue, empty spaces being surrounded by proliferating masses of cells. The condition is malignant. In other parts the cells are in solid masses. The *uterus* presents a firm, white *cervix*, which on section exhibits one or two small cysts. *Microscopically the cervix* presents much fibrous tissue. The covering epithelium is regular, but covered with fibrino-purulent exudate. The glands in some parts are normal, in others dilated and cystic. The *endometrium of the body* is soft and friable. *Microscopically* it shows congestion and neurotic changes, but the glands are quite regular. One *ovary* is firm and hard, showing *microscopically* much fibrous tissue. The *other* has some small cysts.

"(*b*) Examination of the remainder of the *vagina* and the *glands* is quite negative. The *glands* are hard and firm, but do not, as far as examination shows, contain any secondary deposits of cancer."

There was no involvement of the rectum, bladder, or breasts, or of the intestinal tract, or anywhere else that caused any symptoms, or a tumour that could be felt. Such being the case, he thought it prudent to remove the remainder of the vagina and inguinal glands.

Dr. **Hastings Tweedy** said it appeared to him, from the description, to be a case of malignant disease of the vagina, pure and simple; he was therefore anxious to know why Dr. Jellett considered the removal of the uterus necessary.

Dr. **Rowlette** said the pathology of the tumour was of great interest because of its peculiar type. On first examining the vagina he had little doubt that he would find adeno-carcinoma of the body of the uterus, but on cutting the uterus and finding no primary focus of the disease he had, he thought, to conclude that it was primary in the vagina. It was possible that it was an adeno-carcinoma originating in Wolffian remains, or it might be an endothelioma.

Dr. **Jellett**, in reply, said the uterus was removed both because he believed the case to be one of intra-cervical carcinoma extending into the vagina, and because in any case of vaginal carcinoma, if the entire vagina had to be removed, it is necessary also to remove the uterus. He had previously cystoscoped the bladder and found the wall healthy.

THE REPORT OF THE ROTUNDA HOSPITAL FOR THE YEAR 1905-6. ADJOURNED DISCUSSION.

Dr. **Neil** congratulated Dr. Hastings Tweedy, the Master of the Rotunda Hospital, on the extent of the report and the work done. In the case of unavoidable hæmorrhage, he thought it would have been better to have brought down a leg and to have allowed the patient to deliver herself.

Dr. **Jellett** referred at some length to a case of concealed accidental hæmorrhage to which he had been called from the Rotunda some ten years before. He had found a patient with a pulse of anything above 120 and a uterus which had increased in size in a few hours from the umbilicus up to near the ensiform cartilage, and with the diagnosis of concealed accidental hæmorrhage on her face. He performed Porro's operation, and found the placenta floating about in the uterus, which was full of blood. At a subsequent discussion his treatment was objected to on the ground that a large number of cases of concealed accidental hæmorrhage had been successfully treated by other means. If that were so, then Porro's operation was unjustifiable, but he was of opinion that the cases referred to were in reality cases of external hæmorrhage Dr. Tweedy stated that the case in the report was the first case he had ever seen, and he, Dr. Jellett, had made out some statistics on the matter, which showed that up to the year 1896 only five cases had occurred amongst 43,000 patients in the practice of the Rotunda. He believed Dr. Tweedy's statement to be perfectly correct, that such cases were of extreme rarity, and that, considering the very severe mortality in them, it was a mistake to try to promulgate the idea that they were common, and that they were amenable to treatment suitable and excellent in the case of external accidental hæmorrhage. Dr. Tweedy had a theory that a plug in the vagina would compress the uterine arteries; that theory was susceptible of proof, as, if the uterine arteries were compressed, the child would die, and that the child did not always die was proved by a case in Dr. Tweedy's present report. If a uterus from which no blood was escaping went on increasing in size, he thought it was fallacious to suppose that a plug would make any difference, and the only thing that could be said for it was that it might bring on labour. He suggested that the condition was to all intents and purposes identical with that of internal hæmorrhage anywhere else, and consequently the correct treatment was to get to the bleeding point from above or from below and stop the hæmorrhage at its point of origin.

Professor **Alfred Smith** regretted he could find no advance in the teaching of midwifery in the report, or that the recognised methods of treatment were not set out in greater detail. As a teacher of students he would be glad to know why Dr. Tweedy altered the old-established division of ante-partum hæmorrhage. Again, he thought the results of the standard of morbidity were extremely remarkable. The Rotunda Hospital estimate made it a remarkably good standard, whereas the British Medical Association standard made it the same as last year. The question of which was the better standard was of importance to anyone estimating statistics. Then in the treatment of abortions, it was not stated what kind of active interference was resorted to. He made the criticisms with a view to eliciting greater detail for the benefit of those who, like himself, would turn to it for information and enlightenment. He congratulated Dr. Tweedy on the excellent results which had been achieved.

Sir **William Smyly** said that, while he recognised the great difficulty in compiling tables, he agreed with Professor Smith as to the advisability of having more details in regard to interference in abortion, particularly as to the number of cases in which interference was necessary, and the nature of the interference. He regarded the introduction of separate cost for infants as a matter of great importance. He had never seen a case of death from labour shock in the report before or had he met with a case. He had, however, seen two cases in which patients very nearly died without any hæmorrhage; ultimately, however, they pulled round, and so he could quite believe that there was such a thing as death from shock after labour. As to his cases of concealed accidental hæmorrhage, it was probable that there had been only one case in the house and Dr. Baggott's case in the extern maternity. If there was any external hæmorrhage at all it showed that the uterus had some resisting powers, and that therefore that case could not be put in the same class as internal hæmorrhage without any external escape. The latter showed absolute atrophy of the walls of the uterus, and inability to resist the pressure of blood. He did not see how plugging the vagina could save the life of the person in such a case. He considered that Porro's operation was the less dangerous. He wondered if the increase in the mortality of post partum-hæmorrhage was connected with the modern method of treating the third stage of labour. It showed the care that had to be exercised in watching the uterus, as there was a risk of hæmorrhage going on which they did not either see or feel.

Sir A. V. **Macan** said he would like to have the dates of cases given for easy reference. In his memory the extern cases had increased from 70 to 2,254. He thought it was a great pity that they could not refer to the same standard of morbidity as the Continental hospitals. He had no doubt that there were many cases of slight concealed hæmorrhage that were never diagnosed. In cases of post-partum hæmorrhage, any treatment that omitted opium as a stimulant was not quite up to modern views. It was not, he thought, possible, in an annual report, such as they were considering, to enter into the details of treatment in every case.

Sir **William Smyly** explained that his observations as to concealed accidental hæmorrhage applied only to severe cases.

Dr. **Spencer Sheill** said it seemed a peculiar thing to him that a patient in a healthy condition could die of labour collapse. The three cases referred to by Dr. Tweedy bore a strong resemblance to each other in respect of causation. He did not think shock was the correct term. If the normal shock of labour acted on a patient in an unhealthy condition it was not the shock that was the primary cause of death. He thought it would be better to put such cases down as death from unknown causes rather than under the ambiguous term of shock.

Dr. **Ashe** said he thought they could greatly improve their methods of giving morphia salts. There were derivatives of morphia which were not so depressing as the hydrochloride.

The **Chairman** said the occurrence of mammary abscess in the case of septicæmia was of great interest, as it was a rare accompaniment of the condition. In the other case of septicæmia it would occur to him that probably rupture of the uterus had taken place. He found it hard to understand what circumstances in a case of hydrocephalic head could have justified version. He thought it was a pity that they had not a standard of morbidity identical with the Continental for purposes of comparison. He doubted if so much benefit had followed the discarding the use of the blunt flushing curette, and douching as was expected. He agreed with the Master of the Rotunda that pubiotomy would go a long way to rendering the induction of premature labour unfashionable; but he still thought that cases would be found for a while longer in circumstances which would justify induction.

Dr. **Hastings Tweedy**, in reply, said he was not responsible for the diagnosis in cases of extern maternity. The point which Dr. Jellett had made in regard to concealed accidental hæmorrhage was a particularly good one. If he stopped the hæmorrhage in the uterine arteries the child died because he stopped the blood that went to the placenta, that was an apparently weak point in the theory; but he could say that he had never yet failed to stop hæmorrhage coming through a plug in the vagina, and he had never known of hæmorrhage pouring out over the plug. He had shown over and over again that there was no blood collected in the uterus when once the vagina was plugged. The plugging of the vagina caused a considerable amount of shock to the patient through pressing on the cervical nerves, and he regretted to say that patients often did not get better, in spite of the plugging of the vagina, even though the hæmorrhage ceased; nor had he ever had a living child born after plugging the vagina in the manner recommended as treatment for accidental hæmorrhage. He thought it was understandable how the uterine arteries could be stopped, when there was a plug pressing up with a binder pressing down the uterus. He dreaded the alternative of cutting out the uterus from a woman suffering from shock. As regards details of cases where he had glossed over a subject, it would be found that the method had been given in a former report; if the treatment had been altered in any way it would be referred to in the new report. He had been led to suppose that he had hit on an improved standard of morbidity, as it showed a high percentage when the hospital was really unhealthy, and a low percentage when the hospital was in an extremely healthy state, as in the present year. He could assure the Section that there was no more regularity among Continental authorities than in their own country. The method standardised by the British Medical Association had the merit of being simple. As regards the cases of death from labour shock, Dr. Sheill would see that Dr. Rowlette could find nothing to account for death; and, though some other condition might have produced the shock, it was the shock that killed the patient. Sometimes the retention of the placenta gave rise to profound shock quite apart from hæmorrhage. He had therefore made it a rule that the Sister should constantly take the pulse and examine the aspect of the patient while the placenta was in, and summon the Assistant-Master the moment the least change was seen, whether there was hæmorrhage or not.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held June 5th.

President, Dr. J. O. **Affleck**, in the Chair.

Dr. R. W. **Philip** showed a series of specimens from cases of poisoning by hydrochloric acid:—(1) Extensive slough of œsophagus; (2) large slough, probably gastric; (3) two large sloughs, passed per rectum.

Mr. **William Guy** read a paper on the

ADMINISTRATION OF GAS AND ETHYL CHLORIDE.

His experience extended to nearly 56,000 dental operations, and from it he elected to use gas alone in operations which could be completed in 30 seconds, gas and ether for operations which required from 1½ to 3½ minutes, and gas and ethyl chloride for operations lasting from 30 to 90 seconds. The last group comprised 90 per cent. of extractions. One of the objects of his paper was to rescue ethyl chloride from the disrepute into which it was falling in some quarters. The objections raised to ethyl chloride were the numerous fatalities which had occurred, and the unpleasant after-effects. There were now about 30 deaths on record, and some estimated the unpleasant after-effects at as high as 20 per cent. of cases. Fatalities were due to improper administration or to the use of an unstable preparation. In the speaker's opinion it was a perfectly safe anæsthetic if properly administered. The lethal properties of ethyl chloride were due to stimulation of the cardio-inhibitory centre in early anæsthesia, and to asphyxia and paralysis in the later stages. These were due, he thought, to the use of too concentrated a dose. A combination of gas and ethyl chloride was superior to ethyl chloride alone; it avoided the risk of cardiac inhibition in the early stage of anæsthesia. He had devised a special apparatus of a simple, portable nature, for administering the two. It consisted of a face piece resembling that of a Clover's apparatus, which was attached to a one gallon rubber bag through the intermediary of a three-way tube. Attached to an opening in the tube there was a glass measure graduated in cubic centimetres and into this a fixed dose (3 to 5 c.c. of ethyl chloride) was put. By simply tilting up the measure the ethyl chloride flowed into the bag. The method of administration was as follows:—The bag being full of nitrous oxide, the face piece is fitted closely over the patient's mouth, and he is allowed to breath air, the cock of the three-way tube being turned over to the valve opening. At the end of an inspiration the cock is turned over so that he breathes into the bag of nitrous oxide; then the residual air in the lungs is included along with the nitrous oxide in the bag. He is then allowed to take 5 respirations of nitrous oxide, and then the ethyl chloride is allowed to flow into the bag and the face piece is kept in position for 25 seconds. The points about the method are (1) exact dosage, there being no lint or gauze in which the ethyl chloride is poured; and (2) a definite time limit for inhalation. Given in this way great uniformity of results was obtainable; no objectionable consequences were seen; while the duration of anæsthesia, up to 90 seconds or more, was enough for most extractions. He wished it to be distinctly understood that he regarded gas and ethyl chloride as a single dose anæsthetic, and under no circumstances would he sanction repetition with a view of prolonging anæsthesia.

Mr. C. W. **CATHCART** read a paper on

"THE USE OF MASSAGE AND MOVEMENT IN THE TREATMENT OF FRACTURES."

(which will be found on page 673). In the discussion that followed, Mr. **WALLACE** said he agreed with Mr. Cathcart as to the superiority of the methods advocated; he thought, however, that they had really been in regular use for many years, and suggested that one reason why it was well not to do away with splints entirely was, that in certain cases it might give rise to an action for negligence. In a recent case he thought the verdict of the jury turned largely on the question of the use, or non-use, of a shoulder cap.

Mr. **MILES** also agreed with Mr. Cathcart, and said that in his wards the introduction of massage by the nurses had greatly improved the result of fractures. Mr. **DOWDEN** spoke of the benefits of setting fractures of the surgical neck of the femur in the abducted position. In reply Mr. **CATHCART** said his reason for bringing up the subject was because he doubted whether early movement and massage was actually as systematically carried out as his critics asserted.

Dr. J. S. **FRASER** and Dr. J. D. **COMRIE** read a paper on

"THE NASO-PHARYNX AS INFECTION CARRIER IN EPIDEMIC CEREBRO-SPINAL MENINGITIS."

Reference was first made to Dr. Jehle's views on the epidemiology of the disease as it occurs in Silesia and the Rhine coal districts. Jehle found that school epidemics were unknown, that second cases in the same house were uncommon, and that the infection did not spread in hospitals. He therefore concludes that the disease does not spread like other infectious diseases, and that children are not dangerous as infection carriers. He points out that coal mines are good incubators on account of their heat, darkness and moisture; miners make good carriers of infection on account of their liability to catarrh, accompanied by hawking and spitting. They use the same tools and drinking vessels in the mines, and consequently infect one another. On returning to their homes they infect their children. Jehle found that affected children were drawn from families the fathers of which worked in particular shafts, and that there was no intercourse between the families except through the fathers. He also found that a mine which had previously been exempt, became infected after the transference to it of miners from an infected shaft, the infection being shown by the outbreak of the disease among the miners' families. Jehle therefore supposes that mines play the same part in spreading cerebro-spinal fever as schools do in disseminating scarlatina.

Dr. **FRASER** then pointed out that seaport towns had been particularly affected by the present epidemic, and suggested that ships below decks presented conditions not unlike mines. In Leith there had been 83 cases and 53 deaths, many drawn from the neighbourhood of the docks, and from the lowest section of the population. The method of investigation was to withdraw secretion from the naso-pharynx by means of a sterilized swab. The secretion was immediately smeared over sloped blood agar or ascitic agar. During the epidemic 7 double cases have occurred, the intervals being 20 days, 14 days, 6 days, 5 days, and 3 days respectively. With regard to prophylaxis, closing schools was of little value. Contacts should be isolated and their naso-pharyngeal cavities disinfected. Since this has been done in Leith only one second case in a family has occurred.

Dr. **COMRIE** dealt with the bacteriological investigation. After referring to the characters of the meningococcus, he described the methods employed by them in identifying the organism. Subcultures were made, and stained by Gram, and also inoculation on bouillon, glucose and litmus. Serum agglutination was avoided on account of its doubtful value. The meningococcus was found in the nose in 2 out of 13 cases of meningitis, and in 10 out of 69 contacts. Of these 10, 5 were fathers, while only 15 of the whole 69 were fathers. The organism was therefore found in the nose of a much larger proportion (33 per cent.) of fathers than of other contacts (9 per cent.)—a fact which went to support Jehle's theory. Five of the 15 fathers worked on a ship in the dry dock, and on exposing Petri plates containing ascitic agar in various parts of the 'tween decks and engine room the meningococcus was found. A whole series of cases in children were traced to this focus of contagion.

Dr. **BRUCE** complimented the writers on their work, and Dr. **KER** also spoke. He thought that the incubation was not more than a few days as a rule.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

ORDINARY MEETING JUNE 13TH, 1907.

PRIESTLEY SMITH, F.R.C.S., President, in the Chair.

MR. **NETTLESHIP** communicated a genealogy in which congenital, stationary night-blindness without ophthalmoscopic changes occurred in nine consecutive generations during about 250 years. This disease, often hereditary, was less known than retinitis pigmentosa and its so-called unpigmented variety, and, unlike them, did not progress. A great part of the present case was published by Cunier nearly seventy years ago, and had been mentioned by many writers. But the nature of the disease was unknown until a year ago, when, at Mr. Nettleship's request, Professor Truc, of Montpelier, examined several living night-blind descendants, established the diagnosis, and instituted a fresh enquiry, resulting in an extension of Cunier's tables from upwards of 600 persons in seven generations, to nearly 1800 in ten generations. Only certain branches of this large tree, containing about 260 persons, bore the disease, and of this number, just one half (129), contained in 60 childships, were affected. In half the affected childships (29), the proportion of diseased to healthy agreed with the Mendelian theory; others show a near approach to agreement, and others again would conform if the dominance were supposed to have been reversed.

About a quarter of the cases seemed inconsistent with Mendelism, but incompleteness of record doubtless accounted for some of these. The disease always passed from parent to child without a break, was rather commoner in females than males, did not lead to blindness, and was not accompanied by any other defects or peculiarities. It was not due to consanguinity; there were only two first cousin and seven second cousin marriages, and only one of these nine produced night-blind children.

Mr. L. **Werner** (Dublin) showed a coloured ophthalmoscopic drawing, lantern slides, and microscopic sections of a subretinal cysticercus. The patient, a man, æt. 19, had noticed a failure of sight in the right eye for four months. The eye was normal in outward appearance, and the tension was also normal, but in the fundus, close to the optic disc, was a large spherical projection, covered by the retina, and resembling an intra-ocular tumour. It presented a transparent bluish-white appearance, with a very delicate margin in some parts. The surface was smooth, and marked with white connective tissue-like areas, and a small portion was pigmented. A remarkable feature was the presence of a deep pit in the tumour, and also an enormously dilated retinal vessel which disappeared abruptly in the growth. The diagnosis, was doubtful, and the eye was removed. On examination, it was found that the growth was an intra-retinal cyst, in which a cysticercus had been encapsuled. The animal was dead, and portions of it were found in various states of preservation, external to the capsule, chiefly in the angles between it and the retina. One well-preserved sucker was discovered, but no hooklets, The parasite evidently succeeded in escaping from the capsule, and became imprisoned in the anterior layers of the retina and died. The pit seen in the growth with the ophthalmoscope was found to be due to a mass of granulation tissue, which divided the cyst into two cavities in the sections. It extended from the posterior to the anterior wall, and by its retraction of the latter, produced a depression in it, The blood supply of the granulation tissue was derived from the dilated vessel alluded to before.

He stated that intra-retinal cysticerci were very rare, for of twenty-nine cases anatomically examined, only three were in the retina. It was a curious coincidence that this was the third time that Mr. Werner had met with bladder-worm cysts in connection with the eye, and that those were the only examples of eye affections of this nature which had ever been observed in Ireland.

Mr. **Whitehead** read notes of (*a*) a case of metastatic tumour of the choroid. A mammary tumour, which had been present two years, was removed seven years ago. Recurrence took place in the scar, and many metastatic tumours appeared in various parts of the body. Vision failed in the right eye, and after four weeks the eye became blind, and glaucoma set in. The eyeball was excised, and a flat growth found to be present in the choroid. Microscopically, the growth was found to consist of closely-packed spindle-shaped cells, with an excess of fibrous tissue between irregular groups of tumour cells. (*b*) A case of multiple cysts of the retina, associated with glaucoma. Vision had been defective in the affected eye from birth, for three months there had been complete blindness, and for two months glaucomatous symptoms were present. Examination of the eyeball after removal showed no intra-ocular growth, but numerous translucent cysts in the retina, which was not detached. These appeared to be lymphatic cysts, developed within the retina, and separating its layers. The causative association between the cysts and the glaucoma was not clear.

The weekly report of infectious diseases issued the other day by Dr. A. K. Chalmers, the Medical Officer of Health, shows a further decrease in the number of cases of cerebro-spinal fever under supervision in Glasgow. There were 104 patients under treatment, as against 110 the previous Friday, giving a reduction of six cases during the week.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Meeting held June 7th, 1907, at the West London Hospital.

The President, Dr. **Leonard Mark**, in the Chair.

Dr. **Addinsell** read a paper, illustrated by lantern slides and photographs, on

METRITIS.

The paper dealt more particularly with the morbid anatomy and pathology of those cases of metritis considered to be due to chronic infection, especially as a result of gonorrhœa. In the intractable cases, marked by severe and exhausting hæmorrhage, hysterectomy was considered to be generally indicated.

The paper was discussed by the President, by Dr. Mansell Moullin, and by Dr. Robinson, who referred to the good results obtained by curettage followed by the application to the cavity of the uterus of pure nitric acid.

Dr. **Arthur** read a paper on

SOME ASPECTS OF X-RAY WORK;

also illustrated by lantern slides, and spoke in detail of the diagnostic value of skiagraphy in thoracic diseases, insisting on the significance of difference between the diaphragmatic excursions on the two sides, as shown by the use of the screen, in those cases of early phthisis in which no apical deposit can be demonstrated. He explained the method of taking ortho-diascopic tracings, and pointed out its extreme value in enabling the localization of inter-thoracic conditions such as abscess or tumour. An interesting account was also given of the manner in which different positions are assumed by the heart in certain circumstances of disease. A discussion followed, in which Dr. Rice Oxley and Mr. Macadam Eccles took part.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 16th, 1907

The Three Doses of Digitalin in Cardiac Disease.

Prof. **Huchard**, who is the greatest French authority on heart disease, recommends three methods of administering digitalin in cardiac affections. The first is a massive dose, which is also anti-systolic and diuretic. Fifty drops of the solution of crystalised digitalin (1-1,000) are given in one or two doses for one day. After 36 or 48 hours, abundant diuresis sets in; absorption of œdema and decrease of visceral congestion and elimination of chlorides follow. If the effect is not sufficient, the same dose might be repeated eight or ten days afterwards. As soon as the diuretic action ceases, which is observed by the disappearance of the œdema, and if the cardiac contraction remains weak, very small doses of digitalin should be prescribed after a fortnight, and continued two or three weeks.

The second consists in the administration of weak or sedative doses which have an effect on the palpitations and the dyspnœa of mitral disease even at its period of perfect compensation.

From five to ten drops are given for five consecutive days and repeated every three or four weeks.

The third and last is the cardio-tonic dose which exercises only a cardiac and not diuretic action, and can be continued for weeks and months with intervals of rest from time to time; three to four drops of the solution once a day are sufficient.

By following these rules laid down by Prof. Huchard no trouble nor fear need be experienced in the administration of digitalin.

Treatment of Diphtheritic Paralysis.

According to Prof. Comby, the recognised authority on children's diseases, the best treatment of paralysis of the fauces following diphtheria consists in injections of the anti-diphtheritic serum of Roux.

Every child or adult suffering from paralysis following diphtheria, recent or of old standing, slight or grave, localised or generalised, should be immediately treated by injections of serum. The injections should be made every day for five or six days according to the gravity of the cases, the doses employed being 10 to 20 cubic centimetres.

This intensive sero-therapy presents no inconvenience, and applies to every form of the disease and should be prescribed in every case, even where the diphtheria had been already treated with serum.

Prof. Cornby treated in this manner thirteen cases, and each time the cure was complete and rapid.

GERMANY.

Berlin, June 16th, 1907.

At the Medizinische Gesellschaft, Hr. E. Barth spoke on the

Functional Changes in the Vocal Organs and their Treatment.

The voice, he said, was formed by intermittent gusts of air. The various interruptions caused by closure of the glottis must be complete, but so that the vocal cords shall not be damaged by being pressed too hard together. Disturbances of the voice might be caused by organic lesions of the voice-forming apparatus, but they might be of a purely functional nature. The type of the latter was hysterical vocal paralysis, in which voluntary phonation was lost. Another form was spastic aphonia; here, also, the larynx was healthy, the patient could breathe freely and cough. This occurred in professional speakers, and arose from excessive irritation. The treatment consisted in causing people whose vocal cords closed tightly on trying to speak, to do systematically and voluntarily what they otherwise did unconsciously—that was, in making them speak in whispers, and then, with the use of the autolaryngoscope, showing them how to speak; often, also, the introduction of a sound into the larynx whilst phonating was successful, as it kept the vocal cords apart.

A third type was the paralysis of the vocal cords that came on after laryngitis, in which the cords did not gape so widely as in the hysterical form; the conditions were similar in the case of sub-glottideal tumours, even when they had been removed, when the aphonia must be looked upon as auto-suggestive.

We found a thin, piping voice, occasionally in young people with larynges quite normally developed; this was brought about by trembling movements of the cords on phonation, and was a relic of the developmental period where the development of the tensors of the larynx and of the vocal muscles did not keep equal pace with each other. By practice, for example, under an intelligent singing master, a great deal could be accomplished.

B. Fraenkel had described a voice disturbance under the name of "Mogiphonia." It was not a complete aphonia; after a time a painful feeling came on in the throat on speaking, that made further speaking impossible.

In more recent times phonasthenia had played a great part. This might have its origin either in the respiratory or in the vocal apparatus; for example, on long speaking with a raised voice, in which the vocal cords and the elevator of the larynx were immoderately taxed. Such patients must learn to speak at first in a deep voice, and also on raising it to depress the larynx, as good singers always did. In doing this, the larynx at the same time made a forward movement, and thus the air passing outwards had a straighter course as far as the velum palati, where it found the necessary resonance.

Imperfect movement of articulation might be another cause of phonasthenia.

Hr. Gutzmann pointed out that local treatment in functional vocal disturbances sometimes not only did no good, but actual harm. Imperfect inspiration might be an important cause of disturbance; many people inspired noisily, positively with a sound. They did not relax the vocal cords sufficiently, and thereby deprived them of their needed rest. Treatment must begin in learning to respire properly.

Hr. Katzenstein remarked that anæmia was a predisposing cause of functional vocal troubles; as was seen not unfrequently in music students. Perhaps another contributory cause was a thick tongue, a sloping position of the glottis, &c.

The speaking vocal asthenics were to be distinguished from the singing ones; in these, the respiratory movements were not in unison with the musculature of the larynx; this led, by excessive strain of the latter to injury of the muscles and nerves by the air passing out. The result was a proper neuritis of the recurrent nerve with pains in the neck. Grasping the neck near the larynx gave an extraordinary sensation of pressure, and confirmed the diagnosis. Here the treatment must be that of neuritis—first, complete rest, and then slow advance in voice technique.

At the 24th Congress für Innere Medizin, the subject of

Neuralgias and their Treatment

was introduced by Hr. Schultze, of Bonn. He discussed the general points of view and the new achievements regarding ætiology, pathogenesis, and pathological anatomy, symptomatology, diagnosis, and treatment. Here first of all the chemical remedies were in place; if these failed we turned to physical methods—Nægeli's "hand-gripp," the galvanic current, warmth and heat, hot-air douches, and massage, warm sand-baths, Scottish douches, stretching of perineuritic adhesions, in the use of which, however, paralysis might be developed; (3) mixed physical and chemical treatment—injections of morphine, atropine aconitine, silver nitrate, alcohol, salt, solution of osmium, methylene blue, air, water antipyrine, Schlösser's and Lang's methods. After relief of pain had been obtained, stretching. (4) Surgical operations, when they could not be avoided—resection of ganglia, plombiering with bony exit openings, tearing out of nerves (not section).

Hr. Schlösser, Munich, found that alcohol in 70 to 80 per cent. solutions brought that part of the nerve to which it was applied into a state of degeneration with absorption of its parts except the neurilemma. The greatest possible stretches of nerves were injected as centrally as possible. For avoiding injury of neighbouring parts, strong needles with blunt, straight points were used. Curved needles only in diseases of the branches of the trigeminus. In sensory nerves, repeated injections of 2 to 4 grm., in motor nerves successive injections of small quantities with addition of alcohol after five minutes, in case of mixed and energetic treatment. Improvement continued for about a year. An anæsthetic was not advisable. Unhappy accidents were pareses, also paralyses and lockjaw. Krause's operation was to be preferred on account of the more lasting results; its high mortality was against it. With repeated injections the recurrence came on later.

Hr. Lange, Leipsic, found that after injection of 75 to 150 grammes, the pain diminished at once. He recommended 1 per cent. of eucain, in an ·5 per cent. of saline solution.

Hr. Hanaw recommended dry cupping over the painful spot for ten minutes every two or three days.

AUSTRIA.

Vienna, June 16th, 1907.

French Visit.

The medical circle in Vienna are now making preparations for a visit from the medical profession of France under the leadership of Prof. Roux. The Gesellschaft has appointed a sub-committee to provide a royal reception for August 15th, on which date the guests will arrive. The object of the visit is to make an educational tour of all the Vienna institutions and exchange ideas on the various advantages and other wise in the different countries. The event is anticipated with great enthusiasm by the Viennese.

Congress for the Protection of Children.

No public movement can be made unless a congress leads the way. The first for the protection of the child in all classes of society has just been closed. Many harrowing tales were told of the miseries of the past and the difficulties of the present. Selling and buying children is still practised with impunity in Russia and the Levant. Various speakers discoursed on the law as it was and as it should be to prevent children from being abused, overworked, underfed, and ill-used. The moral and psychic condition was also considered and the law impugned. Lydia Wolfring, President of the Pestalozzi Society for the training of children discussed the abuses of children in Vienna, and neighbourhood and complained that eight days' imprisonment was the greatest punishment she had obtained for these abuses. The greatest incidence was amongst the guardians of illegitimate and step-children whose charges were unwelcome members. One of the causes of this blot is the action of the Foundling Hospital in letting out all illegitimate children to professional baby farmers. In Vienna 17,000 of these children have to be provided for annually, of whom one half die the first year.

Eczema Universale.

Leiner presented a child, six weeks old, to the members of the Gesellschaft, suffering from eczema. He has had a large number of these within a very short period and all were breast-fed children. The cause he considered was overfeeding in infants disposed to the disease which he considered as of bad prognostication for the future health of the child as statistics prove that one-third of them die.

Surgical Therapy of Puerperal Fever.

Fabricius continued the discussion of Latyko's paper on puerperal fever. He was firmly convinced that the removal of the uterus for sapræmia was a useless operation. Washing out the interior of the organ was the first and supreme duty of every accoucheur, but when the septic infection got into the lymphatic vessels and glands there was no operation left but to remove the germs surgically. Scraping the organ when thrombi and venous infection existed was not only useless but injurious. The idea of removing an infected uterus is not a novel operation, but happily it has been seldom practised. In 1895 Fabricius himself undertook one hopeful case with fatal results. Tying of the veins was another operation that he had little faith in, although he had practised it. In the case of peritonitis he had practised the radical cure since 1896. His method was to make a long abdominal incision, wash out the pus, partially close the wound, leaving it filled with gauze. He cannot agree with Latyko in performing laparotomy for incipient peritonitis as many severe cases of pelvic peritonitis terminate without any interference.

Halban thought Latyko's rule of forty-eight hours with 39 and 40 degrees of temperature rather vague to determine on an operation. He also disagreed in tying the veins for metro-phlebitis where no better results than 30 per cent. of cures could be obtained. Tying the veins in the vaginal passage was only opening a new path for thrombi which few would risk.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Glasgow University and Medical School Appointments.—The Glasgow University Court have decided to establish a Lectureship on pathological histology, and have appointed Dr. Teacher for one year. The Governors of Anderson's College Medical School have elected Dr. John Cowan to the Chair of the Practice of Medicine at the School, in succession to Professor R. Barclay Ness, resigned.

Edinburgh Royal Infirmary.—At the weekly meeting on June 11th, the managers presented Miss F. E. Spencer, the lady superintendent, with a silver tea service and salver, on the occasion of her retirement. The plate bore the following inscription:—"Presented with a silver tea service by the members of the Board of Management of the Royal Infirmary, Edinburgh, to Miss F. E. Spencer, as a token of their high appreciation of her most efficient, valuable, and devoted services to the institution during 30 years, first as assistant superintendent, and then for the past 20 years as lady superintendent of nurses."

Complimentary Dinner to Professor Beattie.—The occasion of the meeting of the Pathological Society of Great Britain in Edinburgh last week was fittingly seized upon to entertain Dr. Beattie, who recently left the pathological department in Edinburgh University to take up his duties as Professor at Sheffield. The dinner, which was given him on June 7th, was largely attended, and was a tribute to the high esteem in which Professor Beattie is held, not only in Edinburgh, but among his colleagues generally. Dr. P. A. Young, President of the Edinburgh Australasian Club, congratulated another Colonial on being appointed to an important chair, and Professor Greenfield, in proposing the guests' health, spoke most appreciatively of his old assistant.

Professor Sir Thomas Fraser, the popular occupant of the Chair of Materia Medica, in the University of Edinburgh, has received the degree of LL.D. from the University of Cambridge. Professor Fraser's work on the Plague Commission, his high reputation as a scientist, and his position as a member of the General Medical Council have made him one of the recognised leaders of the medical profession in Scotland, and the honour which has now been bestowed on him by the Southern University is as gratifying to his colleagues and old pupils as it is flattering to the recipient.

BELFAST.

The Corporation and the Forster Green Hospital.—For several years the Belfast Corporation have been discussing the question of providing more accommodation for the treatment of consumption, but for various reasons have delayed. One reason has been the great outlay on the infectious diseases hospital at Purdysburn, and another the desire to see how the Workhouse Sanatorium at Whiteabbey succeeds, as much may be learned from its success or failure. Meantime negotiations have been going on for the extension of the work of the Forster Green Hospital for Consumption, which has ample room for increase if funds permitted. It has been arranged by the Public Health Committee to recommend to the Corporation to adopt an agreement by which they shall take twenty-five beds at a charge of 35s. per bed per week, the agreement to run for ten years, and the Corporation to have two representatives on the Board of Management of the Hospital, the Lord Mayor and the Chairman of the Public Health Committee. The reason of the long period for which the agreement is made is of course to make it worth while for the hospital authorities to provide additional accommodation, which it would not be if the agreement were a short one. It is not yet announced what arrangement has been made, or is to be made with the medical staff of the hospital, which is an honorary one. Presumably they will hardly be expected to attend the new class of patients gratuitously. It would be a most lamentable precedent if they did so.

The Health of Lurgan. In his annual report on the health of Lurgan, Dr. Agnew, the energetic medical superintendent officer of health, makes an interesting suggestion. He shows that the ravages of phthisis are very severe, and specially among young adults, and he suggests that the Town Council should acquire ground and build twenty or thirty comfortable, airy, and sanitary cottages, after the manner of the labourer's cottages built by the rural sanitary authority, which could be let at two shillings or half-a-crown a week to families in which consumption existed or threatened to break out.

Cerebro-spinal Meningitis.—The epidemic of cerebro-spinal meningitis continues to diminish. Last week there were only thirteen cases notified, and the deaths numbered ten. There are still 36 cases in the fever hospital.

Post-Graduate Work at the Royal Victoria Hospital, Belfast.—During the summer of 1907 a post-graduate course of Practical Demonstrations of cases and clinical methods will be given by the Medical staff. The course will last for a fortnight, beginning on Monday, July 1st, and terminating on Saturday, July 13th. The inclusive fee is £3 3s. The hospital contains 300 beds, and affords splendid material for clinical and post-graduate work. Practitioners who wish to attend should send their names as early as possible to the Hon. Sec., from whom any further information desired can be obtained.

LETTERS TO THE EDITOR.

THE HOSPITAL FUNDS AND THE EXCLUSION OF SCOTTISH DIPLOMATES FROM THE MAJORITY OF LONDON HOSPITALS.

To the Editor of The Medical Press and Circular.

Sir,—On behalf of the Council of the Association of Scottish Medical Diplomates, I beg to draw your attention to what we consider a grave injustice to those holding the Diploma of the Scottish Colleges. We refer to the clause in the laws of many medical charities of the metropolis making the possession of a London qualification an essential condition of election to a post on the honorary medical and surgical staffs. The effect is to make those posts a monopoly in the hands of certain London corporations. We submit that this practice inflicts a gratuitous injury upon the diplomates of the Scottish Colleges, who have obtained their legal qualifications after stringent examination. We submit that the exclusion of which we complain is contrary to the elementary grounds of justice, and that its result, if not its intention, is to swell the ranks and to increase the revenues of certain London corporations at the expense of rival colleges, of Scottish diplomates, and, as we think, of the community in general. This arbitrary practice is in our opinion a relic of class privilege absolutely out of touch with the trend of modern thoughts and ideas, and one calculated to close the door to many a fine career, and in the long run to inflict injury upon the public by narrowing the field of competition. If the London qualification be of such supreme excellence, why should their holders fear competition in the open market? Why resort to such a weapon as disqualification of all Scottish and Irish competitors?

This exclusion of Scottish diplomates from the majority of London and provincial hospital appointments has been going on for many years. Our present object, however, is to draw attention to its revival in an insidious form, and its imposition by a side issue upon two institutions that previously welcomed Scottish Diplomates to its honorary staffs. We wish to show how the Hospital Sunday and King Edward's Funds have helped, doubtless unwittingly, to bring about that injustice.

There were lately three London Orthopædic hospitals—The Royal, the City, and the National. The above-mentioned Funds have for some years pressed the policy of amalgamation upon these hospitals by every means in their power. Of these three hospitals, the Royal and the City admitted Scottish diplomates to their staffs, while the National excluded them. All three institutions are now amalgamated. It seems incredible that the Funds should have permitted the new charter of the Consolidated Hospitals to exclude Scottish diplomates. Such, however, has been the case. In other words, the National Orthopædic Hospital has been enabled to force its exclusiveness upon the other two partners in the new institution. One holder of a Scottish qualification has been allowed to join the new staff, apparently in defiance of the charter. Another member of the City Orthopædic has been denied any staff appointment in the new institution on the ground of not possessing a higher English qualification.

That gentleman naturally protested against his exclusion. To investigate the facts of the case, Sir Edmund Hay Currie was appointed arbitrator. His report stated that:—

(1) The Charter could be amended.

(2) That an exception should be made in favour of the gentleman concerned.

(3) And that the conditions as to qualification would doubtless be retained in the new charter.

We submit, Sir, that this charter in its present form is unjust, inasmuch as it excludes Scottish diplomates. We submit further that its amendment should be made to cover not only the specific hard case of a single Scottish diplomate, but to throw open all staff appointments to all registered medical practitioners.

His Majesty King Edward and the Prince of Wales are deeply interested in the two Funds which have been mainly concerned in bringing about this amalgamation scheme. We hereby appeal to them earnestly and solemnly to assist in removing an intolerable injustice from the shoulders of the Scottish diplomates. The King Edward's Fund has recently applied to Parliament for incorporation, but we venture to say the assent of the Commons is not likely to be unanimously secured if it be known that a body not amenable to public control sanctions, and in one instance has actually encouraged the exclusion of Scottish diplomates from London Hospital appointments.

We trust, Sir, that your columns will be thrown open to the discussion of a subject that, directly or indirectly, affects the interests of thousands of Scottish diplomates in various parts of the United Kingdom.

I am, Sir, yours truly,
Claude St. Aubyn-Farrer, President.
11 Chandos Street, W., May 31st, 1907.

THE CASE OF DR. HEBERT.

To the Editor of The Medical Press and Circular.

Sir,—I do not know whether any accounts of my late unfortunate experience in France have appeared in your columns; if so, or under any circumstances, I should feel obliged if you would kindly publish the result of the case, so far as I am concerned, as I am most anxious to show that I have brought no disgrace on the medical profession to which I belong and that I have been a victim instead of a guilty man. I enclose herewith a report which appeared in the *Daily Telegraph* of the 4th inst., and would esteem it a great favour if you would copy it in your journal:—

"The judicial authorities at Versailles have just announced that there is no charge whatever against Doctor Hebert, so that his character is without a stain. I had considered all along that there was no evidence whatever against him, and it seems very hard that he should have been detained so long in custody, when, moreover, he was suffering cruelly from the effects of the murderous assault perpetrated on him at Bois-le-Roi, and should have been subjected to so many unkind remarks and criticisms. The trial of Madame Guerin is now fixed to take place at the Versailles Police Court, on July 11th, and Doctor Hebert will, as is understood, lay claim to damages."

I am, Sir, yours truly,
P. Z. Hebert, M.D.
14, York Place, Portman Square, W.,
June 15th, 1907.

[We are very glad to give publicity to Dr. Hebert's letter, as so many wild and sensational accounts of the affair have been current that it has been impossible for medical men in England to arrive at the truth.—Ed.]

THE SOCIETY OF APOTHECARIES OF LONDON BILL, 1907.

To the Editor of The Medical Press and Circular.

Sir,—This Bill having been passed by both Houses of Parliament (The Medical Press and Circular

June 12th, page 661), now only awaits the Royal assent to become law. It changes the title of L. S.A. to the more appropriate one of Licentiate in Medicine and Surgery, and gives authority to the Society to confer the latter title, by diploma, on all of its Licentiates who have qualified since June 30th, 1887. Authority is also given to the General Medical Council to enter the new description on the *Medical Register*. Power is given to the Society to restore (with the consent of the Medical Council), the name of any Licentiate who may have been removed from the Roll. Heretofore, the Society had only the power to remove a name. The cost of obtaining this Act has been considerable, and the Council of the Association of Physicians and Surgeons of the Society of Apothecaries undertook to raise £250 towards it. Of this sum £222 5s. 6d. has been subscribed by the Licentiates, £25 was voted by the Association from its funds, leaving a deficit of £2 14s. 6d. The expenses of collection amount to £13 1s. 9d., bringing the total deficit to £15 16s. 3d. May I ask those Licentiates who have omitted to send a donation, to send their contributions to me without delay? It is scarcely fair that the members of the Council of the Association, who have had all the hard work, and who have already borne more than their share of the expenses should also be saddled with this deficit.

I am, Sir, yours truly,
A. Rivers-Willson.

42 Wellington Square, Oxford,
June 15th, 1907.

THE TREATMENT OF CANCER.

To the Editor of The Medical Press and Circular.

Sir,—With reference to a leading article in one of your contemporaries on June 15th, entitled "Another Cancer 'Boom'" I would ask you to allow me to point out that I cannot be responsible for treatment which is not in accordance with my original recommendations, any more than that I am responsible for the numerous references to the trypsin treatment appearing in the lay press. In no instance have I made any claim in a curative sense for the trypsin treatment of cancer, or suggested it as opposed to primary operation or to other methods of treatment.

Whatever its initial defects, limitations or value may be, I have from the first fully and freely published details of treatment, with from time to time additional aids and recommendations as they seemed to me. It is not my fault if in numerous references to the method, technique and treatment, which have been taken, so far as I can see, from my work, my recommendations have not been followed or ignored, or asserted improvements introduced.—I am, Sir, yours truly,

J. A. Shaw-Mackenzie, M.D.Lond.

London, June 17th, 1907.

OBITUARY.

JULIUS DRESCHFELD, M.D., F.R.C.P.

We regret to announce the death of Dr. Julius Dreschfeld, of Manchester, who died suddenly at Withington on Thursday night from heart failure, at over 60 years of age. Dr. Dreschfeld was a native of Niederwern, Bavaria, and was educated at Bamberg, Owens College and School of Medicine, Manchester, and Würzburg University. During the Austro-Prussian War he served as assistant surgeon in the Bavarian Army, in 1872 he became assistant physician at the Manchester Royal Infirmary, in 1873 lecturer and 1874 professor of pathology at Owens College. Latterly he held the chair of Medicine in the same college until ill-health compelled him, about a year ago, to retire. In 1886 he was Bradshaw lecturer, and among other appointments he held were those of examiner in medicine at Cambridge and at the Royal College of Physicians, of which he was a fellow. Dr. Dreschfeld was a man of great ability, and his contributions to medical literature were numerous and important. As a professor he did much to raise the tone of Owens College, and his services as a consultant were in large request in Manchester and throughout the north of England.

SPECIAL REPORTS.

LONDON COUNTY ASYLUM.

On Saturday last, June 15th, the new Long Grove Asylum, Epsom, erected by the London County Council, was opened for inspection by invitation. In 1889 the responsibility for providing asylum accommodation was transferred by the Local Government Act, 1888, from the County Justices to the London County Council, and the Asylums Committee of that body—as a statutory authority—has had the serious responsibility of coping with the task of providing accommodation for the greatly increased number of lunatics. The number of lunatics in the County of London for whom the Council was responsible to find accommodation was on the 1st January, 1890, 10,104. On the 1st January of this year the number had increased to 18,841. The increase has therefore been at the rate of over 500 a year. The asylum now completed is the tenth for the County of London and the sixth asylum erected by the London County Council. Early in the year 1903 the want of asylum accommodation became acute owing to the loss of 300 beds at Colney Hatch Asylum by the lamentable fire which occurred in January, 1903, and in order to save time it was decided to utilise a plan which had been used for two former asylums at Bexley and Horton. By the utilisation of this plan the Committee were enabled to get the sanction of the Lunacy Commissioners and the Home Secretary much more rapidly than if an entirely new design had been presented.

The entire buildings are constructed to accommodate 2,020 patients. The patients' quarters comprise wards on each side for the different classes, viz., sick and infirm, acute and refractory, epileptics and chronic, quiet and working patients—800 males and 800 females. The wards are in continuous buildings on the pavilion principle, all inter-communicating, so that the medical officers on their rounds can pass from ward to ward quickly without having to retrace their steps by returning to the main corridors before entering another ward. There are, however, main corridors communicating with each block for general service, and through these patients will pass to the recreation hall, workshops and laundry buildings. These corridors, unlike those in asylums generally, are merely covered ways, being open at the sides, and in consequence of this it is anticipated a more healthy condition will result and also a greater immunity from fire. In the main asylum are the administrative departments, the offices for the staff and quarters for the medical officers and others; also a recreation hall, 120 feet by 60 feet, with a well-equipped stage at one end and, adjoining this, a club or recreation room for the attendants and nurses when off duty. On the male side are the workshops, in which patients who are able to work are employed—tailors, shoemakers, upholsterers, also the carpenters' and plumbers' workshops, and the engineers' shops and boiler-house, where steam is generated for heating, cooking, washing, etc. Electricity for lighting and power purposes is generated at the Central Station of the Horton Estate, where the Asylums engineer has installed an electric plant sufficient for lighting three of the existing asylums on this estate. Adjoining the boiler-house is a water tower 130 feet high, in which the tanks holding 80,000 gallons of water for domestic use, and to serve as a reservoir in case of fire, the boiler chimney being incorporated in this tower.

In addition to the main asylum there are eight detached blocks or villas accommodating 400 patients; two of these for 50 patients each are designed as hospitals for the reception of new cases, where they can be medically treated and, if cured, discharged without entering the main asylum, or passed on into one of the Convalescent Homes, two of which are provided for 25 patients each, where they can be housed in a home-like way as a probationary step before being returned to their own homes. Two other villas, accommodating 65 patients each, are erected at some distance from the Asylum, for workers, one near the farm buildings for men and the other near the laundry for women. Lastly, there are two one-storey villas, each accommodating 60 quiet chronic cases, some of whom on the male side will probably work on the land, and will thus have their home in the "country" near the scene of their labours. A small Isolation Hospital for infectious cases completes the accommodation provided for patients.

A detached residence for the medical superintendent is erected away from the asylum at one end of the estate, and a detached chapel of ecclesiastical design on the south side abutting on the Horton Lane.

It will be interesting to know that the entire buildings, including all engineering work, cookery and laundry plant, lighting, telephones, etc., also the main roads on the Asylum estate, and half cost of the new road through the Horton Estate, cost of main sewer, from the Asylums, etc., to Epsom sewage farm, contribution to Epsom Urban District Council towards extension of sewage plant, airing courts, lodges, gates and fencing, together with professional charges, will come well within the estimate authorised by the London County Council and approved by the Home Secretary, viz., £514,313, it being now estimated that £490,000 will cover the entire outlay. This will show an average cost of £243 per bed on the 2,020 beds provided, accounting for everything excepting land and equipment. Mr. Thomas Hunter, L.C.C., who has been the chairman of the Building Sub-Committee from the beginning, was re-elected by the new Council.

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

AT a meeting of the Council of the College held last Thursday, Mr. HY. MORRIS, F.R.C.S., President, in the chair, a report was read from the Deputation of the Council to the Lord President of the Privy Council upon the subject of the

DIRECT REPRESENTATION OF MEMBERS ON THE COUNCIL

of the College. The deputation consisted of the President and Vice-Presidents, together with Mr. Howard Marsh, Mr. Henry T. Butlin, and Mr. Pearce Gould, who attended at the Privy Council Office on the 31st ultimo., and placed the views of the Council of the College before the Lord President.

The following alterations in the regulations for the

LICENCE IN DENTAL SURGERY

were made with a view to affording Colonial dentists greater facilities for obtaining the College diploma: "That Colonial dental practitioners who have completed a course of not less than three years' instruction in mechanical dentistry and who have been registered in British Colonies under conditions which do not require the passing of a recognised preliminary examination, be admitted to the Examination for the Licence in Dental Surgery, provided they pass the required Preliminary Examination in general education and complete the course of study required by the regulations at a recognised medical school and hospital and a recognised dental school and hospital." It was also determined that a candidate who possesses a registrable dental qualification be admissible to re-examination without producing certificate of additional study.

THE BOARD OF EXAMINERS.

The following examiners were elected for the ensuing collegiate year:—Board of Examiners in anatomy and Physiology for the Fellowship.—Anatomy: Arthur Keith, M.D., Wm. McAdam Eccles, M.S., Christopher Addison, M.D., A. H. Young, M.B.; Physiology: W. H. Thompson, M.D., G. A. Buckmaster, M.D., T. G. Brodie, M.D., C. F. Myers-Ward, Conjoint Examining Board.—Elementary Biology: T. G. Stevens, M.D., H. W. M. Tims, M.D.; Anatomy Wm. Wright, M.B., W. H. Clayton-Greene, M.B., A. Robinson, M.D.; Physiology: J. B. Leathes, M.B., B. L. Abrahams, M.B., Midwifery: A. N. Lewers, M.D., W. R. Pollock, M.D., W. W. H. Tate, M.D., H. J. M. Playfair, M.D. Public Health (Part I.): H. R. D. Spitta, M.D. (Part II.): H. T. Bulstrode, M.D.

It was resolved that, in accordance with the desire of the Royal College of Physicians, the committee of Management of the two colleges be authorised to enter into negotiations with the examining bodies with a view to securing the necessary re-arrangement of the curriculum in order to obtain two and a half years for the clinical portion. The President reported that at the meeting of Fellows to be held at the College on July 4th next for the election of four Fellows into the Council of the College, the following would be the candidates:—Mr. Herbert Wm. Page, Mr. Mansell Moullin and Mr. Frederic Eve, who seek re-election and Mr. Charles Higgens, Mr. Bruce Clarke, Mr. Charters J. Symonds and Mr. W. D. Spanton (Hanley, Staffs.), who will also be candidates for election

A letter was read from the president reporting proceedings at the recent session of the General Medical Council, and a vote of thanks was given to him for his services as the representative of the college on that Council. It was decided to close the library during the months of September and October next for the purpose of re-decoration.

REVIEWS OF BOOKS.

SURGERY BY MANY AUTHORS. (a)

THE large volume before us is the first of a series of five volumes which are in process of publication under the general editorship of Dr. William Keen who, in association with Dr. White, is already well known as a surgical author. We may say at once that the work promises to be of great value and importance, and one which will lay before the surgeon all the latest principles and practices of his art.

The first volume consists of twenty-two chapters. The first ten of these deal with general subjects related more or less intimately to surgery. Each of these chapters constitute a monograph on the subject with which it deals. Amongst them may be particularly mentioned the chapter on "Surgical Physiology," by G. W. Crile; on "Infection and Immunity," by Ludvig Hektoen; on "Inflammation," by J. G. Adami; and on the "Process of Repair," by F. C. Wood. The remaining twelve chapters are occupied by more special subjects, and of these the chief are on "The Traumatic Fevers," by Eugene A. Smith; on "Surgical Tuberculosis," by J. C. Da Costa; on "Chancroid" and "Syphilis," by E. Martin; on "Tumours," by J. Bland Sutton; and on "Wounds and Contusions," by G. W. Crile. In the last-named article an interesting account is given of the writer's experience with his "pneumatic suit," which he adopts in cases of shock as a means of raising the blood pressure.

The illustrations throughout are very good, and, save in a few cases, are new. In this respect, Mr. Bland Sutton is perhaps the greatest sinner, as a number of the illustrations which appear in his article on tumours have already appeared in other works. There are eighteen full-page plates, most of which are executed in colours.

We look forward with great interest to the publication of the subsequent volumes of this work, as, if the present high level is preserved in the different articles, it will constitute a landmark in the field of surgical literature.

ESSENTIALS OF HISTOLOGY (b).

SCHAFER'S Histology is a book with which most of us have been familiar since our student days, and which long since made its place amongst the books which the English medical student must possess. It has been considerably enlarged since its first appearance, and now attains the respectable size of over 500 pages. We have always held it to be by far the best of the existing student's manuals on the subject, and the present edition amply justifies this opinion. The text is clear, and not over-burdened with detail, though important additions have been made, which add to the completeness of the book. The author has all along recognised the supreme importance of numerous and good illustrations in teaching the subject, and in enabling the student to understand the application of what he reads to the structures which he sees under the microscope. This edition contains 553 illustrations, many of which are in colour, and almost all of which are good. The principal additions, both in text and illustrations, are in the section on the nervous system, a proper knowledge of which, as the writer very justly points out in his preface, is essential to students of medicine. We cordially recommend the book, and believe that it will long continue to preserve its present high reputation.

(a) "Surgery: Its Principles and Practice." By various authors. Edited by William Williams Keen, M.D., LL.D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia. Vol. I. With 261 text-illustrations and 17 coloured plates. Pp. 983. Philadelphia: W. B. Saunders and Co. 1906.

(b) "The Essentials of Histology." For the use of Students. By E. A. Schafer, Sc.D., F.R.S. Professor of Physiology in the University of Edinburgh. London: Longmans, Green and Co. Seventh Edition. 1907.

HUMAN ANATOMY (*a*).

The book we have before us is the succeeding volume to that which we lately had the pleasure of reviewing, by Professor Sobotta and McMurrich, and it fully maintains the standard reached by its predecessor. As was remarked at that time, we regard the text as complementary to the plates, rather than the plates as illustrating the text, for by their numbers and fidelity they constitute the leading feature of this noteworthy work. Especially would we commend the illustration of the peritoneum and those of frozen sections for they are secondary only to the human body as a means of practical instruction. The verbal descriptions of the parts dealt with are of the same character as before—clear, business-like, and straightforward, but again we have to regret, speaking from the point of view of the British student, that Dr. McMurrich uses a terminology which, while it has much to commend it from a scientific standpoint, is alien to the student over here. We cannot help fearing that the use of a good many strange words may militate aginst the success of an otherwise admirable work. In general terms we have nothing but admiration for it, and we warmly commend the book to those seeking a trustworthy and graphic guide to regional anatomy.

HYPNOTISM (*b*)

"Waking Suggestion, or Psychotherapy, is a very important and proper thing, and every capable medical man must have some acquaintance with it. . . . But hypnotism is quite another matter; it is a suspicious thing, is unscientific, humbugging quackery—is, at all events, disreputable, and it is harmful and even dangerous." That, according to Professor Forel, is the official medical view, and his book is designed to make skittles of it. We may say at once that he certainly makes out as good a case for scientific and medical hypnotism as we have ever read, and although naturally a partisan, as becomes a convinced believer, the author has a clear and consistent theory and explanation for the faith that is in him. The first half of the book consists mainly of psychology, and of explanations and theories concerning the hypnotic state. These chapters are well thought out and composed, and if at times rather subtle, they are never wild. The same characteristics mark the later chapters, and we may certainly congratulate Professor Forel on his honesty in showing both sides of the case, for he indicates clearly the limitations of hypnotism and a good many of the dangers. These latter have no doubt been exaggerated, but while hypnotic influence is so little understood, it is only to be expected that very different results from those calculated for will at times accrue. For instance, in Vogt's cases of hysterical fits (p. 75), when the suggestion not to have fits only induced fresh ones, or in those of irregular defæcation where the suggestion that the habits should be regular brought on obstinate constipation. The difficulties of a subject, however, do not mean that its pursuit should be abandoned, and it is possible in the future that some reasonably stable therapeutic benefits may be derivable from the hypnotic methods. At present even some of the best and most striking of Professor Forel's cures will not satisfy the critic, either as to *post* or *propter*, though we have no doubt that they satisfy his own judgment. The most readily observable phenomenon that hypnosis should bring about is sleep, and if the hypnotist could always, or even with fair regularity, remove insomnia, his function would be established. At present all is so uncertain, vague, and unsatisfying that it is not wonderful that medical men still mistrust hypnotism. But it may safely be affirmed that their fears as to its honesty in good hands will be removed, and their interest in it awakened by the reading of this book, which, moreover, they should find uncommonly well adapted to be a source of after-dinner enjoyment. Mr. Armit has done his translating well—indeed, very well—on the whole, and he certainly deserves thanks for presenting the profession in this country with a work which is quite a standard one on the Continent.

BUILDERS OF THE BODY (*a*)

Children have some extraordinary books written for their edification, and the volume under consideration appears to us to fall into this category. We are not explicitly told that it is a child's reading book, but after a careful perusal we are forced to this conclusion. It is profusely illustrated, and sometimes it would have been better to omit the illustration. The danger of diagrammatic illustration is exemplified by the representation of a fresh cod, where the head is shown to consist entirely of proteid and salts, while the remainder of the body is labelled "water." After this it seems sinful to reject the head for edible purposes. One of the artists, whose work shows great promise, is obviously a most modest man (such modesty would not be found in the other sex), and he has felt constrained to label the articles depicted in his illustrations to show what they are intended to represent. We find that our powers of observation are developed sufficiently to enable us to differentiate between his loaf of bread and cup of cocoa without such aid. Extremely interesting is the information as to the particular foods that do not agree with Mr. Miles, and all true Scotchmen will regret that oatmeal is one of these. It must be a cause for regret to most medical men that Mr. Miles holds such perverted views on food, and wastes his talents that might otherwise be of incalculable service to the nation in propagating these ideas. Among the nonsense in this book is a large amount of valuable knowledge that would benefit a child, whose parents did not object to their offspring being taught about its "innards."

OPERATIONS UPON THE INTESTINES AND STOMACH (*b*)

The author has carried out a valuable piece of research work by an experimental study of gastro-intestinal technic on dogs and cats. In this book, which is the result of three years' work of research, are collected certain of the standard operations upon the intestines and stomach.

The importance of a work of this kind cannot be over-estimated. The author gives a description of the generally accepted methods explaining the technique with excellent illustrations, followed by the views of the various authorities supporting the different methods. Take, for example, the important question

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(*a*) "Atlas and Text Book of Human Anatomy." By Dr. Johannes Sobotta, Professor of Anatomy in the University of Würzburg. Edited, with additions, by J. Playfair McMurrich, A.M., Ph.D., Professor of Anatomy in the University of Michigan. Vol. II. The Viscera, including the Heart. 214 Illustrations, mostly in colours. Philadelphia and London: W. B. Saunders and Co., 1906.

(*b*) "Hypnotism, or Suggestion and Psychotherapy." By Dr. (Med.) August Forel, Dr. Phil. (H.C.) et Jur. (H.C.), Chigny, Switzerland. Formerly Professor of Psychiatry, and Director of the Provincial Lunatic Asylum, Zurich. Translated from the Fifth German Edition. By H. W. Armit, M.R.C.S., L.R.C.P. London and New York: Rebman, Ltd. 1906.

(*a*) "Builders of the Body." By Eustace Miles, M.A., and Mariella John. Pp. 179 with 99 illustrations. Price 1s. 6d. London: George Philip and Son, Ltd.

(*b*) "The Technic of Operations upon the Intestines and Stomach." By Alfred H. Gould, M.D., of Boston, U.S.A. Pp. 302; 190 illustrations. W. B. Saunders and Co., Philadelphia. 1906.

of intestinal anastomosis. Here we find an account of the various suture operations, the various mechanical devices such as rings, bobbins and McGraw ligature. The advantages and disadvantages of the various methods are fully considered and pointed out; the steps of the technic are clearly explained and illustrated.

The value of the book is increased by an interesting chapter on the repair of intestinal wounds, a subject not often fully considered in books dealing with intestinal surgery. The illustrations are so clear and numerous that the book might be called an atlas.

We must congratulate the author on the important work he has added to surgical literature, and we have much pleasure in strongly recommending it to all surgeons and students interested in intestinal and gastric surgery.

LITERARY NOTES.

We are asked to announce that the forthcoming quarterly issue of *The British Journal of Tuberculosis* will be a special number devoted to children and will contain articles from British, American and German experts touching all aspects of the tuberculous problem as it concerns child life.

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The sixth edition of Professor Halliburton's admirable little book on "The Essentials of Chemical Physiology" (Longmans, Green and Co.) is now out. It bears evidence of a thorough revision necessitated by the results of recent research. The book is so well known and so much appreciated that it needs no other recommendation than the testimony of the hundreds of medical students and teachers who have borne witness to its value.

⁂

Dr. J. S. Milne has now completed an illustrated monograph on "Surgical Instruments in Greek and Roman Times," which will be issued from the Oxford University Press within a few days. No clear conception of a surgical operation, ancient or modern, can be formed from a written description without some previous knowledge of the instruments, and the author points out that many interesting operations described in detail in the clinical authors, are rendered obscure or quite unintelligible from lack of such knowledge.

⁂

"The Disinfectant Value of Chlorine" is the title of a collection of reprints on the subject from the *Public Health Engineer* (price 5s nett), which is published at the offices of that paper. The contributors of the papers (which deal with the disinfection of water, sewage, sputum, etc., by means of chlorine), include such authorities on the subject as Professors Klein, Sime Woodhead, and Delepine, and other well-known bacteriologists. Where there is but little organic matter, chlorine has shown itself to be a disinfectant of wonderful efficiency, and this small volume shows both the applications and the limitations of its activity.

⁂

Professor Oppenheim has conceived the happy idea of publishing a series of letters that he had originally written to various patients. The patients were chiefly neuropathics suffering from obsessions, phobias, &c., though some cases of organic disease are also included. The author ("Letters on Psychotherapeutics." By Professor Oppenheim. Translated by Alex. Bruce, M.D., F.R.C.P.E. 1907. Pp. 60) well demonstrates how hopeless it is for the physician to succeed in his object—the curing of the patient—unless he adopts a sympathetic and understanding attitude. The little essay is one we can warmly recommend to our readers, especially so in that writings of value on this important branch of therapeutics are so scarce in this country. The author has considerable literary capacity and power of expression, to which Dr. Bruce has done full justice in his excellent translation.

⁂

We have received a well-got-up little brochure prepared by the Medical Committee of the Cheltenham Spa, which should be acceptable to medical men who are disposed to recommend their patients to be treated by their colleagues at home health-resorts, rather than by those abroad with whom they are less intimately acquainted. The brochure gives a little historical and geographical resumé of the Cheltenham country, and then proceeds to describe the various waters, a full analysis of each being set out. As there are three types of water available, namely, a Chalybeate, a soda saline, and a magnesia saline type, Cheltenham presents advantages for a wide variety of cases, and it would be much to the advantage of patients generally if medical men were *au fait* with the different indications for their use. These may be found concisely stated in "Cheltenham Spa," and we trust it may be widely read and appreciated.

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A cheap and valuable series of monographs is being published in the French language by Messrs. Bailliere, of Paris; the most recently issued "L'Obésité et Son Traitement," by Dr. P. Le Noir, will be specially welcomed because the preventive and curative treatment of obesity is a matter that appeals to all classes of practitioners.. Not without reason the author insists upon the necessity of forming an opinion as to the proper physiological weight of the individual before attempting to modify the actual weight, because it is only by so doing that we can obviate damage to health as the result of our intervention. The author devotes most attention to the purely scientific aspect of the question, and in our opinion deals far too briefly with the actual treatment, which after all is what most readers desire. It is a fair synopsis of current methods, but this part of the work might advantageously be expanded. There are some useful tables of comparative age-weights and alimentary values.

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A valuable paper on the smoke question is contributed to the current number of *Progress*, the new quarterly. Dr. Markel describes smoke as one of the greatest factors in the physical degeneracy of our urban population, and offers concrete facts in support of his statement. The most interesting of these facts are, perhaps, afforded by the analysis of the deposits during a fortnight on the roofs of glasshouses at Chelsea. Besides 15 per cent. by weight of a sticky oil, not less than 5½ per cent. was made up of sulphuric and hydrochloric acids. The total deposit was estimated at six tons to the square mile. The next injurious effect examined into was the deprivation of sunlight. This may be gauged by the fact that during a foggy month the hours of bright sunshine were, in London, 62; at Kew (a suburb), 222; at Eastbourne, 300. The effect upon the health of children reared in such an atmosphere needs no demonstration, whilst the influence of fog on the rate of mortality is clearly shown in the Registrar's returns. During the prevalence of fogs there is always an enormous increase in the death-rate, especially in diseases of the air-passages and lungs. The greater part of the smoke in London is the product of domestic fireplaces—the most expensive, wasteful, and unsatisfactory method of warming rooms. Most houses could be heated throughout by central apparatus with a consumption of fuel no greater than now used in two or three rooms. The coal might be of a smokeless variety, small and open fires might be provided in the living-rooms of wealthier people who demanded this luxury. The change which would of course cost in the aggregate a vast sum, might be gradually brought about. Seeing that a single day of bad fog means injury and loss to the amount of hundreds of thousands of pounds to the inhabitants, any sacrifice would seem not too great in bringing about a mitigation of evils which now return with every recurring winter season.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

Elimination of Sodium Chloride.—Gennari points out that sodium chloride is only sparingly found in the fæces (*Clin. Med. Ital.*, 1906, No. 8). By the use of purgatives, however, the amount found in the fæces can be enormously increased, while a corresponding diminution of chlorides in the urine takes place. When very large quantities of chlorides are ingested moreover, either by healthy individuals or by sufferers from Bright's disease, the quantity in the fæces increases. The author believes that this effect of purgatives explains the value of such medication in cases of kidney disease, as it must aid the general dechlorinisation, which has been shown to be of so much value in diminishing the œdema and effusions into serous cavities. M.

The Iron-content of the Liver. — Castaigne has exhaustively studied the question of the iron-content of the liver (*Presse Med.*, 1906, Nos. 95 and 97). Starting from the fact that the normal liver contains a small quantity, equivalent to about .2 gramme of the metal, he has examined this organ in various diseased states. At birth he finds that a large store of iron is present, and that this gradually diminishes during the period before weaning. This store and its subsequent diminution is presumably due to the utilisation of the iron in forming hæmoglobin, during a time when the food (milk) is almost iron-free. During pregnancy also the amount of iron in the liver diminishes, due to the demands made on it for the blood of the growing fœtus; and after hæmorrhages a similar diminution takes place. The most frequent cause of an increase of the quantity in the liver appears to be blood destruction, and its storage seems to be a reserve necessary for the new formation of red cells that takes place in compensation. An increase is also found in cirrhosis and in bronzed diabetis, while in chlorosis the quantity is much lessened, probably due to diminished functional activity on the part of the liver cells. M.

Function of the Supra-Renal Capsules.—Mariani has made several observations on the function of the supra-renal glands (*Clin. Med. Ital.*, 1906, No. 8). Operating on dogs, rabbits and guinea-pigs he finds that when bilateral extirpation is practised, with an interval of some days between the operations, all the animals die with the symptoms of severe intoxication. He finds also that if the glands be destroyed *in situ*, the animals die; in these cases the cortical part shows some signs of regeneration, but not the medulla. The subcutaneous injection of cortical and medullary substance has very slight curative effect in animals who have suffered bilateral extirpation. The serum of such animals and of patients suffering from Addison's disease is highly toxic, and causes a lowering of blood pressure. This toxic effect is, however, fully neutralised by extracts of supra-renal medulla, and partially by cortical extracts. The author thinks that arterio-sclerosis of young individuals may be due to hyper-activity of the medulla, and could be treated by the serum described above. The cortical substance is very slightly toxic, whilst .5 cc. of a 10 per cent. solution of the medulla proved always fatal to rabbits weighing a kilogramme. M.

The Opsonic Index as an Aid to the Early Diagnosis of Tuberculosis.—Drs. Stewart and Ritchie report their conclusions as to the value of the opsonic index in the early diagnosis of tuberculosis (*Edin. Med. Journ.*, May, 1907, p. 435). They are as follows:—(1) A single estimation of the opsonic index is an unsatisfactory method of diagnosis, as both tuberculous and non-tuberculous cases fall within and without normal limits. Thus in eighty-two tuberculous cases, forty-one had an index within normal limits and forty-one outside; these cases including pulmonary, gland and bone tuberculosis. In forty non-tuberculous cases, eleven had an index outside the normal limits. (2) If a negative phase appears after inoculation of tuberculin the presence of tuberculosis may be diagnosed. Thus in sixty-five tuberculous cases a negative phase was observed in fifty-six, *i.e.*, in 90 per cent., while in thirteen non-tuberculosis cases no negative phase was obtained. (3) The absence of a negative phase indicates the absence of a tuberculous infection. This absence also may be regarded in a previously tubercular case as indicating complete recovery. M.

Treatment of Cerebro-Spinal Meningitis with Bier's Passive Congestion and Lumbar Puncture.—Vorschütz (*Mun. Med. Woch.*, March, 1907) gives a good review of the present state of our knowledge concerning epidemic cerebro-spinal meningitis, and recommends for treatment a combination of the use of passive congestion with frequent lumbar punctures. He performs lumbar puncture whenever the fever is high, and when there are signs of increased intra-cranial pressure. Passive congestion is applied for twenty-four hours each day by means of a rubber bandage about the neck. This should be put on first tight enough to cause moderate cyanosis of the face. The bandage should be removed during lumbar puncture. The advantages of passive congestion consist theoretically in the increased amount of bacteriocidal substances brought to bear on the inflammatory process, and the increased exudation of lymph which brings fresh leucocytes to the spot, and in combination with the lumbar puncture causes a flushing of the cerebro-spinal canal. From a practical point of view it seemed to diminish the headache and was grateful to the patient. D.

Acute Pancreatitis.—Egdahl (*Bull. Johns Hopkins Hospital*, April, 1907) has analysed 105 published cures of acute pancreatitis, with the purpose of determining the relative frequency of the different factors which have been considered to have ætiological significance. Most prominent among these is the action of gall-stones in causing a retrojection of bile into the pancreas. Bacterial invasions of various kinds from the intestines or other sources undoubtedly play an important part. Entrance of gastric juice through the ducts of the pancreas has been thought by some to occur. The action of ferments originating in the pancreas particularly the action of steapsin in the production of necrosis, has attracted much attention. Egdahl, from the results of his studies, concludes that gall-stones are probably the most common single cause of pancreatitis, occurring in 42 per cent. of the cases. Gastro intestinal disorders are the next most common causes, being present in 32 per cent., of which seventeen gave a history of alcoholism. It is probable that retrojection of bile may be caused by these intestinal disorders. The organism most commonly present is B. Col. Communis; next come the streptococcus and staphylococcus. Acute pancreatitis, may occur in a large variety of conditions of which typhoid fever, tuberculosis, trauma, syphilis, emboli, appendicitis, malaria and gastric ulcer deserve mention. D.

Pleurisy with Effusions. — Chapin (*Boston Med. Journ.*, April, 1907) reports a case of pleurisy with effusion, in which he injected intra-plurally a 2 per cent. formalin solution in glycerin. Only one injection was made, but it resulted in a cure. Other treatments, which had been employed previously, did not prevent a re-accumulation of the fluid, so that repeated tappings were necessary. D.

The Effect of Salt in the Diet.—Magnus-Levy (*Der Therapie d. Gegenwart*, April, 1907) reviews the subject of the action of salt in the diet in producing œdema in diseases of the kidney. He describes the classical experiments of Widal and Javal, who caused œdema to appear and disappear at will simply by increasing or removing the salt from the diet. It is possible, however, to have a retention of salt in the body without œdema, the salt being taken up by the cells instead of remaining in the lymph spaces. The œdema of cardiac disease is not due primarily to salt retention, but to mechanical causes, and therefore the reduction of salt cannot have such a marked effect as in nephritis. Indirectly, however, it may be advantageous by reducing the thirst and consequently the ingestion of water and the work of the heart. The effect of the exclusive milk diet in the reduction of œdema is due probably to its small salt content, 3 litres of milk containing 5 gms. sodium chloride. A mixed diet prepared without the use of salt contains even less, approximately 2 gm. After the œdema has gone it is best to continue a moderate restriction of salt, allowing about 8 gm. per day. With regard to the use of salt by the healthy, a moderate amount is probably beneficial, although many vegetarians remain healthy on a salt free diet. Excessive amounts of salt have never been known to act injuriously on a healthy person. D.

A Study of Five Hundred Cases of Pleurisy.—Fraley (*Amer. Journ. of the Med. Sciences*, May, 1907) brings together some interesting information on this subject based on a study of the cases admitted to the Pennsylvania Hospital from the year 1896 to the year 1905. The tables show that the disease is more or less prevalent at all seasons of the year, but is decidedly more frequent in the colder and wetter months. Among children, sex appears to have no influence on the incidence of the disease, but after the age of fifteen years, when the modes of life of the different sexes begin to differ, men are found to be affected four times more frequently than women. Almost three-fifths of the cases occurred in patients between twenty and forty years of age and over one-third between the ages of twenty and thirty. Fifty-two cases in the series followed croupous pneumonia, and of these 48 were empyemas; while in only 30 cases could direct evidence of tuberculosis be demonstrated ante-mortem. In three-fifths of the cases, there was a serous effusion; in one-fifth there was a purulent effusion, and in the others no effusion occurred. Large effusions were slightly more frequent on the left side than on the right. In regard to treatment by tapping some very interesting information has been obtained. In this connection only uncomplicated cases are compared, and only cases discharged as cured are considered. From such cases taken as a series it appears that "uncomplicated cases of serous effusions aspirated recovered in three weeks, whereas another week was necessary to effect a cure in the non-aspirated." The contrast was more marked in the case of small effusions than in those of moderate size. In the massive effusions the contrast is afforded by those patients who refused operation, and it was found that the average duration of treatment of those aspirated was 24.7 days as against 55 days in the non-aspirated cases. Among the empyema cases the mortality was 22 per cent. for the entire series, but only 17 per cent. for those resected as against 40 per cent. for those not resected. In the cases in which simple incision and drainage was performed the mortality was 27 per cent. K.

Heart-Block.—Butler (*Amer. Journ. of the Med. Sciences*, May, 1907) records a typical case of this condition which ended fatally in ten days. The patient, a man, æt. 43, had had a slow pulse ever since an attack of typhoid fever some twenty years before his death, and it is recorded that during an attack of croupous pneumonia which occurred some two y before his death his pulse never rose above 42 minute. At the autopsy slight mitral insufficie and thickening at the base of the mitral cusps w discovered, and considerable fatty degeneration the myocardium. Microscopic sections of the bur of His showed that it was infiltrated with fat and undergone fatty degeneration to such an extent t it was atrophied to not more than one-fifth of normal size. K

Treatment of Gonorrhœa. — French (*R.A.M Journ.*, June, 1907, discusses the treatment of disease among soldiers. He is of opinion that view put forward by Major Pollock in the final Rep of the Advisory Board on the treatment of vener diseases is not correct; and that irrigation in initial acute stage of gonorrhœa is more likely cause than to prevent infection of the posterior ureth French is of opinion that during the acute stage of disease, the patient should be kept strictly in bed a treated with a light farinaceous diet, a daily sal purge, and an alkaline mixture every four hours. injection is to be permitted till the thick yellow pu lent discharge has become thinner, whiter, and m muco-purulent. After this period, the patient allowed to get up, a more liberal diet is given, a anterior irrigation is commenced with a luke-wa solution of two grains of permanganate of potassiu to the pint of water. The treatment should exte over a period of at least six weeks, and the patie should not be allowed to leave hospital as long as a gonococci can be demonstrated in the urine. F the satisfactory treatment of chronic gleet the use a urethrascope is almost essential. By means of th instrument the "granular patch," which is so com monly the cause of the discharge, can be seen, an is to be treated by the local application of a stro solution of nitrate of silver (20 or 30 grains to th ounce). The occurrence of any complication such a cystitis or epididymitis is to be looked on as an abso lute indication for stopping all active treatment the urethra, and for returning to the sedative treat ment adopted in the initial stage of the disease. K.

Carbolic Acid Gangrene.—Wallace (*British Medica Journal*, May 11th, 1907) reports nine cases of gangrene of fingers due to carbolic acid dressings. Probably pure liquid carbolic was used in at least two cases, and a strong solution in two others, but in at least four cases the preparation used was not more than 5 per cent. In none was a waterproof covering used. In none was tight bandaging a possible cause of gangrene. In every case the original injury or sepsis was at most trivial in degree. In two cases gangrene was limited to a part proximal to healthy tissue. The appearance of the gangrenous part is characteristic. The skin is at first dry, wrinkled, and greyish-white in colour; later it becomes darker and more shrivelled. At the junction of the living and dead tissue there is some hyperæmia. As it is difficult to tell how much is actually destroyed, it is proper to wait for a line of demarcation before amputation is performed. In no case was swelling of the proximal part observed. The condition is, as a rule, similar to a typical case of dry gangrene. S.

An Important Action against Dental Companies.

During the past week a case of great importance not alone to the dental, but also to the medical profession has been at hearing in the Dublin Courts.—The Attorney-General at the instance of Mr. Kevin O'Duffy, Secretary of the Irish Dental Association. *v.* Myddleton, Ltd., a limited liability company which practises dentistry in Belfast. The action was brought at the instance of the Irish Dental Association for an injunction restraining the defendants, who carry on business in Belfast and other towns in the north of Ireland, from carrying on business under the style and title of "Surgeon Dentists," and thereby infringing the provisions of the Dental Act. The defendants denied that they had been guilty of any illegality. The arguments in the case have been concluded, and the Court has reserved judgment.

Medical News in Brief.

Royal Society of Medicine.

For nearly a hundred years there have been movements in the medical profession for a union of the societies which concern themselves with the various aspects of medical practice. Some two years ago Sir Richard Powell once more raised this ancient topic. Since then negotiations have been continually in progress, and, these negotiations have resulted in the formation of a Royal Society of Medicine, which was formally constituted at a meeting of the Fellows held on June 14th at 20 Hanover Square. The Societies represented were the following: Royal Medical and Chirurgical Society, Pathological Society of London, Epidemiological Society, Odontological Society of Great Britain, Obstetrical Society of London, Clinical Society of London, Dermatological Society of London, British Gynæcological Society, Neurological Society; British Laryngological, Rhinological and Otological Association; Laryngological Society of London, Dermatological Society of Great Britain and Ireland, Otological Society of Great Britain and Ireland, British Electro-therapeutic Society, and Therapeutical Society. The committee of representatives of the societies which had indicated their adhesion to the project have drawn up a series of bye-laws, which were adopted at yesterday's meeting. They provided, among other things, for the establishment of the following sections: Clinical, Dermatological, Electro-Therapeutical, Epidemiological, Laryngological, Medical, Neurological, Obstetrical and Gynæcological, Odontological, Otological, Pathological, Surgical and Therapeutical and Pharmacological.

Sir William Church was elected the first president, and the officers and councils were appointed as follows: Dr. F. H. Champneys and Mr. A. Pearce Gould, M.S., honorary treasurers; Mr. Rickman J. Godlee, Dr. Henry Head, and Dr. Norman Moore, honorary librarians; Dr. Arthur Latham, and Mr. Herbert S. Pendlebury, honorary secretaries; and Sir Richard Douglas Powell (President of the Royal College of Physicians), Mr. Henry Morris (President of the Royal College of Surgeons), Mr. J. Warrington Haward, Mr. G. H. Makins, Sir Shirley F. Murphy, Mr. Thomas Lawrence Read, Sir Felix Semon, Dr. Frederick Taylor, and Dr. Thomas J. Walker, members of council.

The speakers at Friday's meeting included Sir Richard Powell, Sir William Church, Sir Thomas Smith, Sir Thomas Barlow, Dr. Barlow, Professor Osler, Dr. Pye Smith, Mr. Henry Morris and Mr. Clinton Dent. The opinion was unanimous that great advantage will result from the establishment of this Royal Society of Medicine. Not only will the special objects of research of each of the amalgamated societies be preserved, but the result of such a joining of forces will tend to the establishment of more comprehensive libraries, the collection of documents bearing on medical research and jurisprudence, and incidentally much economy in administration.

Apothecaries' Hall of Ireland.

At a general meeting of the members of the Apothecaries' Company, held at 40 Mary Street, Dublin, on June 7th, Dr. Seymour Stritch, J.P., in the chair, it was proposed by Dr. Montgomery, seconded by Dr. Finucane, and passed unanimously—"That the best thanks of the Company are hereby tendered to Colonel Adye-Curran, M.D., F.R.C.S., for his untiring and successful efforts on behalf of this Hall in the General Medical Council."

Ambulance Contest in the Rhondda.

The second annual competition for Sir Charles Warren's ambulance challenge shield for the Rhondda and other prizes took place at Ferndale on June 8th. As indicative of the strides made in ambulance work in a short space of time, it may be mentioned that, whilst not many months ago those capable of rendering first-aid to their comrades who might be the victims of accidents at the collieries were few, at present almost every colliery can soon turn out a squad of efficient ambulance men. All the arrangements, which had been made with thoroughness by Mr. Tom Davies, the chief superintendent of the Rhondda Fawr Corps. The attendance included a large number of medical men and colliery officials from all parts of the Rhondda, as well as the following distinguished officers of the St. John's Ambulance Brigade:—Colonel Sir Herbert C. Porrott, C.B., London (who, in the absence and on behalf of General Sir Charles Warren, presented the shield to the winning team); Surgeon-colonel E. Cureton, V.D., M.D., deputy-commissioner No. 7 District; Surgeon-lieutenant-colonel J. D. Lloyd, Chirk, district chief-surgeon No. 3 District, &c.

Colonel W. D. Steel, V.D., M.D., Abergavenny and Mr. J. H. Woolston, Worcester, the assistant-commissioner, acted as judges. The teams entered the lists in the following order:—Ferndale (the shield-holders), Mardy, Tynybedw, Great Western, Ystrad-Rhondda, Llwynypia, and Treherbert, whilst the awards were made as follows by Colonel Steel:—

First prize (shield and money prize), Mardy, 185 points.

Second prize, Ystrad-Rhondda, 167 points.

Third prize, Ferndale, 153 points.

Fourth prize, Llwynypia, 141 points.

Departmental Committee on the London Ambulance Service.

The committee appointed by the Secretary of State for the Home Department to inquire as to the ambulance provision for dealing with cases of accident and illness in the streets and public places in the metropolis, met at the Home Office on Friday, Sir Kenelm Digby (chairman) presiding. Evidence was given by Dr. Arthur W. James, honorary secretary of the Metropolitan Street Ambulance Association, and by Mr. T. Duncombe Mann, clerk to the Metropolitan Asylums Board.

The Red Cross Conference.

The eighth International Red Cross Conference came to an end on the 15th inst. The Marquis de Vogüé (France), one of the vice-presidents, took the chair in the Examination Hall, Victoria Embankment. Colonel William C. Sanger (U.S.A.) offered the hospitality of the United States to the next Conference if it should not be found possible to accept that of Japan on account of the remoteness of that country. Dr. Ferrière (France) read a report on the awards of the Marie Feodorowna prizes, which are given out of a fund established by the Dowager Empress of Russia. A cordial vote of thanks was carried to the Marquis de Vogüé, who had presided over the Conference with marked tact and ability. In the afternoon of the 15th inst. the King and Queen received at Buckingham Palace the delegates of the International Red Cross Conference, together with a number of the presidents of the British Red Cross Society, nearly all of whom were the wives of Lords Lieutenant. Altogether there were about 300 guests, including Lord Rothschild, Lord Londonderry, the Duchess of Montrose, Georgiana Lady Dudley, Lord Roberts, Sir William Butler, Lady Lansdowne, Lord Knutsford, Sir Frederick Treves, and the President of the Royal College of Surgeons. The company were received in the Picture Gallery. The presentees were marshalled by officials of the Lord Chamberlain's department, and afterwards passed in turn before their Majesties. The less formal method of greeting took place subsequently as their Majesties moved about among the assembled guests. Tea was afterwards served in the State dining-room. Baron Ozawa, the chief Japanese delegate, was the bearer of a message from the Emperor and Empress of Japan, in which their Majesties acknowledged the great humanitarian work of Queen Alexandra, especially with reference to the Red Cross League, and stated that the Empress intended to follow the Queen's example. The Queen replied to the effect that she was very much touched by the message, and desired that her greetings should be conveyed to the Empress.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

FUNDUS.—Successful transplantation of the cornea has only been reported once, we believe, viz., by Herr Zirm at the Vienna Medical Society. The patient's eyes had been damaged by lime, and the grafts were taken from a healthy eye removed from another patient because of a wound. Both corneæ were grafted, but only one was successful.

THE RULING PASSION.

One of the witnesses at the Derbyshire Summer Assizes related a most terrifying experience he had recently undergone. While asleep in a Welsh hotel he was awakened by heavy footfalls in the room. An individual struck a match, lighted the gas, and approached the bed Seizing his hand and feeling his pulse, and then tapping his chest, the mysterious visitor solemnly said: "You have a most serious attack of pneumonia. You may possibly live seven days, but no more." Later on the landlord explained that he had a son seriously ill in another bed. The nocturnal visitor was a doctor who had mistaken his patient.—*Daily News*.

BARBER-SURGEON.—Perhaps the best instance of the factotum doctor we can give you for your lecture is the following, which appeared in an Elizabethan newspaper:—"Wanted—In a family who have bad health, a sober and steady person in the capacity of doctor and surgeon. He must occasionally act as butler and dress hair and wigs. He will be required sometimes to read prayers and preach a sermon every Sunday. A good salary will be given."

CHILDREN'S HOSPITALS.

We are sometimes asked by men recently qualified how to set about obtaining appointments at a children's hospital. There can be no doubt that, as a subsequent introduction to general practice, a resident appointment in an institution of this nature is of inestimable value. One such is advertised in our present number, viz., a house surgeoncy at the largest hospital for sick children in the United Kingdom, for particulars of application and appointment for which we refer our readers to the Index on page iv.

M. S. P.—The figures for industrial poisoning and anthrax show a distinct decline for the first four months of this year, viz.: 161 cases with 14 deaths, against 225 cases with 23 deaths in the corresponding period of last year. In addition there were 47 cases of lead poisoning with 13 deaths among house painters and plumbers for the same period, against 52 cases with the same number of deaths in the first four months of 1906.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JUNE 19th.

ROYAL METEOROLOGICAL SOCIETY (70 Victoria Street, Westminster, S.W.).—4.30 p.m.: Exhibition of "Step" Anemometer by Mr. W. Child. Papers:—Mr. F. C. Bayard: Weather and Crops, 1891-1906.—Mr. C. P. Hooker: The Relation of the Rainfall to the Depth of Water in a Well at Cirencester, 1903-1906.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—8 p.m.: Paper:—Mr. E. M. Nelson: Eye-pieces for the Microscope. Lecture:—Mr. F. Enock: The Life History of the Tiger Beetle (Cicindela campestris) (illustrated by lantern slides).

ROYAL MEDICAL AND CHIRURGICAL SOCIETY (20, Hanover Square, W.).—5.30 p.m.: Mr. D'Arcy Power: Dr. Walter Bayley and his Works, 1529-92. (There will also be a number of exhibits of medical and antiquarian interest.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Outpatient (Dr. Whipham).

THURSDAY, JUNE 20th.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—5 p.m.: Croonian Lecture:—Dr. W. J. R. Simpson: Plague.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:— Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m.: Special Demonstration of Cases of Children's Disease (Dr. T. R. Whipham).

HOSPITAL FOR SICK CHILDREN (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. Kellock: Affections at and about the Umbilicus.

FRIDAY, JUNE 21st.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—9.30 a.m.: Clinique: —Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. C. A. Parker: Clinique. (Throat.)

Vacancies.

Bradford Royal Infirmary.—Resident Surgical Officer. Salary £150 per annum. Applications to J. J. Barron, Secretary.

London County Asylum, Horton, Epsom.—Fifth Assistant Medical Officer. Salary £150 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Asylums Committee Office, 6, Waterloo Place, S.W.

Oldham Union.—Resident Medical Officer. Salary £150 per annum, together with furnished residence, coal, gas, rations, washing, and attendance. Applications to Horace A. Quarmby, Clerk to the Guardians, Union Clerk's Office, Rochdale Road, Oldham.

General Post Office—Medical Department (Male Staff).—Assistant to the Medical Officers at Headquarters. Salary £300 a year. Applications to the Secretary, General Post Office.

Egypt.—Sub-Inspector of Ophthalmic Hospitals. Salary £500 a year. Applications to A. F. MacCallan, Esq., 32, Bedford Gardens, Kensington, W.

West Bromwich District Hospital.—Senior House Surgeon. Salary £110 per annum, with board, residence, and laundry. Applications to T. Foley Bache, Esq., Churchill House, West Bromwich.

Canterbury City Asylum.—Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, and laundry. Applications to Medical Superintendent.

The University of Sheffield.—Demonstrator in Physiology. Salary £150 per annum. Applications to W. M. Gibbons, Registrar.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary £160 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26, Mosley Street, Newcastle-on-Tyne.

Newcastle-upon-Tyne.—Assistant Medical Officer of Health. Salary £300 per annum, with board, lodging, etc. Applications to the Medical Officer of Health, Town Hall, Newcastle-upon-Tyne.

Fermanagh County Hospital.—House Surgeon, salary £52 per annum.—Applications to C. Wilson, Secretary. (See advt.)

Battersea General Hospital (anti-vivisection).—Honorary Surgeon to the Eye, Throat and Ear Department.—Apply Secretary. (See advt.)

Appointments.

CALTHROP, LIONEL C. E., M.B.Durh., M.R.C.S., L.R.C.P., Medical Superintendent of Woodhall Spa, Lincolnshire.

DAWSON, GEORGE W., F.R.C.S. Irel., D.P.H., Surgeon to St. John's Hospital for Diseases of the Skin, Leicester Square, W.C.

FAIRCLOUGH, W. A., M.B., Ch.B.N.Z., House Surgeon at the Royal Westminster Ophthalmic Hospital.

FIELD, F. E., M.B., Ch.B. Edin., Clinical Assistant at St. John's Hospital for Diseases of the Skin, Leicester Square, W.C.

HARE, T. G., M.D. Freib., Pathologist and Bacteriologist to St. John's Hospital for Diseases of the Skin, Leicester Square, W.C.

HOLLICK, BERNARD SEPTIMUS, L.R.C.P. Lond., M.R.C.S., Medical Officer of Health for the Sturminster (Dorset) Rural District Council.

KELYNACK, T. N., M.D. Vict., M.R.C.P. Lond., Honorary Physician and Medical Adviser to the Children's Home and Orphanage (London and nine country branches).

RICHARDSON, M. J., M.B., M.S. Edin., Certifying Surgeon under the Factory and Workshop Act for the Wolston District of the county of Warwick.

Births.

CHAPPEL.—On June 13th, at Lansdowne House, Tottenham, the wife of George P. Chappel, M.D., of a daughter.

GERVIS.—On June 14th, at Hurdis House, Seaford, Sussex, the wife of Charles Berkeley Gervis, M.D., of a daughter.

HIGHAM.—On June 11th, at Murree, Punjab, India, the wife of Lieut. Bernard Higham, I.M.S., of a son. (By cable.)

POOLE.—On June 11th, at Hampton, South Teddington, the wife of J. C. Poole, M.R.C.S., of a daughter.

Marriages.

GROVES—MILLER.—On June 12th, at St. Mary's Church, Speenhamland, Newbury, Charles Nixon Groves, M.A., M.D., Oxon., only son of the late Charles Groves, to Frances Minnie, younger, daughter of Frederick Montague Miller, J.P., M.R.C.S., L.R.C.P., of Northolme, Upper Clapton, London.

ROBERTS—HOBDAY.—On June 8th, at Holy Innocents' Church, Hornsey, John Thomas Roberts, L.R.C.P.Edin., Meadow Lodge, Park Road, Crouch End, to Mabel Caroline, fourth daughter of H. T. Hobday, Esq., "Bougaree," Manley, Sydney, N.S.W. Australian papers, please copy.

TAYLOR—CLAY.—On June 11th, at the Parish Church, Dewsbury, Henry Percy Taylor, only son of Henry Taylor, of Whitehaven and Wakefield, to Norah, second daughter of Charles Clay, M.R.C.S., The Manor House, Dewsbury.

Deaths.

COATES.—On Sunday, June 16th, at The Hill, Laverstock, Salisbury, Harcourt Coates, M.R.C.S.E., L.R.C.P.Lond., aged 54. For 21 years hon. surgeon Salisbury Infirmary.

DRESCHFELD.—On June 13th (suddenly), at Stanley House, Withington, Manchester, Julius Dreschfeld, M.D., F.R.C.P., B.Sc., aged 61 years.

LANE.—On June 12th, at 19 Priory Street, Cheltenham, Brigade-Surgeon Benjamin Lane, late A.M.S., eldest son of William Lane, M.D., of Limavady, Co. Derry, aged 80 years.

STRAHAN.—On June 8th, at Dalbrack, Glenesk, Forfarshire, suddenly, Alexander Bannerman Strahan, Lieut.-Colonel I.M.S., Retired, in his sixty-fifth year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIV. WEDNESDAY, JUNE 26, 1907. No. 26

NOTES AND COMMENTS.

Principles of Provident Medical Associations

AT a successful Conference held at Norwich early this month the Charity Organisation Society got up a debate on Provident Medical Associations in which many lay and medical men interested in the question took part. It is satisfactory indeed to record that although there was naturally a good deal of difference in detail, the speakers seemed generally to be in agreement as to the main principles on which such associations should be founded. These, of course, are that all medical men in a town should have the opportunity, after a short probationary residence, of being on the staff, that the members be free to choose and change their medical attendants, that a reasonable wage-limit be enforced, and that the management be wholly or in the most part in the hands of the profession. It is on the two last points that the non-medical man usually comes into conflict with the medical man, for either it is wished to strengthen the society by bringing in well-to-do people who can well afford to pay medical fees, or there is some lay person or persons who wish to "boss" the show themselves, if not actually to profit financially. Now it is obvious that as provident medical associations cater only for the poorest classes, families earning less than thirty shillings a week, the margin of profit to the medical men is small and precarious enough in all conscience, especially as the management and collection expenses have to be paid. There is no room for another slice to go into the pocket of anyone else. The Conference seemed generally to see the force of these points, Mr. Fred Henderson, the socialist, only objecting on the ground that as the worker cannot afford to pay adequately for medical attendance, a free public medical service should be available for everyone who chooses to use it.

And their Application.

COLONEL MONTEFIORE, who opened the discussion in an excellent speech, dwelt at some length on the organisation of such public medical services in connection with hospitals, dispensaries, and other charitable agencies, and gave some striking figures as to the extent to which charitable medical relief prevails. He quoted a statement that in greater London no less than 1 in 2·2 of the population is in receipt of free medical attendance, and showed that in London 1,859,809 out-patients and casualties had been treated in London hospitals in 1905. Now appalling as these figures are, and disgraceful as they are to the civilisation that makes them possible, it is not in doubt that the vast bulk of these people are needy workers to whom adequate medical fees are impossible, so that it is clear that only by the most careful organisation can it even be expected that the profession shall earn anything like a just reward from them. The machinery by which such organisation may be brought about appears to lie ready to hand in the "Metropolitan Provident Medical Association," which already has twenty-one dispensaries and thirty thousand beneficiaries in London, but in order for this consummation to come about, all the present free dispensaries should be brought into line, and the hospitals be enlisted to work in co-operation, so that nothing but consultations and casualties be carried on in the out-patients departments, whilst the beds themselves are ear-marked for association members. It is, however, a great thing that a number of philanthropic gentlemen are now beginning to see eye to eye with the profession in this matter, and though doubtless a long evolutionary period will have to be gone through, there does seem to be hope of order eventually coming out of chaos.

Doctors and Alcohol.

UNDER the title of "Doctors and Alcohol," the *Licensing World* is sending out far and wide a circular in praise of moderate drinking, and needless to say the unfortunate manifesto sent to the *Lancet* last March forms part of the propaganda, several of the most telling sentences in connection with it being printed in leaded type. There is also a reference to the *Hospital*, in which are quoted some remarks by Dr. Savage, made in his recent Lumleian lectures, throwing doubt upon the relationship between the increase in insanity and the consumption of alcohol, and further some weird statements from a paper by Dr. Haydn Brown in the *General Practitioner*, from which we gather such gems as that were alcohol forbidden by law "the death-rate would increase to an appalling extent," and "many people would soon die were it not for the stimulants they take at meal times." Now within the ranks of a liberal profession such as medicine it is not only probable, but almost inevitable, that every kind of opinion should find a representative somewhere, so that it is always possible to get some medical authority for almost any view of life, but the bulk of the profession, though it takes a certain quantity of alcohol with meals and prescribes the drug for patients in certain cases cannot but view with disfavour the exploitation of its opinion, or even the opinion of some of its members, for the purpose of pushing the sale of alcohol in general. The difficulty is not in getting men to buy drink, but to stop them buying too much of it.

Science and the Indian Government. IN *Nature* Professor Ronald Ross has a stinging article on the want of science in general administration, the Indian Government especially coming in for his castigation though the tergiversations of home governments, swayed as they are by the exigencies of party warfare, by no means escape stricture. While we recognise the Titanic task that a handful of European officials have to cope with in governing the three hundred millions of India, we would think that the advantages scientific methods offer would be all the more eagerly seized on that account, but Professor Ross, though admitting a small improvement of late years, shows how the paralysing influences of routine crush enterprise and ideas. He tells again the tale of malaria; how for fifteen years after Laveran's discovery official India took no notice of it, and how when he himself set to work vigorously at the subject of transmission every kind of official difficulty was thrown in his way. The story of cholera, of plague, and of vaccine obtained from variolisation of the calf are much the same, and the story of typhoid but little better. Knowledge has been offered to the Government, and it has either been frowned upon or treated with sparse courtesy And yet the problem of India is so indissolubly bound up with the prevalence of these diseases that its economic administration may be considered almost a department of epidemiology. Well, a change is gradually coming, so Professor Ross says, for whereas in former years not a thousandth part of the medical budget was spent on investigation, now about one-hundredth is; but even that amount is pitiably small.

Sir Frederick Treves and the Public. SINCE his successful operation on the King and his subsequent abandonment of practice, Sir Frederick Treves has become the Sir Oracle of medicine to the public, and he seems to fill their medical horizon with the almost same completeness that Lord Rosebery does their social one. Both orators have the same happy knack of emphatic and picturesque statement which arrests attention and influences opinion. Some three weeks ago Sir Frederick delivered a speech at Preston which created such a stir that the echoes are still ringing throughout the country. Two views he put forward one would have thought so nigh commonplaces as to have amounted almost to platitudes, namely, that with proper education and care fever hospitals would lag superfluous on the stage, and secondly, that the bottles on the doctor's shelf are melting away before fresh air, good food, and bright sunlight; but judging from the astonishment these "remarkable statements" have created, they might almost be classed with the utterances of Elijah or the Delphic oracle. The real lesson the phenomenon conveys is that the public are still sitting in terribly sanitary darkness, and that they are really hungering for good teaching, wherefore we hope that Sir Frederick Treves may continue his beneficent mission till people are surprised into a little common-sense on medical subjects.

LEADING ARTICLES.

THE MEDICAL INSPECTION OF SCHOOL CHILDREN.

THE necessity of the systematic medical inspection of school children has been formally recognised by the legislature of the United Kingdom. The present Government, in their Education Bill of 1906, accepted the permissive clause introduced by the President of the Board of Education. The Commons, however, were not in the mood for half-measures, and the clause was rendered mandatory. In this matter our countrymen are simply bringing themselves into line with the methods adopted by most civilised countries. During the past thirty or forty years, for instance, the medical inspection of schools has become part and parcel of the administration of State education in Austria, Sweden, the Argentine, Hungary, Norway, Switzerland, Servia, France, Japan, and Roumania. Even in Russia, that country of backward administration, the system has for some time past been applied to her secondary schools. In other countries inspection is local and voluntary, as, for instance, in Belgium, Germany, and the United States of America. So far as similar partial action is concerned, the necessity for some step of the kind has been recognised in some parts of England during the last eighteen or twenty years. A more scientific knowledge of the conditions of school life and of school diseases, and of the bearing of health questions upon the regulation of education has enabled the matter to be handled in a much more satisfactory manner than would have been possible in a previous generation. That the time for dalliance with the question has gone by is fully recognised by the attitude of the Government, which has at the present moment two Bills in hand, each of them containing provisions for the mandatory medical inspection of school children. The only plan likely to give permanent satisfaction is the creation of a central authority in the shape of a medical department of the Board of Education. The body thus created would become directly responsible to the Minister of Education for the proper organisation and efficiency of local medical inspection throughout the country. In no other way is it likely that any sound system can become established. Clearly it would connote a staff of specially skilled inspectors, for the duties of the school medical officer are multifarious and many of them of a highly technical nature. He must have a practical acquaintance with disease, for instance, especially in its communicable forms; he must be more or less of a dermatologist, an ophthalmologist, an alienist, a dental surgeon, and an expert generally in the diseases of children, not to mention that he must be able to investigate the sanitary condition and the proper construction of school premises; and to be a competent consultative authority upon a host of other technical questions. In this way the State school system of the future is likely to become a great factor in the prevention of disease, infectious and non-infectious, and most assuredly will deeply influence the future of the race. By looking after the feeding of school children, and by nipping many disorders and defects in the bud, medical inspection would be able to keep a host of citizens from swelling the vast sum total of our Poor-law wreckage. Compulsory medical school inspection, in short, belongs to that class of legislation which is penny foolish and pound-wise. It spends money in looking after the bodily welfare of the children of the people in their tender years with the view of keeping them in later life clear of the workhouse where they would have to be maintained at a vastly greater cost to the community. The desirability of medical inspection, indeed, rests on economic grounds not less obvious than those dictated by common-sense and humanity. Now that public opinion is ripe for the legislation which cannot long be delayed, it is a fitting moment for a great and well-informed international discussion to take place. Such an opportunity is forthcoming in the International Conference on School Hygiene to be held in London from August 4th to 10th, under the distinguished presidency of Sir Lauder Brunton. It is well that at this precise juncture we should obtain an authoritative account of the views and experiences of other countries on this most important social question.

CURRENT TOPICS.

Tuberculosis in London.

An important and significant meeting was held in Paddington the other day with regard to the administrative measures against tuberculosis which are considered advisable and practicable in London. The meeting was in effect a conference of representatives of all the Metropolitan boroughs, and comprised no less than seventy delegates who exhibited a remarkable degree of unanimity. The first resolution was one recommending the compulsory notification of consumption, and this was only one that met with any opposition. The general opinion of representatives of boroughs in which voluntary notification already prevails seemed to be that it had been a failure, and after discussion the resolution in favour of compulsion was passed by 47 votes to 8. The delegates perhaps hardly realised all that is involved in the resolution, for if voluntary notification has been unpopular it stands to reason that compulsory notification will be more so, and if the measure is to justify its existence it must be supported with its logical corollaries—isolation and sanatorium treatment. Considering the present state of public feeling with regard to the infectivity of consumption it is not a matter for surprise that workers who live by their own exertions should shrink from the knowledge that they are suffering from the disease coming to the ears of their employers and fellow-workers. The next resolution which was passed unanimously urged that the Local Government Board should make the regulations under the Dairies, Cowsheds, and Milkshops' Order 1885, and its amendments, compulsory on local authorities, as also that Section 69 of the Public Health (London) Act should be extended to pulmonary tuberculosis so far as it relates to the milk of cows and the sale and storage of milk. With those proposals we are heartily in agreement, but they come rather curiously on the heels of the resolution of the new London County Council to withdraw from the consideration of Parliament the milk claims that had been inserted in its new General Powers Bill. Finally it was resolved that the Metropolitan Asylums Board should be made a sanatorium authority for London—a very large and complicated question. The meeting decided to ask the President of the Local Government Board to receive a deputation, and we shall be much interested to see if the Board has altered its well-known views on these highly important questions.

The Queen's Nurses.

The issue of an appeal by Queen Alexandra's Committee reminds the world of the excellent work done by the Queen's nurses. It is hardly necessary to recall the fact that the late Queen Victoria devoted to the maintenance of nurses for the poor the interest on the sum of £70,000 subscribed by the women of the United Kingdom in honour of the Jubilee. The aim of the Queen's Institute is to supply town and country districts requiring the services of trained and competent nurses to visit and minister to the sick poor in their own homes. The value of such a movement is obvious, and it is remarkable that the Committee have been enabled to achieve so much upon the comparatively small yearly income of £8,000, of which £2,100 is from her late Majesty's endowment. A sum of £10,000 is now asked for yearly by Adeline Duchess of Bedford, who has succeeded the late Countess Cadogan as President of Queen Alexandra's Committee.

Identification by Palate.

The infinite variations of individuals from standard race peculiarities of structure have been made the basis of various systems of identification. It has remained for Dr. Paul Pragen, an Austrian Army surgeon, to point to the measurements of the human palate for that purpose. He maintains that a system founded on that basis is more efficacious than the one dependent on finger prints. He states that among the thousands of casts he has taken of the arch of the human mouth, he has failed to find any two resembling each other. Though the teeth alter greatly from time to time at various periods of life, he maintains that the markings of the palate remain unchanged throughout. The individuality of the palate, in short, is more marked and permanent than that of any other part of the human body. These observations possess a considerable scientific interest, and it is obvious that, if capable of wide application in criminal anthropology, they may prove of much practical value to the community.

The Teaching of Physiology.

WE have great pleasure in publishing in our correspondence columns a letter from Dr. D. T. Barry, Demonstrator of Physiology in Queen's College, Cork, on the teaching of physiology to medical students. This is a subject on which opinions are greatly divided at the present moment. There are not wanting those who maintain that physiology is as yet in so nascent a stage that its conclusions are of little value for the purpose of medical instruction. One well-known physician at least has not hesitated publicly to proclaim this view in print quite recently. On the other hand, there are those who wish students to delve still more deeply than they do at present into the teachings of pure physiology, holding that the present knowledge they gain is a poor equipment for scientific medical practice in after life. The overcrowded curriculum, however, may want improving; it certainly cannot stand any further loading. No practical medical educationalist, we venture to think, would propose any further addition to the student's programme, however much he might desire to see substitution and transposition brought about. The teaching of physiology is, however, a question so practical and so vitally important that we should be glad to hear what our readers' opinions on the subject are.

An Anti-Vivisectionist "Expert."

THE evidence given by Dr. Arabella Kenealy before the Royal Commission on Vivisection may, we presume, be regarded as typical of the opinions of a section at least of the anti-vivisectionist party, as otherwise she would hardly have been chosen to give evidence. This lady, who retired from practice some seven or eight years ago and has devoted herself since to what she calls "literature," has original ideas both on pathology and on treatment. "In all diseases," she says, "Nature selected the organ that should throw out the poison. In typhoid fever it was the glands of the small intestine. . . . In diphtheria Nature has selected the tonsils as the best route of eliminating the disease. By giving antitoxin one might relieve the tonsils, but one threw the poison back into the blood, so that it causes paralysis; it causes albuminuria, it causes convulsions and sudden death, rashes, and inflammation of joints. *I would make the use of the serum a penal offence.*" This is a fair example of the extravagant nonsense with which the witness regaled the Commission for many hours. It is perhaps as well that Miss Kenealy has retired from practice if she allowed the treatment of her patients to be guided by her own dictum that "disease is a natural operation of Nature, and when we attempt to thwart the operations of Nature I think we are trying to put back evolution."

Straw and Strawberries.

Now that the strawberry season is in full swing it may be well to give a word of caution to purchasers. The main thing is to choose perfectly fresh and firm fruit. Mouldy fruit is not only undesirable in itself, but in many cases it points to a special risk of infection. Most folk know that straw, placed beneath the young fruit, enables it to ripen more readily, and protects it from the depredations of various insects. So long as good straw is used, the advantage is very much in favour of the ultimate consumer. Some growers, however, replace clean straw by unclean manure. The result is that the fruit soon turns mouldy and the berries are liable to be infected with all kinds of unwholesome bacteria. The moral is, to avoid strawberries that are off colour or present a moist or mouldy surface. Fine fresh strong fruit has a look of its own, and may be consumed with a fair amount of confidence, that is to say, if we accept the doctrine of an unavoidable margin of risk. If there be any suspicion about the fruit it may be washed, or, better still, rejected altogether. Fortunately, the process of jam making involves the destruction of harmful germs.

A Royal Commission on Cancer.

THE announcement made by the Prime Minister the other day that he had in mind the question of appointing a Royal Commission on Cancer naturally marks an epoch in the history of medical science, for though other diseases have been the subjects of Royal Commissions there has always been a prospect of more or less immediate remedial benefit. With regard to cancer this cannot be expected, but on the other hand the educative value of such a Commission would be enormous. It would, or should, show the immense difficulties of the problem, and the Commissioners should certainly recommend a permanent scientific bureau adequately endowed for the systematic, continuous, and organised study of the disease. Money thus spent would be invested to the greatest advantage and would be infinitely better expended than in the pursuit of some petty party question which has existence only in the imaginations of heated politicians. Even if the Royal Commission did nothing more than inquire into the effect of cancer "cures," and the claims of irregular practitioners to treat the disease, much good might be done, especially if followed by legislation prohibiting this cruel and nefarious traffic. We have reason to believe that the Cape Parliamentary inquiry into Mrs. Van Niekerk's petition to practice cancer-curing in Cape Colony, which was described in the MEDICAL PRESS AND CIRCULAR at the time, has had a most beneficial effect, and we should warmly welcome a Royal Commission on Cancer, if only as an instalment of the Royal Commission on Quackery, which we have consistently advocated for so long. We hope Sir Henry Campbell-Bannerman will allow nothing to stand in the way of its appointment.

Administration of Anæsthetics.

A considerable amount of public attention has recently been drawn in the lay press to the administration of anæsthetics in the hospitals by unqualified men. As a matter of fact, the administrator is almost always a qualified resident, but now and then the duty is discharged by a senior student. So far as can be seen, there is no particular risk involved if the student be under supervision and is grounded in the principles of the work. The newspapers are making much of the dictum of a well-known anæsthetist to the effect that the danger is with the administrator. As a matter of fact the majority of deaths under anæsthesia take place under the hands of skilful professional anæsthetists. The plain facts of the matter appear to be that there is a certain irreducible minimum of fatal cases and that some drugs are safer than others. Under these circumstances it seems a thousand pities to attempt to prevent students from acquiring an art that they will be certain to need in many emergencies in later professional life. If it can be shown that more deaths occur under unqualified than qualified administrators at the hospitals, there is good ground for reform. On the surface it is not easy to understand why the mere acquisition of a degree or a diploma should increase the capabilities of an anæsthetist. A matter that deserves careful attention is the quality of the drug used. In some cases it is rumoured that cheap and inferior stuff is supplied to certain hospital authorities. At any rate, coroners would do well to inquire carefully into this point in dealing with cases of fatal anæsthesia.

Dugong Oil as Medicine.

The value of readily-assimilated fats and oils in many wasting diseases has long been recognised. Of late attention has been called to the dugong as the source of a medicinal oil, especially in tubercular disease. Thirty or forty years ago Dr. Hobbs, of Brisbane, pointed out the value of dugong oil in consumption, and made the further practical observation that patients could take it in a readily-assimilable form by eating the cured flesh of the animal. Fortunately dugong bacon is famed amongst epicures for its delicacy and toothsomeness, and it possesses, moreover, the sovereign quality of digestibility. As dugong fishing is chiefly a Queensland industry, an excellent opportunity here presents itself of providing our consumptives at home with an excellent remedy, and at the same time of encouraging a colonial trade. We hope to see the dugong oil and other preparations subjected to a thorough trial at our great consumption hospitals and sanatoriums.

The Queen has sent a present of boxes of chocolates to the Chelsea Hospital for Women.

PERSONAL.

We learn that Dr. Theodore Williams has been elected Honorary Fellow of Pembroke College, Oxford.

The Isle of Wight Rural District Council have appointed Dr. J. A. Gibson as medical officer for the rural district of the Isle of Wight, to fill the vacancy caused by the death of Dr. Joseph Groves, who held the appointment for a quarter of a century.

Mr. H. Rider Haggard, J.P. will distribute the prizes in the Governor's Hall, at St. Thomas's Hospital, on June 26th, at 3 p.m.

Dr. Evan Thomas and Dr. John L. Davies have been made Justices of Peace for the County of Monmouth.

Colonel Douglas Duncan has been reappointed chairman, and Professor David Finlay, vice-chairman of the St. Andrew's Ambulance Association.

Dr. R. Welsh Brainthwaite, Inspector under the Inebriates Act, will give the Norman Kerr Memorial Lecture at the Society for the Study of Inebriety, on Tuesday, October 8th.

Dr. Richard Harding, of New Radnor, has been placed on the County Commission of Peace for Radnorshire.

Sir Patrick Manson, K.C.M.G., will deliver the opening address at the first meeting of the Society of Tropical Medicine and Hygiene at 20 Hanover Square, W., on June 26th, at 8.30 p.m.

Mr. C. B. Keetley, F.R.C.S., as Cavendish Lecturer, attracted a large audience on Friday last at the annual function of the West London Medico-Chirurgical Society. An abstract of the lecture will be found in another column.

Professor Schueller, known for his investigations into cancer, has died in Berlin in consequence of infection whilst making experiments with a sort of serum.

At the Bedford County Hospital on June 20th, Mr. C. B. Lockwood, surgeon at St. Bartholomew's Hospital, gave an address entitled, "Some Remarks on Clinical Pathology in its Relation to Diagnosis and Treatment."

The last of the series of post-graduate lectures arranged for the summer session in connection with the Faculty of Medicine at the Birmingham University was delivered on June 20th, by Dr. John Robertson (Birmingham Medical Officer of Health).

It is understood that Dr. Dyer, Medical Officer of Dartmoor Prison, will succeed Dr. George Beamish at Wandsworth Prison. Dr. Beamish is retiring shortly.

The Right Hon. Sir Walter Foster, M.D., is announced to take the chair on Friday next at a public meeting of "The Association for the Prevention of Premature Burial."

At the meeting of the Board of Management of the Salford Royal Hospital on June 20th, the following appointments were made:—Resident Surgical Officer, George E. Seldon, M.D. (Toronto), M.R.C.S. (Eng.), L.R.C.P. (Lond.); House Physician, G. A. Adshead, M.B., Ch.B. (Edin.); House Surgeon, W. S. Moore, M.B., Ch.B. (Glas.).

The new Government lymph laboratories at Hendon costing upwards of £20,000, were on Saturday formally taken over by the Local Government Board medical staff. This is the only Government lymph-producing station in the country.

A Clinical Lecture
ON
DISORDERS OF MICTURITION IN WOMEN (a).

By PETER HORROCKS, M.D.Lond., F.R.C.P.,

Senior Obstetric Physician, Guy's Hospital, Lecturer on Obstetrics and Diseases of Women, Guy's Hospital Medical School, &c.

LECTURE II.

II.—FREQUENT MICTURITION.

This is a very common complaint in women. Sometimes you will find that the patient is always wanting to pass water, and she only passes a few drops at a time, after which she is scarcely at all relieved of the desire. At other times it is not so much the desire to pass it as the fact that she cannot hold it for long. You will be able to differentiate between the two classes of case by careful cross-examination. Again, it may be that she is passing a great deal too much urine, and so, relative to the quantity, it is not too often. Perhaps one of the commonest causes is a so-called *irritable bladder*. It is not always possible to discover the cause of the irritability, but if you can find a cause, it is half the battle in treatment. *Irritating urine*, caused by an excess of acidity, uric acid, urates, oxalates, and phosphates may be the cause. *Cystitis*, no matter how produced, is a common condition found, and may be acute or chronic. A careful analysis of the urine is required. *Gravel* is only excess of the solid ingredients of urine deposited in the bladder, and, passing out no longer dissolved in the urine but precipitated. *Overdistention* is often followed, for a time, at all events, by an inability to hold the urine for long. *Inflammation* round about the bladder, as in pelvic peritonitis, general peritonitis, perimetritis, parametritis, metritis, and vaginitis may produce it.

Urethritis is a prolific cause of painful and often of frequent micturition. During *pregnancy*, especially towards the latter months, it is often impossible to hold the urine long. In *diabetes*, both saccharine and insipid, micturition is frequent, because there is such a lot of urine secreted in the 24 hours. Excessive drinking of fluids acts in the same way, and when there is alcohol in the drink it aggravates it. Occasionally you will find it is due to a very *small bladder*—small congenitally, or following prolonged cystitis or injury to the bladder with sloughing. I have seen two or three cases where the lining of the bladder has been so injured during a neglected second stage of labour that it has sloughed, peeled off, and come out through the urethra. In one of these cases which was under my observation, the bladder subsequently shrank in size so much that it could not retain more than two ounces of urine, so that the lady had to pass it every half hour.

Bright's disease is sometimes indicated by frequent micturition, though in the majority of cases of nephritis it is not present. *Pyelitis* and *pyonephrosis* may cause it. *Injuries* to the bladder, as, for example, parturition, operations, explorations of bladder by dilators, cystoscopes, etc., may be followed by frequent micturition. *Coitus*, especially when excessive, acts in the same way, as does also riding on a saddle, as in *cycling*, especially when the peak is too prominent.

Pessaries which fit badly, or which are left in too long, will cause it.

Prolapse of the anterior vaginal wall with the bladder *(cystocele)* is sometimes the only cause to be discovered.

Displacements of the uterus seldom give rise to it, though you may find the cervix in retroversion and retroflexion apparently causing some irritation of the bladder. Remember that displacements are often compound; for example, you may find prolapse and cystocele, as well as the backward displacements. Pathological *anteversion* may cause it, but *anteflexion*, even when extreme, is mostly congenital, and is not a cause.

Urethral caruncle, *prolapse of the urethral mucous membrane*, *vulvitis*, *thread worms*, *irritation from dirt*, *smegma*, *etc.*, may all cause frequent micturition.

In some cases you will find the urethra apparently very thick, and this is usually due to chronic urethritis and *periurethritis*, mostly of gonorrhœal origin. *Calculus* in the bladder is a cause, but is seldom met with in women. Occasionally a small one gets stuck in the urethra, and becomes buried in the mucous membrane. If detected it can be removed, but if undetected, it may eventually either escape in the urine, or set up a small abscess, or become encysted. Careful examination along the urethra ought to enable you to discover such a condition. *Foreign bodies* in the vagina, urethra, or bladder will cause it. It is met with also, though but rarely, in *tumours*, such as fibroids, ovarious cancers, hydatids. In *extra-uterine fœtation* it is occasionally complained of, though not so often as in ordinary pregnancy.

Finally certain *nerve conditions*, spinal cord diseases, and brain affections will cause it.

TREATMENT.

Remove the cause if possible. Careful *dieting* to lessen the amount of any ingredient of the urine which appears to be in excess. Too much water, tea, coffee, mineral waters, alcoholic liquors must be remedied by taking less. Too much nitrogenous food is often the cause of uric acid troubles. A complete *change of environment* is often most beneficial, because there is not merely a change of air and scenery, but because there is rational exercise in sufficient amount, and a plain, wholesome diet. Hence the good effect of the various *hydros*, *spas*, etc., at home and abroad.

Drugs.—The most popular drug at the present time is *urotropine*. It is given in 10 grain doses in Mist. Acidi Co. ℥j. (Guy's), three times a day, and certainly it is a most useful drug in properly selected cases. My own experience has been that it acts best, speaking broadly, in cases where the urine is alkaline. It often fails to give relief where the urine is acid. One always gives it in cystitis, and it does good as a rule. But it may fail to do good, and in that case you can try one or other of the older remedies, such as buchu, uva ursi, copaiba, sandalwood oil (in capsules of 10 to 20 minims t.d.s.), or the alkalies. Benzoic acid is useful, and salol gr. x. t.d.s. have been recommended. Washing out the bladder is required to cure most cases of chronic cystitis.

(a) Two Clinical Lectures delivered at Guy's Hospital, October, 1906, and January, 1907.

Thompson's fluid, consisting of biborate of soda (borax) ʒj., glycerine ℥jj., and water ʒjj., is a good solution to use once or twice a day.

Two ounces of nitrate of silver solution (1 in 1,000, or even 1 in 500) may also be used.

A 2 per cent. solution of acidi borici; Formalin lotion (1 in 3,000).

Hydrarg perchloride (1 in 10,000).

Nitric acid (2 drops to an ounce).

Sulph quinine, gr. j., ad. ʒj.

Salicylic acid, 1 in 2,000.

Creolin, ½ per cent.

Resorcin, 1 in 750.

Iodoform Emulsion (℈jj. (scruples) ad. ℥j.).

Argyrol (30 per cent. of silver with proteid of wheat). One ounce of a 20 per cent. solution being left in the bladder.

Morphia, gr. ½ in bladder.

The above are some of the substances recommended in the treatment of chronic cystitis.

Hot hip baths and hot vaginal douches often give relief to pain. Sometimes it is a good plan to keep the bladder empty by inserting a self-retaining catheter, to which is attached a short piece of india-rubber tubing, which lies in a small dish between the thighs.

If it be necessary to examine the interior of the bladder, this can be done with a cystoscope, or the urethra can be dilated sufficiently to pass in the finger in order to make a digital examination. It is necessary to dilate with Hegars or some other form of dilator up to a diameter of from 16 to 18 millimetres, according to the size of the operator's finger. After dilatation, it is possible to use a larger cystoscope, and if need be to obtain urine from one or other of the ureters for examination, and to apply treatment to any part requiring it. The patient is apt to have incontinence of urine for some time after such an exploration. The artificial production of a vesico-vaginal fistula, by vaginal cystotomy, may be done in rare cases, for exploration, or treatment, or drainage. Suprapubic cystotomy is seldom performed in women.

In pregnancy posture often relieves the patient. The prone or semi-prone position is the best, but merely lying in a horizontal position is often sufficient, with the the feet raised or not. Any injuries caused by riding on a saddle (horse, cycle, etc.) must be remedied as much as possible. Special saddles are made with no peak or very little. Ladies complain, however, that they cannot ride so well unless there is some peak on the saddle. Still, when damage is done it should be altered, and in some cases complete rest from riding is required. Similarly, it may be necessary to remove or to alter a pessary. Tumours must be removed where possible, and inflammatory conditions in the neighbourhood of the bladder or urethra must be treated. Diabetes and Bright's disease require the treatment due to each, apart from the symptom of frequent micturition. After operations and parturition the complaint does not usually last long, time being all that is required for the parts to recover themselves. In a few cases, however, it persists a long time, and may even become permanent.

Correct uterine displacements and, if need be, fit the patient with a suitable pessary. Remove or cauterize urethral caruncles, and prolapse of urethral mucous membrane.

Urethritis frequently requires treatment by means of a solution of nitrate of silver (10 grains to the ounce), applied by means of a Playfair's probe thinly wrapped with cotton wool. It should be inserted with great care, as it is rather painful, but it is a most efficacious method of treatment. It should be done two or three times a week at first, and less frequently afterwards.

Tubercle of the urinary passages is not common. It is found more often in children and young people than later in life. There may be painful as well as frequent micturition, and sometimes a few drops of blood follow the urine. The tubercle bacilli may be found, and the patient may react to tuberculin. The opsonic treatment seems to afford a better hope of cure than older-fashioned methods.

III.—PAINFUL MICTURITION.

This often accompanies frequent micturition. Sometimes, however, the patient will hold her water longer than usual to avoid the pain set up by the act. The commonest cause is *urethritis*, which is usually of gonorrhœal origin. When acute, the pain is mostly described as scalding. This smarting, scalding sensation, caused by the urine flowing over the inflamed urethral mucous membrane, lasts from a few days to a few weeks, or even months, according to the severity of the case, the sensitiveness of the patient, and the treatment. The pain gradually lessens and finally disappears, long before the urethritis is cured. On pressing the urethra from the sphincter vesicæ to the meatus, a drop of pus is squeezed out. This is considered by some quite pathognomic of gonorrhœa. In *acute cystitis* there is often painful micturition, but it passes off as a rule when the cystitis has become chronic. It is a curious fact that gonorrhœa is not usually a cause of cystitis in women. It produces vulvitis, vaginitis, and urethritis almost invariably, but it seldom spreads into the bladder.

Urethral caruncle. The ordinary one, so frequently met with is very red in colour, much brighter than the pale rose colour of the vaginal mucous membrane. It is usually small, not bigger than a pea, but more pyriform in shape. It is exquisitively sensitive. The pale variety of caruncle is as a rule not at all sensitive, does not cause painful micturition, and is mostly a product of gonorrhœal inflammation. *Irritating urine*, containing pus, blood, urates, oxalates, phosphates, sugar, or too much acidity, may cause pain.

Inflammations round the bladder and urethra (parametritis, perimetritis, and periurethritis), are causes.

Lupus minimus nearly always causes painful micturition, and is often met with in women after the climacteric. You find tiny, painful red spots, mostly with small ulcerated surfaces, which are very tender. Their favourite site is along the line of the hymen or carunculæ myrtiformes up to the meatus urinarius. Hence the urine is apt to flow over them and cause pain.

Growth in the bladder (cancer, villous, polypi-tubercle) may or may not cause pain. In some cases they cause pain owing to the formation of clots, which have to be expelled.

Injuries to meatus urinarius, urethra, or bladder, caused by excessive riding on horseback, cycling, coitus, parturition, accident, operations, kicks, blows, stabs, insertion of foreign bodies into urethra and bladder or vagina, may cause or lead to painful micturition.

Fissures or *ulcers* or *spasm* about the neck of the bladder are rare causes of this complaint.

Eczema vulvæ due to pruritus, diabetes, or other cause, may give rise to pain if the urine flows over any part of it, which will occur in some cases when the parts are greatly swollen.

Foreign bodies are much more frequently found in the urethra and bladder of women than in men. Hairpins, pencils, pens, etc. If within reach it is easy to diagnose the case; but where the substance has passed into the cavity of the bladder, it is not always easy to make it out, particularly as the girl (she is usually young) is too much ashamed to tell what has happened. *Calculi* may cause pain, but it is generally the gravel that accompanies it that is responsible. In rare cases, however, a calculus sticks fast in the urethral canal, and so causes pain. It is easily felt, but it may become embedded and encysted, and cause suppuration, which may open into the urethral canal, or it may open (or be opened) into the vagina. *Cancer* about the meatus, vestibule, vulva, urethra, may have a sore surface which causes great pain when the urine flows over it. In some cases no cause, apparently, can be discovered, and one is obliged to resort to the term *hyperæsthesia*.

TREATMENT.

Acute urethritis and acute cystitis should be treated by rendering the urine as non-irritating as possible, namely, by a careful diet of plain food without any alcohol, the administration of alkalies, a great favourite being the following mixture: Pot. citratis ʒss., Tinct. Hyoscy. ʒss., Inf. Buchu ad. ℥j t.d.s. You must insist on a fresh solution of the buchu to obtain a good result. It is not at all a nice medicine to take, but it is very efficacious. Hot applications over the bladder and vulva give relief, and in some cases, especially if carefully done, a hot stream of water made to impinge on the urethra per vaginam, gives ease. Later, when the acute stage is over, you can apply local applications along the urethral canal, of which a solution of nitrate of silver, gr. x. ad. ℥j., is the best.

The treatment of chronic cystitis has been already described. The ordinary bright-red painful urethral caruncle should be burnt off by means of the thermo-cautery. It is much the best plan to give an anæsthetic in order to save the patient pain, and to enable the operator to burn out the root. It is possible to remove them under cocaine, but you will find this method less satisfactory. A few drops of a 20 per cent. solution should be applied or, better still, two drops of a 5 per cent. solution injected with a needle into the root. Never snip them off with scissors, as they are apt to bleed a long time. Of course, if you are prepared to burn the root after snipping off, well and good. Also never try to tear them off by twisting, or to cure them by a ligature; in both these ways you leave roots from which another caruncle may grow. If, after burning a caruncle out, recurrence should take place, suspect malignancy. It may not be malignant, but it should now be removed with the knife or scissors, the base being cauterized, and the part removed carefully examined microscopically. The pale varieties of caruncle can often be cured by applying lotio nigra, or $AgNO_3$ solution (gr. x. ad. ℥j.). They may be snipped off, or cauterized, if need be.

Irritating urine should be treated by careful dieting, according to the ingredients which are in excess. Frequently it is necessary to lessen the amount of nitrogenous food, and to omit alcohol absolutely. The administration of alkalies, acids, antiseptics, urotropine, must be left to your discretion. You may be called upon to treat kidney disease, or to wash out the bladder.

Inflammation must be treated as has been already described.

Lupus minimus is by no means easy to cure. As a rule sedative lotions give most relief, such as lead and opium lotion; hot boracic acid lotion and the like. But lotio nigra, or touching the spots with the cautery, are more likely to cure them. Growths in the bladder must be removed when possible. Rendering the urine alkaline relieves the pain in many cases.

Injuries must be repaired as far as possible, and any source of injury constantly taking place, such as excessive riding and cycling, must be lessened. Mention has been made of the shape of the saddle, the peak being sometimes too pointed, thus pressing unduly on the lower end of the urethra. Coitus may be excessive or may cause painful micturition through some peculiarity of relative position, even when not excessive, both of which may be remedied if you give suitable advice. Other injuries must be treated on ordinary lines. Tears, cuts, lacerations, may be sewn up. Fissures and ulcers and spasm about the neck of the bladder may be treated by local application of caustics, but dilatation of the urethral canal is, as a rule, necessary. In obstinate cases it may be necessary to do cystotomy per-vaginam and so get at the seat of trouble. Foreign bodies and calculi must be removed. Cancer must be removed if possible. In cases of hyperæsthesia the application of sedatives locally, and alkalies and bromides and the like internally, give the best results. Eczema must be treated according to the cause.

IV.—INCONTINENCE OF URINE.

Sometimes, when the bladder gets over-distended, urine is either constantly or intermittently dribbling away. This is called false incontinence, and is easily diagnosed by discovering the distended bladder, and easily cured by passing a catheter until the normal tone has been regained.

True incontinence is where the urine dribbles away as fast as it flows into the bladder, as, for example, where there is a large vesico-vaginal fistula, or where it dribbles more or less intermittently in spite of the patients efforts at control, and without any distention from retention. The commonest cause of true incontinence is some form of fistula. The commonest is a vesico-vaginal fistula, and is most frequently caused by damage done through the pressure of the child during a prolonged second stage of labour. Given a disproportion of parts caused by a large child, or a small pelvis, or by both, it is obvious that the pelvic viscera will be damaged, particularly if the condition is not recognised early enough to afford relief before the damage is done. As a rule, the incontinence does not begin directly after the child is born. But, more or less, of the trigone of the bladder, with the corresponding portion of the anterior vaginal wall, has its nutrition interfered with to such an extent, and for so long a time, that it sloughs out some days after labour, and leaves a hole between the vagina and the bladder, through which the urine flows as fast as it escapes from the ureters. The patient is constantly wet. If she is in bed everything under her is wet. If she is walking about her vulva and thighs and linen are constantly soaked in urine, which decomposes and gives rise to a strong ammoniacal odour. Deposit of salts from evaporation results, and the irritation and friction of the thighs lead to an eczematous condition of the skin.

Fistulæ may result from the ulcerating progress of cancer of the cervix uteri, vaginal walls, urethra, or, in rare cases, the body of the uterus. They may follow operations on the same parts, and from other injuries, accidental or wilful, and they may be congenital. Sometimes there is true incontinence with hypospadias. In addition to the ordinary and most common fistula, namely, that between the bladder and vagina (vesico-vaginal), you meet with urethro-vaginal, vesico-utero-vaginal, vesico-uterine, and uretero-vaginal fistulæ. Cystitis is sometimes a cause of incontinence. According to some authorities, hysteria is never a cause, and if there is incontinence of urine in a woman with convulsions, it is said this proves they are not hysterical. In an epileptic fit the urine is not infrequently voided involuntarily. When the fit is not epileptic, but simulates hysteria, the mere fact of voidance of urine during an attack brings the case, according to some, into the category of Hystero-epilepsy. I cannot say that I altogether agree with this, for I have seen cases which appeared to me to be genuinely hysterical, and yet where the patient passed urine and wetted herself during the attack, and hence I feel inclined to put hysteria down as an occasional cause, although I am free to admit it is open to doubt. Incontinence is met with also in certain cases where the bladder is displaced by tumours, especially when the neck of the bladder (sphincter vesicæ) is disturbed.

Again, there is an involuntary dribbling of urine in some women whenever they do anything which increases the intra-abdominal pressure more or less, as, for example, during coughing, laughing, sneezing, retching, defœcation, etc., and, *a fortiori*, during heavy work, such as washing, laundry work, lifting patients or other heavy weights, scrubbing floors, etc., or during play which involves strain, such as golf, tennis, hunting, etc. This kind of dribbling is very common in the latter months of pregnancy in some women. You will frequently find it associated with more or less prolapse of the bladder and anterior vaginal wall, especially when the cystocele involves the neck of the bladder and the first portion of the urethra. Incontinence sometimes follows dilatation of the urethra by dilators, cystoscope, etc.

Nocturnal incontinence is met with chiefly in children. Every child requires training, but it takes a much longer time to train some children not to wet the bed during sleep than others. Where this bad habit remains, it is in some cases apparently no more than a bad habit, in others it is hereditary, and in some instances it is distinctly the result of a bad dream, the urine being voided at that point of the dream where the individual is in terror. Most of these cases dating from childhood get better about or soon after puberty. If you find a case where good habits were instilled in childhood, and where nocturnal incontinence has begun subsequently, as, for example, after puberty, always suspect epilepsy. It has been my privilege to see many cases of nocturnal incontinence due to unsuspected epilepsy, either the Petit or Haut Mal. In one case the mother told me her daughter was always very lethargic, and had a headache the morning after there had been nocturnal incontinence. In another case a little blood was found on the pillow, and on examining the tongue I found it had been bitten during the epileptic attack. In another the pillow was always wet with salivary foam, caused by the fit. In any case, therefore, of nocturnal incontinence coming on, say, after puberty, or even before, when there has been some years of a normal condition, it is as well to make minute inquiries to throw light on the possibility of epilepsy as the cause, and to get the patient to sleep with her mother, sister, or lady relative or friend, or a nurse, in order to establish the diagnosis. This is easy if it be a case of Haut Mal, but difficult in the Petit Mal instances. The diagnosis of the latter can be fairly established when the patient only occasionally passes urine in her sleep, and when on each of those occasions she wakes up with a headache and feels lethargic.

TREATMENT OF INCONTINENCE.

Marion Sims first became famous by his success in repairing vesico-vaginal fistulæ, and since his time the evolution of asepsis has made possible the repair of fistulæ which used to be considered hopeless. Some are quite easy to do, and some very difficult. It is not always possible to cure a case by one operation, it may be necessary to do it in two or more steps. The edges of the opening are made raw, and are then carefully brought together by sutures, and the bladder is kept empty by means of a self-retaining catheter until the surfaces are united sufficiently to hold—that is, for three or four days at least. If catgut be used, it will not be necessary to remove the ligatures by cutting them, at any rate. If silk, or silkworm gut, be used, then, of course, they must be removed in seven to ten days. Incisions of cicatrices to loosen the parts, separation of bladder wall from vaginal wall, separation of bladder from anterior surface of the cervix uteri, may be severally required to permit the raw edges to be brought together.

In some cases transplantation of mucous membrane has been successful. Colpocleisis, or closing the vagina, is condemned by some authorities. I have no experience of it, but I think it is worth trying in bad cases. When it is impossible to cure the case the question of wearing a urinal arises. I have never come across a satisfactory urinal. They are expensive and inconvenient, and troublesome to keep clean, and so I generally recommend such patients to wear a thick pad of some highly absorbent and cheap material, throwing it away as often as need be. The thighs and vulva are to be protected by smearing over them some unguent like vaseline.

Incontinence due to bruising and injuries must be treated by rest, hot application, and drainage of the bladder, and, if need be, temporary cystotomy. Cystitis must be treated as already described. Hysteria must be treated by studied neglect. Cystocele requires a suitable support, according to its severity. A small ring pessary, a Galabin's anteversion cradle pessary, or a red rubber cup and stem (Napier's) pessary, are, I think, the three best. Colporraphy is seldom required. Incontinence following dilatation of the urethra usually gets well itself after a few days. If not, assistance may be given by the application of astringents.

Nocturnal incontinence is treated by careful training, giving little fluid at night before going to bed, giving large doses of belladonna, in some instances beginning with ten drops of the tincture bellad. in a little syrup and water, it has been found necessary to gradually increase the dose up to as much as sixty drops or more of the tincture every night before attaining the desired result. Its physiological effects must be watched carefully. Sedatives, such as opiates and chloral, are sometimes useful. The injection of half a grain of morphia, in solution, into the bladder has been recommended, as has also a solution of nitrate of silver, 10 grains to the ounce. It must always be remembered that children tend to grow out of the habit as they obtain and pass puberty. When due to epilepsy, of course the cause is of far greater import than the symptom. The epilepsy must be treated. The dribbling from over-distention is treated by catheterism, a self-retaining catheter being worn for a time if requisite. Sedatives and injections into the bladder are sometimes helpful, but a little time and patience is all that is usually necessary so long as the cause of the retention can be removed. The dribbling in pregnancy is best treated by posture, the prone or semi-prone being the best. That which occurs during coughing and other strains is treated by curing the cough, diminishing the strain if possible, giving astringent vaginal injections, or fitting a suitable pessary.

HÆMATURIA.

Always make sure that the blood does come from the urinary passage. As you know, menses often get into the urine, and sometimes blood from other parts, such as from the cervix uteri, or from piles, may simulate hæmaturia. Whenever there is any doubt, it is well to obtain a catheter specimen and examine it when freshly drawn. Be sure it is blood. Test for albumen, and blood, and see the corpuscles under a microscope. The blood may come from the urethra, bladder, ureter, or kidneys, and, theoretically, it may get into those urinary passages from neighbouring parts, though this is rare. Probably the most frequent cause of hæmaturia in women is congestion or inflammation of the kidneys in pregnancy, especially in primiparæ. You may get it from the same cause apart from pregnancy. Injuries to the kidneys or any part of the urinary passages, calculi, pyelitis, cancer in kidney, ureter, bladder, or urethra, cantharides and other drugs, some fevers, and the bilharzia hæmatobia, all cause hæmaturia. Tuberculous disease sometimes affects the kidneys, or ureter, or bladder, and may cause some hæmorrhage. In a few cases the hæmaturia is factitious.

The treatment of hæmaturia resolves itself into the treatment of its causes. In the common form of congestion, and perhaps inflammation, of the kidneys associated with pregnancy, and particularly in primiparæ, you have to carefully estimate the amount of albuminuria, the amount of urea, and the state of the patient. A threatening eclampsia may necessitate the premature emptying of the uterus, which will usually relieve the kidney condition. The hæmaturia in these cases is not of long duration, but subsides sooner or later into mere albuminuria. Cancer tubercle and injuries must be treated as the case requires. Bladder tumours can often be removed, either by dilatation of the urethra, vaginal or supra-pubic cystotomy, and then the use of the finger, knife, scissors, snare, or cautery,

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Leonard Williams, M.D., M.R.C.P., Physician to the French Hospital, London, Assistant Physician to the Metropolitan Hospital. Subject : "Some of the Organic Consequences of High Blood Pressure."*

ORIGINAL PAPERS.

THE VALUE OF THE WIDAL REACTION IN THE DIAGNOSIS OF TYPHOID FEVER, AS ASCERTAINED BY ITS USE ON 230 OCCASIONS (a).

By W. JAMES WILSON, B.A., M.B., D.P.H.Camb.

Riddel Demonstrator in Pathology and Bacteriology, Queen's College, Belfast.

The apology I have to offer for bringing at this late date this subject before a meeting of this Society is the fact that many clinicians here are still unconvinced that the Widal test is thoroughly reliable, and fail to recognise that apart from the isolation of the typhoid bacillus it is the most specific factor to be reckoned with in the diagnosis of enteric fever.

Before dealing with an analysis of the cases, I should like to mention some of the essentials necessary to obtain accurate results in performing the test :—

(1) The strain of bacillus employed.—A culture is required which forms a uniform emulsion in saline solution, and which is readily clumped by typhoid immune serum, but which has no tendency to form "pseudo"-clumps. A young (*i.e.*, 12-24 hours old) Agar culture should always be employed, as the bacilli then clump readily when the specific agglutinins are present, but do not form spontaneous clumps.

(2) I have found a 1 in 50 dilution of the serum and a time limit of 1 hour satisfactory.

It must be borne in mind that it is not possible in every case to say definitely that the reaction is positive or negative. In most cases a definite expression of opinion can be given; in a few, however, in which indefinite clumping and loss of motility occur, one cannot be dogmatic. In making a diagnosis in such a case, one would have to be guided by the other signs and symptoms. To make my meaning plain, I should say that in performing the Widal test we do not always get black or white effects, but occasionally grey.

ANALYSIS OF THE CASES.

Of the 230 cases, 112 gave a positive and 118 a negative reaction. Of the 112 positive reactions, 108 were definitely pronounced positive, whilst four gave indefinite clumping and were pronounced "feebly positive."

Let us first of all dispose of these four cases. One of them was eventually diagnosed gastritis, a second mild typhoid, whilst two were cases of typhus fever. On inquiry it was found that both these typhus fever cases had had typhoid fever; one of them nine years previously, the other at a later date.

The previous attack of typhoid fever probably accounts for the reaction occurring in these cases, as I have found that the blood of a healthy individual who had had typhoid fever 22 years ago still caused a feeble agglutination of the typhoid bacillus in 1 in 50 dilution of the serum. I may add that I have examined the blood of four other cases of typhus fever, and have found it give a negative reaction.

Of the 108 cases definitely pronounced positive, 105 were suffering from typhoid fever at the time, one, a case of influenza, had had typhoid fever six months previously, one had purpura, and another a disease which was not typhoid fever. In these last two cases it was not ascertained whether the patients had previously had typhoid fever.

Taking the Widal test to indicate that the patient either was suffering from or had suffered from typhoid fever, we find that this is indicated in 109 of the 112 cases giving a positive reaction; in other words, the laboratory diagnosis corresponded with the clinical course of the disease in 97.3 per cent. of the cases.

Of the 118 negative results, 108 had not, whilst 10 had typhoid fever. In other words, our results were correct in 91.5 per cent. of the cases.

REMARKS ON SOME OF THE POSITIVE CASES.

A case which shows the value of the Widal test, and its immense service in the sphere of preventive medicine, is the following :—A woman, the wife of a byreman, had an attack of what appeared to be influenza complicated with jaundice. The patient was back at her work—milking cows—three weeks after the onset of the illness. A fortnight after the woman resumed milking an outbreak of typhoid fever occurred in the Windsor district of Belfast, and it was found that nearly all the cases, some 30 in number, received milk from this particular dairy. On inspection by the Public Health Authorities it was found that the premises occupied by this woman were in a highly insanitary state. A specimen of the woman's blood sent to the laboratory for examination gave a markedly positive reaction with the typhoid bacillus. The woman was then prevented handling the milk, with the result that three weeks later the last case among customers supplied with milk from this dairy occurred. I have no doubt that the secretions and excretions of this woman contained the typhoid bacillus.

(a) Read before the Ulster Medical Society, March, 1907.

The noteworthy points in this case are: (1) That an infection with the bacillus typhosus may be present and yet the patient may not present the classic symptoms of typhoid fever; (2) That in this case the examination of the blood indicated the cause of the outbreak, and the information afforded was proved to be correct by the subsequent history of the epidemic. Epidemics which at first sight appear to support the *de novo* origin of typhoid fever may be due to the fact that the carriers of infection have not presented a typical clinical picture. Cases of catarrhal jaundice due to the typhoid bacillus have been reported in patients who had not suffered from typhoid fever (*vide Lancet*, February 23rd, 1907). Many years ago Dr. T. Houston of this school reported from Sir John Byers' wards a case of cystitis due to the typhoid bacillus, and found that the blood of the patient clumped the bacillus. No history of a previous attack of typhoid fever could be elicited.

A case, the blood of which gave a positive result, but in which the clinical course was quite unlike typhoid, subsequently developed purpuric spots, and the diagnosis of purpura was made. Here we may note that De Benedetti (Arch. de Méd. des enf., 1904) has shown that many cases of purpura simplex are due to infection with B. coli communis. Osler mentions that one may get erythema nodosum in the course of typhoid fever. This case, then, if not an instance of infection with the typhoid bacillus, may have been an infection with a closely allied organism.

REMARKS ON SOME OF THE NEGATIVE RESULTS.

It was my custom, on finding a blood give a negative reaction in a case in which the physician in charge strongly suspected typhoid fever, to try to get a catheter specimen of urine, on the chance of finding in it a Paratyphoid bacillus. This procedure brought to light a rather interesting case. A woman, æt. 22, was admitted into one of Professor Lindsay's wards with a history of malaise of over a week's duration. Her temperature was 103.5, pulse 114; she had also the flushed face, severe frontal headache, and distended abdomen characteristic of typhoid fever. Her blood gave a negative reaction. It was found that she had complete constipation for a fortnight. On the day after admission, as the result of an enema, her temperature dropped two degrees. On the following day, after a second enema, her temperature became normal, and continued normal.

The interesting feature of this case was that during the time the girl was in hospital she was excreting large numbers of B. coli communis in her urine, although she had no symptoms of kidney or bladder trouble. The spleen was palpable, and on a certain day she had a dozen typical typhoid spots on the abdomen. Her blood continued to be negative to the bacillus typhosus, and it had no agglutinative action on the colon bacillus isolated from her urine.

This was probably a case of "fæcal fever," a condition for the occurrence of which Nothnagel cites reputable authorities.

In this case bacteriological examination showed that not only toxines, but bacilli also, were absorbed from the intestine and excreted in the urine.

Two other of the negative cases are of interest as being examples of "worm fever." The general appearance of the patients suggested typhoid fever, the temperature was 102 deg. F. After a few days each of the patients passed two round worms, and after this the symptoms cleared up.

Examination of the urine in another negative case in which the medical attendant strongly suspected typhoid fever showed that it contained a pure culture of a streptococcus of the fæcalis type. Inquiry elicited the information that the illness came on after confinement. This was evidently a case of septicæmia. The patient eventually got quite well.

A case of typhoid which showed that it may be late in the disease before a reaction is given was that of a medical student. On two occasions his blood gave a negative reaction; when tried a third time, just before convalescence set in, it gave a positive result.

A short account of a case which appeared to me, and to Dr. E. H. M. Milligen (Belfast), under whose care the patient was, to be one of generalised blastomycosis, may be given here.

The patient suffered from tonsillitis, accompanied by moderate pyrexia. A swab from the throat revealed the presence of yeast cells, which grew at body temperature, and which had no tendency to form filaments such as are met with in cultures of oïdium albicans. The yeasts were found by Professor Symmers on intravenous inoculation to kill a rabbit in two days. The patients general condition may be described as one of continued fever. At times there was pain and swelling of the knee and wrist joints. A pneumonic condition of the lungs occurred in the middle of the illness, and numerous yeasts were found in the blood-stained sputum. Yeasts were also found in two catheter specimens of his urine, but these did not grow at body temperature. After a lingering illness of five months duration the patient died, but, unfortunately, we were unable to get a post-mortem examination. The opsonic power of the patient's blood tested on the yeasts isolated from the throat was double the normal.

This, so far as I know, is the first occasion on which the opsonic index of a person's blood with regard to a pathogenic yeast has been tested. I have found that in films stained by Leishman's method the yeast cells take on a greenish colour quite different from the dark violet colour of the nuclei of the cells with which otherwise they might be confounded.

NOTE.—Since reading the above paper in conjunction with Professor Symmers I have examined the blood of 20 cases of cerebro-spinal fever with reference to its action on the typhoid bacillus in dilutions of 1 in 50 and upwards. On 15 occasions the reaction was negative, on five it was positive. In an epidemic of cerebro-spinal fever the blood of some of the cases may clump the typhoid bacillus in as high dilutions as 1 in 200, and yet the clinical picture and the post-mortem findings point to cerebro-spinal fever. But the agglutinative effect of the blood of cerebro-spinal fever patients on the bacilli of the coli-typhoid group we reserve for a special communication.

Society of Apothecaries of London, June, 1907.

The following candidates passed in:—*Surgery*.—M. L. Ford (Section I.), Charing Cross Hospital; S. F. Fouracre (Section II.), Charing Cross Hospital; O. C. H. L. Moll (Section I.), Guy's Hospital. *Forensic Medicine*.—P. D. Pickles, Leeds; G. L. Walker, Leeds. *Midwifery*.—J. M. Murray, Royal Free Hospital and Durham. A. Sheppard, Guy's Hospital. The diploma of the society was granted to the following candidates, entitling them to practise Medicine, Surgery and Midwifery:—S. F. Fouracre, A. Sheppard, and G. L. Walker.

CONSERVATIVE SURGERY IN ABDOMINAL OPERATIONS:

An Abstract of the Cavendish Lecture. (a)

By C. B. KEETLEY, F.R.C.S.,

Senior Surgeon to the West London Hospital.

There are Liberals and Conservatives among surgeons as among politicians, remarked the lecturer; some, perhaps, too ready to remove parts, and others too anxious to preserve them. After referring to the desirability of not removing ovaries and tubes unnecessarily and of preferring, where it could be safely done, the enucleation of fibroids to hysterectomy, he spoke of the vermiform appendix. In February, 1888, Treves, in a now classical paper read before the Royal Medical and Chirurgical Society, described his first operation on this organ. This was what is now known as an "interval operation." A distorted appendix was straightened out and then left in the peritoneal cavity, but Treves recommended that in future appendices which had caused recurrent attacks of appendicitis, should be removed. The appendix was then and for the next sixteen years regarded as a mere vestigial organism of no value to anybody except the pathologist and the surgeon. But in 1904, Macewen threw doubts on this view, based partly on the after-history of some of his cases and partly upon observations made in a case in which a portion of the abdominal wall had been accidentally removed as well as of the cæcum, and the orifice of the appendix exposed to view. Further, Weir, by his first operation of appendicostomy, had demonstrated that the appendix could be put to a surgical use.

What inference was to be drawn? Why that when about to amputate a given appendix we should ask ourselves whether, in that particular case, it would not be better to preserve it, reverting to the original conservative operations of Treves and of Charters Symonds (who had removed fæcal concretions from the appendix, leaving the organ *in situ*), but modifying them considerably, so as to give them safety and sufficiency.

How was that to be done? The answer was, by transferring the appendix from the peritoneal cavity and embedding it in the abdominal wall, and by opening or amputating its distal end, if its lumen was anywhere narrowed by stricture or by other cause—not a mere appendicostomy in which all but the stump of the organ is cut off, but the preservation and transference of the whole or of the greater part of the appendix. The cases for this proceeding had to be carefully selected. A fair length of the proximal part of the appendix should be free from stricture, kink, ulceration, and perforation, or it should be possible to cure such defects by, *e.g.*, opening the appendix at its distal end. Various kinds of appendix, of which a list was enumerated, were unsuited for preservation, *e.g.*, the tuberculous and actinomycotic. It was important to take care of the appendicular artery. Most of the appendix was to be placed on the external oblique beneath the fat.

The lecturer then spoke of the surgical treatment of chronic constipation. He referred to Mansell Mouillin's application of ileo-sigmoidostomy to this purpose and, at considerable length, to Mr. Arbuthnot Lane's contributions to this department of Surgery. The lecturer did not think that much could be expected from ileo-sigmoidostomy as a treatment of chronic constipation. The fluid fæces must quickly find their way back from the sigmoid or from the rectum up through the whole length of the colon, which, indeed, when the lower end of the ileum was completely divided, became one long cæcum. Experience and experiment showed that this was exactly what did take place. He ridiculed the practice of referring to the cæcum as a cesspool. It was a rounded bag of living tissue, with an aperture of egress of diameter nearly equal to its own, with a lining of secreting and of absorbing epithelium, and a muscular wall. It was compressed by the muscles of the abdominal parieties, and it contained nearly always, gas rather than fæces.

With regard to excising the colon for habitual constipation, that might seem to some the practical application of Metchnikoff's theory of the influence of the bacteria of the large intestine in causing the degenerations of old age. But it was not the only way in which these bacteria could be dealt with. There was Metchnikoff's own plan of a special diet of fermented milk, there were hygienic measures, including strict sterilisation of food, and cleanliness begun in early infancy, and there was appendicostomy.

For the surgical treatment of obstinate chronic constipation, the lecturer himself practised appendicostomy. He had operated in nine cases of the kind, in every one of which the operation had answered its purpose, *i.e.*, the large intestine could be washed out through the appendicostomy with warm water, mixed in some of the cases with a proportion of the sulphates of soda and magnesia. An appendicostomy properly performed was a clean opening not giving egress to fæces, and not requiring a catheter to be kept in. Certain drawbacks were mentioned and modes of dealing with them, and a special catheter noticed. It was made by Montagu of New Bond Street, it was of rubber, and had a long tapering point beyond the eye.

(a) Delivered before the West London Medical and Chirurgical Society, June 21st, 1907.

CLINICAL RECORDS.

THREE CASES OF ACUTE PNEUMONIA.

By S. J. ROSS, M.D.,

Surgeon for Out-patients, Bedford County Hospital.

The first case is that of a youth who caught a chill after a cycle ride. The morning after the cycle ride he complained of a slight sore throat and pains in his limbs. The following evening he had a rigor, and when I saw him his temperature was 104 deg., he was breathing rapidly, and there was impaired resonance at the base of the right lung with crepitations. I ordered a Gamgee jacket to be applied, placed him on milk diet, and gave him an effervescing quinine mixture to be taken every four hours. Crisis occurred on the seventh day, and the patient made an uninterrupted recovery.

Case 2. A child, æt. 6 years, had an attack of vomiting, refused food because it hurt her to swallow, and became feverish. I saw her on the third day of her illness. She was restless, constantly putting her finger in her left ear, had a temperature of 103 deg.; respiration, 26. She had a patch of broncho pneumonia in her left lung. The same evening the left ear discharged pus, which was very thin, and yielded the diplococcus. Crisis occurred on the fifth day. The child made an uninterrupted recovery, the perforation in the left tympanic membrane rapidly healing.

Case 3. The patient was a baker by trade, æt. 75 years. I saw him on the fourth day of his illness, which commenced with a rigor. His left lung was solid, and he had consolidation of the base of the right lung. His pulse was full and regular. Never at any time during the attack was there any sign of circulatory failure. On the fourteenth day I was summoned to see him as he had suddenly collapsed. His temperature I was informed was normal, and he was bathed in perspiration. Crisis had evidently occurred. I saw him about an hour later. He was bathed in profuse prespiration, and was almost pulseless. I gave him a hypodermic injection of strychnine, and a pint of saline by the bowel, but he never rallied, and died about one hour after I saw him.

These cases appear to be of interest for the following reasons: The first two patients complained of sore throats in the initial stages of their attacks. Doubtless the offending organisms primarily attacked the tonsils. The first case shows how simple treatment is required for an uncomplicated case of acute pneumonia occurring in a robust patient. We are apt to forget that pneumonia is a specific fever which runs a definite course, and our chief duty is to watch the circulation carefully, to discover complications if such arise, and treat them energetically.

The second case is of interest on account of the pneumococcic otites which complicated the pneumonic attack. Doubtless this infection occurred from the tonsils by way of the eustachian tube. Unfortunately children do not expectorate, and therefore I could not obtain any sputum for bacteriological examination. It is noteworthy how rapidly perforations in the tympanic membranes of children heal, if the parts be kept clean. I have noticed frequently that pus from a pneumococcic infection is thin, and apparently far less offensive than pus produced by other organisms.

The third case is a warning. The patient's circulatory condition throughout the attack was always satisfactory. No stimulants were given, and when the crisis occurred circulatory failure for the first time appeared. We are apt to regard the crisis of pneumonia as an unmixed blessing, but in aged patients it may, as in this case, spell disaster. I do not think that our medical works lay sufficient stress upon this point. Therefore I think that the notes of such a case as this may help other practitioners to avoid disaster. Many similar cases must have happened in other practitioners' practices, but alas! we hear little of failures but a great deal about successes. It would be a most useful venture if you would publish a "confessional number" of your valuable paper.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

Case of Tuberculosis of the Occipital Lobe.—Mr. Edred Corner operated on a woman, æt. 34, who for many years had suffered from headache and sickness. She had been in several hospitals where she had been treated without success. During the last year or two her vision had become affected: she could see objects, but the field of vision was much contracted. Ophthalmoscopic examination showed optic neuritis of both eyes. Thus she presented the three classical symptoms of cerebral tumour: headache, vomiting and optic neuritis. The headache was referred to the back of the head. She presented neither motor nor sensory symptoms. Operation had been offered to her previously, but had been declined. She had been admitted to St. Thomas's Hospital at her own desire, to undergo operation. The diagnosis made was a tumour above or below the tentorium cerebelli. The right side of the occipital region of the head was, Mr. Corner pointed out, hyperæsthetic to touch and very painful on percussion. The scalp was shaved and prepared previous to the patient being brought into the operating theatre. It had been determined to explore the right occipital region of the skull in the hope of either removing the tumour or of relieving the intra-cranial pressure and ameliorating her symptoms. After a large flap had been turned down from the occipital region of the skull, the bone was trephined. The dura mater, when the disc of bone had been removed from the trephine opening, bulged. The opening was then enlarged so as to expose the lateral sinus which, Mr. Corner had already pointed out, lay between the layers of the tentorium. It was in consequence a useful guide to the operator, as the occipital lobe of the cerebrum lies above it and the cerebellum lies below it. When the opening had been sufficiently enlarged the dura mater below the sinus was incised to expose the cerebellum, which was found to be pale and compressed by the downward bulging of the tentorium. Under these circumstances it was not interfered with. It would be a great pity, Mr. Corner said, to injure the cerebellum, as it swells subsequently, and having the strong tentorium above it, would tend to compress the medulla oblongata which is below it. The dura mater above the lateral sinus was then incised freely to expose the occipital lobe. The source of this patient's trouble was now exposed to view: the brain was adherent to the upper surface of the tentorium; it was studded with tuberculous foci which varied in size from that of a millet seed to that of a small marble; the smaller of these foci were grey, the larger were yellow and consisted of caseous material. The disease was greatest on the posterior and under surface of the lobe, where the tuberculous foci were largest and most plentiful. From these areas the disease extended forwards, the foci decreasing in quantity the further forward they were present. The character and extent of the mischief forbade the practice of any radical measures, and it was necessary to be contented with drawing the flap of dura mater over the surface of the brain. It was not advisable, Mr. Corner thought, to attempt to close the incision in the dura mater in such a case because the only object which the operation could attain was to relieve the intra-cranial pressure, and this might be defeated if the dura mater was sutured. The skin flap was replaced and united with stitches of silkworm gut and the wound dressed.

Mr. Corner said that the operation relieves the headache, the sickness, and stays the optic neuritis. The patient would be much relieved. In their convalescence these patients are prone to develop a hernia cerebri, the results of their raised intra-cranial pressure. This hernia may give a great deal of trouble to those who look after the case. It can only be relieved; it cannot be cured, as it is merely a sign or symptom of the intra-cranial disease, which the operation has been powerless to eradicate. It was, he considered, of assistance in obviating the development of this hernia if at the operation the surgeon was careful to make a large aperture in the skull, because it was a clinical fact that herniæ form more easily through small openings than large ones. This can easily be accomplished by enlarging the original trephine opening by means of Hoffman's forceps; for the effective use of instrument the operator must not be too ambitious, contenting himself with removing small fragments and not attempting to wrench off larger pieces. In tearing away larger pieces of the skull dangerous accidents happen from time to time, such as one of the sinuses being torn. If a little care be exercised in separating the dura mater from the inner table, it is quite easy to remove the bone from over these sinuses.

The woman was much improved by the operation; her symptoms subsided. She developed practically no hernia cerebri. She died in a couple of months from extension of the tuberculosis.

We have been officially notified that the Local Government Board have established new premises for the preparation and distribution of glycerinated calf lymph for the use of public vaccinators, and have notified that all applications for calf lymph should now be addressed to the Government Lymph Establishment, Colindale Avenue, The Hyde, London, N.W.

TRANSACTIONS OF SOCIETIES.

BRITISH GYNÆCOLOGICAL SOCIETY.

Meeting held June 13th, 1907.

The President, Mr. W. Spanton, F.R.C S., in the Chair.

The President said it had been his misfortune on each occasion of their meeting to have to refer to the death of some valued Fellow of their Society. That night it was especially sad to know that their latest loss was their valued honorary president, Dr. Robert Barnes. He had a vivid recollection of the energy Dr. Barnes displayed in the formation of that Society, and probably but for his enthusiasm it would never have been founded. They were deeply indebted to him for the good work and the stimulating influence he brought to bear upon it, and deeply regretted that his declining health prevented him from taking a more active part in recent years. They deplored his loss and desired to express their sympathy with his family in their sad bereavement.

Dr. **Macnaughton-Jones** moved the following resolution of regret:—

"That we, the Fellows of the British Gynæcological Society, desire to express our feelings of deep regret at the loss the Society has sustained through the death of our Honorary President, Dr. Robert Barnes.

"To a large number of the Fellows this loss is a personal one, inasmuch as he was not only their honoured chief, but also in the years that have passed a valued counsellor and friend. His active interest in the work of the British Gynæcological Society from its foundation up to a comparatively recent time, the prestige his name and presence lent to our proceedings and meetings, and the mature judgment of one of the most cultivated minds in the profession, were of incalculable value to the Society, and materially assisted in placing it in a foremost position amongst the scientific medical societies in this country.

"We wish further to record our conviction that no obstetrical authority in England during the past century achieved so remarkable a success as a clinical teacher and lucid writer in this department of medicine. His works were classical, epoch-making, and universally read.

"In character truth-loving, fearless, honourable, and sincere, Robert Barnes has left us a bright example of the highest type of the cultured physician. Only those exceptionally gifted can hope to leave such a record behind them, but he has bequeathed to us all the precious heritage of his life's history as an example for us to imitate.

"In order to convey to his relatives in some faint and imperfect manner proof of the regard in which he was held in this Society, and to express our sympathy with them in their loss, this resolution is unanimously passed."

Dr. Macnaughton-Jones moved the resolution adding the remarks that will be found on page 711.

Dr. **Macan** said it was a great honour to be asked to second that proposal. He endorsed every word that had been said about their lamented honorary President, especially what was stated concerning his literary merits, because these particularly appealed to himself. He was sure every Fellow present would feel that they had lost one whom it would not be easy to replace.

The resolution was carried in silence.

Mr. **Mayo Robson** read a paper on "The Modern Treatment of General Peritonitis," of which the following is a short abstract:—

Mr. **Mayo Robson** said he introduced the subject of peritonitis from a general point of view. Many cases of what was described as shock were really due to sudden and rapid septic absorption and might be avoided by the adoption of preventive treatment. He had seen benefit from the use of anti-streptococcic serum, and if it was always possible to recognise the organism or organisms causing the condition, something could be done to relieve peritonitis. He advised early operation, which, if undertaken within twelve hours of the onset ought to result in saving the patient, if within twenty-four hours there was a probability that the patient's life would be saved; whilst if later there was only a bare chance. The operation should be as short as possible with little exposure of viscera, and the least amount of damage to the abdominal contents. It was not necessary to remove all the pus, as part consisted of dead cells, and the remainder of leucocytes whose office was to destroy the organisms producing the condition either directly or indirectly, and in this way assist nature in restoring the normal condition. Having removed the cause and instituted drainage they should introduce as much fluid as possible either by the rectum or transfusion, and then place the patient in a sitting posture in order that septic fluids might gravitate to the most dependent position.

Sir **William Sinclair** said puerperal peritonitis was the only form that he would refer to. At the present time everybody interested in obstetrics said no time ought to be lost. He would like to quote a case of his own. A woman in Manchester was sent to the hospital by a midwife, who had seen that something was wrong. The next day the patient was ill, had a rigor, high temperature and rapid pulse with constant vomiting and distension. He suggested that the abdomen should be drained and flushed with saline fluid. The flushing was carried on until no turbid fluid was returned; the abdomen was then closed up, the uterus curetted, swabbed and packed. The patient made a perfect recovery. The only drawback was the anæsthetic. He would advise a large dose of morphine to begin with, to be followed by alcohol, and then almost any abdominal operation could be performed, and as soon as it was over sleep would follow. That was the result of his experience of the treatment of puerperal peritonitis, and if patients were watched and treated well they would never have puerperal peritonitis.

Mr. **Charles Ryall** said that the less handling, irrigation or swabbing of the abdominal viscera, so much the better would it be for the patient. A simple laparotomy and drainage gave the most satisfactory results. As to the administration of morphine it had to be considered from the standpoint of the general practitioner and from that of the surgeon. A woman was perhaps seized with sudden pain and sent for the doctor. The pain might be due to perforation or something else and the doctor was bound to give something to relieve it. After abdominal section there always was stasis, and no doubt morphine had a tendency to increase it. The best drainage was by absorption, and the sooner they got the bowels to act the better. He believed in early evacuation of the bowels whether after a simple abdominal section as a preventive measure or after abdominal drainage as an acute measure.

Dr. **Heywood Smith** said that calomel in large doses acted like a charm, and was one of the best ways of giving relief and bringing down the temperature.

Mr. **Alban Doran** said they had a great deal more to learn about peritonitis. The great principle of treatment was to anticipate peritonitis. Where there was shock he deliberately poured in a considerable quantity of saline fluid because that was the best stimulant, far better than any venous injection and far better than the old plan of beef tea enemata. He thought when once peritonitis had appeared it was questionable whether it was advisable to give opium.

Dr. **Bedford Fenwick** said he found benefit from raising the body into a sitting posture when there seemed to be evidence of impending toxic poison. He had had several very bad septic cases in which calomel followed by sulphate of soda was given and it was found impossible to get the bowels to act. In each case the difficulty was removed by raising the patient to a sitting posture in bed. In that way distension of the colon was removed, and also to a large extent danger from upward pressure on the heart. In many cases the heart's action was more or less weakened, and if in addition there was distension of the colon, the result was frequently heart failure. Another point, and one to which he thought attention was not sufficiently directed was the real danger of too much washing out. The avoidance of drainage and washing out were points of very practical importance in treatment of cases of abdominal section.

Dr. H. **Macnaughton-Jones** said in puerperal septicæmia, his experience had been that when the opium had to be administered the case generally proved fatal. The application of ice over the whole surface of the abdomen on the appearance of symptoms of puerperal peritonitis was a most effective treatment as a preventive. Puerperal septicæmia began in the pelvis, and the object should be to limit the spread of the peritonitis. He thought that no modern surgeon in a case of approaching puerperal septicæmia would fail to see that the uterus was free from all toxic products by curettage and free flushing out of its cavity with some bactericidal fluid. As to the administration of calomel, he very much preferred small doses given at frequent intervals to large doses. The most important question of all in cases of general peritonitis was whether to open the abdomen early or only to treat the symptoms. For years he had not flushed out the abdomen except on one or two occasions and that was under very exceptional circumstances. He used mops, contusing the bowel as little as possible and using very weak solutions of formalin. When there had been an escape of fœtid pus into the peritoneal cavity, by simply opening and evacuating the pus, gently mopping out the abdominal cavity, and then employing free drainage, the patients had recovered. He preferred, in the early stages of drainage, the wide rubber tube, as a rule, to gauze. The free use of saline artificial serum by the rectum was most valuable. The first part of the paper was one of great importance, showing that shock was due to a rapid septic infection. In cases of impending shock, the better plan was sub-clavicular or sub-mammary infusion. What he learnt that evening from Mr. Robson had been the application of more recent bacteriological knowledge to the relation between shock and sepsis, and the advantage of forestalling sepsis by the methods that had been advocated. The rest of the paper had been more or less on lines on which for a number of years he had acted, and which he thought were followed by abdominal surgeons generally.

Dr. J. H. **Dauber** remarked that they had heard a great many antagonistic methods of procedure that night. There was one method alluded to that had been little discussed that night, but in which lay their real hope in the future, namely, the anti-toxin method of treatment. Most cases of peritonitis were due to absorption of some toxin and the abdomen was not always full of pus in these cases. People talked about opening the abdomen and putting in a drainage tube, but there was very often nothing to come out at all. The intestines were often merely engorged and red and that only to a slight extent. and the patient died with high or low temperature, distension or otherwise. Dr. Dauber instanced two cases in which antistreptococcic injections had apparently saved life.

The **President** said the author had shown in a lucid manner that many methods of treating peritonitis which had been in vogue were now found to be failures, and that gynæcologists had at last come back to doing as little as possible, and leaving nature to do as much as she could for them.

Mr. **Mayo Robson**, in reply. said his intention had been to bring forward a general subject that might be of interest to the Society, and which they could discuss rather from the point of view, not only of pelvic but also of general surgery. As to the use of antistreptococcal serum, if they could always know the organism with which they had to deal, if they could have the combined anti-toxins and if they could regulate the dose, doubtless they could do something to erlieve general peritonitis by injections. Certainly in puerperal peritonitis where the poison was the streptococcus they would expect to get the greatest benefit from antistreptococcal serum. He had seen benefit from serum in some of those cases. But in the greater number of cases of general peritonitis where they were dealing with the bacterium coli, sometimes with the pneumococcus, and sometimes a combination of the streptococcus with other cocci not much benefit had been apparent. He would say as the first essential, operate as early as they could. An operation for general peritonitis, though the pertonitis be diffuse, if undertaken within twelve hours of the onset, ought to result in saving the patient, if within twenty-four hours the probability was that the patient's life would be saved, if later it was a great chance as to whether life could be saved. They should do as short an operation as they could, they should take care to avoid as much as possible exposure of the viscera, they should do as little damage to the contents of the abdomen as possible, removing the causes whether the cause were the appendix or a Fallopian pus tube, or any other. If the peritonitis were due to perforation of the intestine or duodenum or stomach they should repair the perforation because while they were relieving the tension and removing the effect by drainage they wanted to avoid any other organisms being manufactured and poured into the peritoneum. Let them avoid sponging and washing, and take out as much pus as they could conveniently do, without troubling themselves if they had to leave a little behind. He warned them that they should not create more damage than the pus would do. They should, as he had just said, remove as much pus as they possibly could, because most of the pus consisted of dead cells, but the outer part of the pus consisted of living cells which actively aided Nature. After removing the cause, and draining, and helping Nature by getting in as much fluid as they could either through the rectum or by transfusion they should prop the patient up as nearly in the sitting posture as possible in order that septic fluids might gravitate to the least dangerous part of the peritoneum, from which they could be drained away.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

The annual provincial meeting of this society was held at the County Hospital, Bedford, on June 1 th.

Dr. R. H. **Coombs** in the chair

Dr. C. O. **Hawthorne** opened a discussion on

ACUTE RHEUMATISM IN CHILDHOOD.

He referred to the considerable change which had taken place in the professional view of the age incidence, and to the special characters which distinguish the disease in children, especially the frequency of cardiac complication, which he attributed partly to the absence of restraint of the child's activities resulting from the comparative escape of the joints, and he advocated the practice of informing the parents of rheumatic families of the risks involved even in the apparently trivial illnesses of their children. He thought there was too ready a tendency to apply the term rheumatism to isolated events the nature and origin of which were obscure. He also discussed the curative and prophylactic treatment.

Dr. **Ewart** suggested that the glandular condition of early childhood was less prone to favour retardation in the joints, and the child could rid itself of disease in the joints and it would find a seat elsewhere. He suggested calomel and antiphlogistic remedies in the treatment of endocarditis.

Dr. **Morrison** referred to erythema nodosum, which is not limited to rheumatic subjects It is generally preceded by tonsilitis at an interval of ten to fourteen days. He looked upon this as its incubation period.

Dr. **Hartley** (Bedford) said that in that town, on the banks of a river, with damp climate, it would be expected that rheumatism would be very common, but his experience did not bear this out.

Dr. **Sutherland** thought it was a mistake to prolong rest in bed after active endocarditis had passed away. This was frequently done owing to the reappearance of a murmur He referred to cases of recurring subacute rheumatism, where salicylates failed. He considered there was some source of infection which was not discovered.

Dr. Cautley read a paper on

CEREBRO-SPINAL MENINGITIS.

He referred to the different varieties and the relative age incidence as an aid to diagnosis; also the relationship of the sporadic to the epidemic variety, the means of diagnosis, including lumbar puncture, &c.

Mr. Tubby read a paper on

CONTRACTION OF THE TENDO ACHILLIS

as a cause of the following symptoms: Pains in the calves, shambling gait, sprained ankle, everted feet, turning in of the toes, &c. The contraction of the calf muscles produces lessening of the angle of dorsiflexion of the foot, and shortening of the stride in walking. It is usually due to infantile paralysis, and can be remedied by lengthening the tendon.

Mr. Skelding described a case of "Bilharzia," in a boy, æt. 11, who came from Rhodesia. The symptoms were great drowsiness and hæmaturia, the ova were found in the urine.

Dr. Harry Goldsmith described a condition occurring in children, to which he gave the name of "œdema of the limbus." There were photophobia, injection of the ocular conjunctiva on which are small grey nodules, which never break down. It is rapidly cured by the yellow oxide of mercury ointment.

Clinical cases, pathological and microscopical specimens, and skiagrams were shown by Drs. Goldsmith, Ross, Coates, Phillips, Waller; and by Messrs. Johnson, Sharpin, Skalding, Nash, and Verry.

After the proceedings a well-attended dinner was held at the Swan Hotel, Mr. Clement Lucas being in the chair.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, June 23rd, 1907.

THE LATE PROFESSOR VON BERGMANN.

A commemoration celebration in memory of Ernst von Bergmann is to be held in Berlin on June 29th. Various societies, such as that for post-graduates, that for first-aid and the Aerzte-Kammer of Berlin and Brandenburg have united for the purpose, and invitations to be present will be sent to all scientific societies and other institutions with which the deceased was at all closely associated.

At the Medizinsche Gesellschaft Hr. H. Nicolai described a process by which a

Graphic Representation of the Heart's Action

could be shown. A platinum wire, freely moving between the poles of an electro-magnet is deflected by the strength of the current passing through, and the deflections are fixed on a photographic plate. The experiment was first performed and proof shown on the exposed heart of the dog and afterwards on the living subject.

Hr. Kraus saw an expression of a condition of excitement in the registering of the stream of action of the heart. He showed a large series of curves that he had taken of healthy and diseased hearts. He believed the procedure had an important practical future before it; as it was delicate and exact, and did not call for exertion on the part of the patient. Naturally a good deal would have to be done in the way of study and experiment before results free from ambiguity could be reached.

At the sitting on June 5th Hr. Toby Cohn showed a woman, æt. 64, whose history revealed nothing special, particularly as regarded syphilis. For from 10 to 12 years a great increase in size had taken place in her head that, previous to this, had been normal. Its circumference was now 68 cm. The surface was smooth. Large sinuous and dilated arteries were present over the temples; they pulsated freely. Subjectively there were noises in the ears and some loss of hearing power. It was a case of osteitis deformans (Paget) of the skull, not of leontiasis, as the skull was everywhere smooth. This was shown by the Röntgen image, that showed also enormous thickening of the bony skull.

Hr. J. Israel showed a patient in whom he had diagnosed

Calculus of a Horseshoe Kidney

from palpation. Six years ago the patient began with attacks of colic in the right side. The speaker could then by palpation recognise the connecting part between the kidneys, and diagnosed a horseshoe kidney; at the same time he felt a hard movable body on the right side which was painful on pressure. Palpation always brought on hæmaturia. He exposed the kidney through a large opening, opened the pelvis, removed the stone, and sutured the renal pelvis by a triple row of sutures. Healing *per primam*. Two years later there was pain on the left side. The left kidney was not so readily palpable. This time he made a transperitoneal opening, again removed a a stone after opening the pelvis of the kidney, closed up the wound; the patient recovering. The urine however, still remained thick and the pyelitis continued. Last April the pain was again so severe that the patient presented herself again. The speaker now felt a large calculus with enlarged renal pelvis. He made renal opening on the left side, opened up the kidney extra-peritoneally and removed a rather large stone after incising the kidney. The kidney parenchyma was brought together by suture, the pelvis drained and complete disappearance of the pyelitis followed.

Hr. Grünbaum showed a case of

Primary Carcinoma of the Vermiform Appendix.

The patient was a young girl who had had extirpation of the ovaries and tubes performed in Landau's Klinik for suppuration. At the operation a carcinoma was discovered on the vermiform appendix. She had passed through two attacks of appendicitis shortly before this. The appendix was attached It was the second case of the kind that had been seen in Landau's Klinik during the past year. The process was quite normal at the base, but showed a thickening the size of a cherry at the tip; there were no nodules on the serous surface. The growth was first recognised to be carcinomatous on microscopical examination.

The observation showed how important it was to examine the vermiform process whenever laparotomy was being performed and remove it if it showed signs of any change.

At the Verein für Innere Medizin Hr. Blechroeder showed purpuration from a woman who had died from

Hæmorrhage from Varices of the Œsophagus.

She had been admitted into hospital five weeks before. She was very fat and a drinker. She complained of undefined abdominal pains and suffered from free bleeding from hæmorrhoids. The heart was normal, also the lungs; there was a good deal of urobiline in the urine. On Friday before there was a good deal of hæmorrhoidal bleeding, which ceased after some hours. There was thought to be cirrhosis of the liver, and the patient was put on a dry diet. The following day there was severe hæmatemesis, the heart failed and the patient sank with œdema of the lungs. The autopsy showed hæmorrhage from ruptured varices of the œsophagus. When shown—in the preparation—they appeared insignificant, and not likely to be the source of such severe hæmorrhage. These varices appeared, as was known, from backward pressure from cirrhosis of the liver and might lead to serious hæmorrhages. No varices were visible, but only the collapsed veins. Litten was the first to draw attention to the condition. The liver, spleen and œsophagus were shown, also the sawn off thigh with its red bone marrow.

AUSTRIA.

Vienna, June 23rd, 1907.

Exostosis and Chondroma.

Huberer presented a patient to the members of the Gesellschaft who had been exhibited to the same body in 1887 as a typical case of multiple enchondroma. In the course of time the man had several of these enormous swellings removed at varying intervals as they became troublesome, first commencing with the left forearm, then the right forearm, followed by the left foot. The left forearm had to be amputated at a later period. After the limbs the swellings commenced over the pelvis, upper parts of the limbs, ears, and thorax, till the whole body is now invaded by a typical form of exostosis with chondroma.

Syphilis Maligna Præcox.

Noble showed a patient who had scarcely been four months infected, yet widespread destruction in the tertiary form could not have caused such devastation. The phagœdenic primary sore had quite destroyed the foreskin and penis integuments, with gangrene of the glans and forepart of the corpus cavernosum and urethra. The lymphatic glands of the groin soon became confluent, infiltrating a large area and finally breaking down. This sclerotic and ulcerative condition extended even to the head. The patient was a strong well-built individual at first, but rapidly degenerated in strength and appearance. He was not addicted to drink, which confirmed the opinion that the virus was of a mixed nature rapidly developing an endotoxin which produced the rapid destruction. Throughout this brief history every effort was made by microscopic examination to discover the spirochæta bacillus in the ulceration infiltration and other integuments, but without success.

Disinfection.

Dœrr exhibited a new method of disinfecting rooms and other places by using permanganate of potash with formalin and water, formaldehyde being given off. Two kilogrammes of permanganate of potash, formalin and water cost 4 frs., sufficient to disinfect 100 cubic metres of space. The advantage of this method is cheapness; it is non-poisonous, no expensive apparatus is required, nor even special skill in operation. Weiss remarked that he exhibited an apparatus at the last sitting of the Society for disinfecting catheters and other instruments by a similar use of autan. This substance he contended was a most effectual gas in destroying malignant germs.

Escherich remarked that his experience with these substances required careful closing of doors, windows and other apertures in order to obtain the results described by their proposers, although they consider it unnecessary to take this precaution.

Flick (Gratz) usually forms this substance into a hard roll and then evaporates it when required.

Puerperal Therapy.

Alexander continued the discussion on this subject with reference to the removal of thrombi in the prevention of pyæmia and recorded forty-five cases of otitis, where he removed the thrombus with success. He was still more dogmatic on the importance of tying the jugular vein before operating on the ear, and the necessity of thorough drainage. The lateral sinus thrombi are often thread-like or punctiform producing circumscribed phlebitis. The organised thrombus is usually cylindrical closing the whole lumen of the vessel and must be removed entirely from the sinus by enucleation. The jugular thrombi, however, are most irregular in shape and size, and common in the pyæmia from otitis. The mortality by this operation has been reduced from 81 per cent. to 22 per cent., and the meningitis or purulent encephalitis from 77 per cent. to 25 per cent.

Indian Medical Service.

An Examination for Commissions in the Indian Medical Service will be held in London on Tuesday, July 23rd, 1907, and the four following days. Particulars regarding pay, promotion, etc., in the Service and the necessary forms of application can be obtained from the Military Secretary, India Office, London.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

The Treatment of Consumption.—At a special meeting of the City Council held last week the arrangement already mentioned in this column was ratified, the Council to have at their disposal 25 beds in the Forster Green Hospital, paying 35s. per week per bed occupied. The arrangement had been suggested by the Public Health Committee, but was not accepted by the Corporation without prolonged discussion, some of the members being keen to start at once to the erection of a municipal sanatorium. The arguments against this are several; one is the fact that the Workhouse sanatorium is only just started, and time should be given to see how it works before another is launched in Belfast. Another reason is that in the course of a few years the Forster Green Hospital will come into several large sums of money, and will be enabled greatly to extend the accommodation of the hospital, so that a municipal sanatorium may not be needed. It seems an exceedingly sensible thing, then, to adopt the course that has been decided upon, for the agreement is for ten years, which will allow the Corporation to see how things work, and will also make it worth while for the authorities of the Forster Green Hospital to provide the extra accommodation. The only point on which no information is yet forthcoming is the position of the honorary medical staff towards the Corporation patients.

Cerebro-Spinal Meningitis.—The number of cases of this disease notified last week rose slightly, being 17 as against 13 the week before. The deaths numbered 15, being 5 more than the week before. Of the 81 patients in Purdysburn fever hospital, 36 are suffering from cerebro-spinal fever.

Typhus Fever in Newry.—The town of Newry, in co. Down, is at present suffering from rather a severe outbreak of typhus. There have been about six deaths, including that of Dr. J. J. O'Hare, a young practitioner only qualified five years ago. Dr. Clibborn, the Local Government Board Inspector, is inquiring into the circumstances of the epidemic, and the Public Health Committee has decided to utilise the baths in Canal Street as an isolation hospital, as there is no room in the Workhouse hospital.

Ulster Medical Society.—The annual meeting of this Society was held in the Medical Institute, Belfast, on Thursday evening, the 20th inst., the President, Dr. D. P. Gaussen, in the chair. The annual report read by Dr. Howard Stevenson, the hon. secretary, and the statement of accounts presented by the Hon. Treasurer, Dr. Fielden, showed the society to be in a flourishing condition. The total membership numbering 175. On the motion of the secretary, an alteration was made in the rules to facilitate the admission of officers in the various public services who may only be stationed or on leave in Belfast for short periods. The following were elected office-bearers for the Session 1907-8:—President, Dr. John McCaw; vice-presidents, Dr. Wallace, Knockahollet, co. Antrim; and Mr. A. Fullerton; hon. secretary, Dr. Howard Stevenson; Hon. treasurer, Dr. Victor Fielden; hon. editorial secretary, Dr. Rankin; hon. librarian, Dr. Story; Council, Drs. Craig, Houston, Johnstone, McQuitty, Robb, and Professor Symmers, with the Trustees of the Institute, Drs. John Campbell, Dempsey, Lindsay, McCaw, Mitchell, Nelson, and Cecil Shaw. The President-elect, Dr. John McCaw, is senior physician to the Belfast Hospital for Sick Children, and has for many years taken an active part in the work of the Society, having been successively honorary secretary, treasurer and vice-president. It was announced at the meeting that the Lindsay Challenge Golf Cup will be played for on the Malone Links, Belfast, on Thursday, July 4th. It is hoped that some of the country practitioners in town for the Post-Graduate Course at the Royal Victoria

Hospital may enter for the competition. It is played by strokes under handicap (not exceeding 20), the first eight to qualify to play off by holes.

LETTERS TO THE EDITOR.

PHYSIOLOGY AND PRACTICE.

To the Editor of The Medical Press and Circular.

Sir,—The opinions which I wish to express on the above subject have not been hastily or summarily formed, but are the outcome of several years' experience in extensive practice, as well as in many physiological laboratories. It is often difficult or impossible to convince others of certain things of which we are ourselves fully convinced. While believing that such attempt at conviction in the present instance is unnecessary so far as the majority of your readers are concerned, yet I write with the object of advancing a plea for a wider and more careful study of physiological processes than is generally devoted to them by the average practitioner.

It is unnecessary to mention in detail the simple methods which we learned, or thought we learned, as students, and which one sees forgotten or neglected in practice. Yet these methods are not only useful but absolutely essential to correct observation and treatment of morbid conditions. Quite a large proportion of students who, in their second or third examinations, have successfully negotiated such obstacles as herone bases and amino-acids, or steered clear of such quicksands as balance-sheets and diet-tables, utter a fervent "Deo Gratias" for having done with the disagreeable subject for ever. Many, it is true, even when hampered by difficulties, persevere in maintaining the knowledge acquired because they appreciate its value.

Anything like adverse criticism of the present-day teaching of physiology is far from my mind. But I would suggest that a more systematic reference by teachers to the all-important practical bearing of the subject, to the application of the methods in the treatment of disease, would help materially to allay the vicious tendency of the student to study this branch of science purely for examination purposes.

The annual introductory addresses at the medical schools are interesting and instructive. Perhaps they would be no less so—even a little more so—if prefaced or concluded by an appeal to students to bear in mind that the study of physiology is the backbone of the study of medicine, that it has not been introduced into the medical curriculum to test their powers of memory at examinations, that it will be of vital importance in practice, and that it must be a matter of life-long study. It is not enough, as it may be argued, to read isolated physiological facts in medical text-books. It is the interest which the practitioner takes in the subject as a whole which prevents him from overlooking its facts. Many medical men, of course, cannot do regular, or irregular, work in a laboratory; but an occasional short course is within the reach of most practitioners. They would be immensely pleased with it.

In conclusion, let me state, even at the cost of repetition, that an exact knowledge of normal functions is wholly essential to correct observation of pathological processes and to sound treatment of the same. Failing this, we may be "so blinded as to overlook the truth which is tumbling out, so to speak, at our feet."

Was du lerns't, das lerne recht;
Was du mach, st, das mach' nicht slecht!

I am, Sir, yours truly,
D. T Barry, M.D., F.R.C.S.Eng.,
Demonstrator of Physiology, Queen's College, Cork.

QUACKERY AND PRACTICE BY COMPANIES.

To the Editor of The Medical Press and Circular.

Sir,—The Bill for the prevention of illegal practice under the cloak of the Companies Acts has been duly examined by the Committee of the House of Lords, and no doubt some of its promoters of an optimistic temperament look forward with confidence to its acceptance by Parliament during the present and some future session. I venture to assert that it is really a matter of very little importance whether the Bill becomes law or not. It could have no appreciable effect upon quackery. It would no doubt put to inconvenience a small proportion of fraudulent quacks—certainly not more than one in a hundred of the mass—but it would not hinder them for one day in the pursuit of their nefarious games. To illustrate this I send enclosed some dozen advertisements from London and country papers, including to its shame, be it always said, the *Times*, which, I point out by the way, seems sinking lower and lower beneath the high standard of conduct it formerly maintained. To legislate against fraudulent practice must prove futile unless the blow aimed cannot be evaded; and it is to me amazing that the promoters of the present Bill should not have recognised the weakness of the weapon they were forging, and that they should have incurred the waste of force involved. They can have known very little about quacks, their cunning and resourcefulness. They seem not to have recognised that they could not possibly establish indisputably the case for legislation by the method adopted, that they could not demonstrate clearly that the system they wished to put a stop to was a system of cruel and shameful fraud. Tinkering with the law in such a fashion will never do much good. The present effort has resulted, no doubt, in the enlightenment of a few Peers as to the seamy side of medical life, but it is certain that beyond this few, none of our legislation in either house have been made a jot less ignorant than they have always been on this subject. If the labours which have been devoted to this futile attempt had been directed to the promotion of a Royal Commission the whole story of quackery might have been unfolded, the chapter relating to medical and dental companies would in due course have been also laid bare; the directors of the companies could have been compelled to appear to refute the charges which would have been made against them, and to justify their existence before a competent tribunal. If I speak confidently or dogmatically it is, at any rate, after more than thirty years study of the subject; and this latest episode has further strengthened my conviction that the only way towards satisfactory medical law reform lies through the medium of a Royal Commission. I trust you will continue to keep this question to the front until it receives full recognition from the profession.

I am, Sir, yours truly,
Henry Sewill.

June 16th, 1907.

OBITUARY.

PROFESSOR EDWARD HALLARAN BENNETT.

We announce with regret the death of Professor Edward Hallaran Bennett, which took place at his residence, 26 Lower Fitzwilliam Street, Dublin, on Friday, June 21st. His death was not unexpected, as he had been in failing health for a long time. During the past six weeks he became progressively weaker, and when the end came he peacefully passed away. The primary cause of his death was apparently a form of anæmia. More than two years ago he found himself unequal to the task of delivering his professional lectures in Trinity College, and it became necessary to appoint a deputy to carry on his work. He continued, however, to act as surgeon to Sir Patrick Dun's Hospital until October of last year, but his strength then began to fail so rapidly that he felt obliged to resign his hospital appointment. Indeed from this time onwards he was confined entirely to the house.

Edward H. Bennett was fifth son of the late Robert Bennett, Barrister-at-Law and Recorder of Cork. He was born in that city on April 9th, 1837. His mother was a daughter of William Sanders Hallaran, M.D., of Cork, who published some medical works of repute.

Professor Bennett received his early education at Hamblin's School in Cork, but was subsequently educated at the Academical Institute, Harcourt Street, Dublin. From this institution he entered Trinity College, Dublin, and graduated in 1859 as B.A., M.D., M.Ch. He obtained the fellowship of the Royal College of Surgeons of Ireland in August, 1863. He became University Anatomist in 1864, his predecessor being the late Dr. John Kellock Barton. On the death of Professor R. W. Smith in the year 1873 he was appointed to the chair of surgery in Trinity College. Both appointments carried with them a surgeoncy to Sir Patrick Dun's Hospital. In subsequent years he was made Consulting Surgeon to Dr. Stevens' Hospital, to the Royal Victoria Eye and Ear Hospital, and to the Dental Hospital of Ireland. In the year 1884 he became President of the Royal College of Surgeons in Ireland, and in the year 1900 the honorary fellowship of the Royal College of Surgeons in England was conferred upon him.

Professor Bennett took a deep interest in the Royal Academy of Medicine in Ireland, and acted as the president from 1897 to 1900. During the viceroyalty of the Earl of Dudley he was surgeon-in-ordinary to his Excellency the Lord Lieutenant of Ireland. He represented Dublin University on the General Medical Council for several years, but resigned the appointment two years ago when he felt unable to attend the Council meetings.

Edward Bennett was a man possessed of an attractive personality. With students of medicine he was immensely popular, and generations of undergraduates who attended his lectures and surgical demonstrations were wont to allude to him as "the Boss." They listened to his stories with keen delight, and wondered at his intimate knowledge of surgical lore and his familiarity with the works of the great surgical masters of the past.

As a hospital teacher Bennett was eagerly listened to by his students. His diagnoses were often brilliant, and prior to the X-Ray era his wonderful diagnostic skill in obscure cases of fracture and dislocations was widely recognised. The character of the man was most clearly revealed in his hospital work, and many of those who in byegone years accompanied him on his rounds through the wards will remember the considerate regard which he evinced for his patients. For all he had a pleasant word, a genial smile and full-hearted sympathy. By his juvenile patients especially he was beloved, and he loved them. Indeed it was remarkable how quickly he succeeded in gaining their confidence and setting their fears at rest.

As a surgeon Professor Bennett may justly be regarded as a representative of the older school, although he was quick to estimate the value of modern methods and carry them into execution. It is generally admitted that he was the first to introduce Listerism into Dublin. As a young man he came into close association with Professor Robert William Smith, and it was through the influence of this great surgeon that Bennett acquired such a deep interest in all matters appertaining to injuries and diseases of bones and joints. He made this branch of surgery his hobby, and he has left behind him in the surgical Museum of Trinity College a priceless collection of specimens. Whenever Professor Bennett made a communication on any subject bearing on osseous pathology he showed himself a master of his subject, and made it replete with interest for his hearers. He made many and valuable contributions to surgical literature, the principal of which dealt with the subject of fractures. He was the first to recognise a form of fracture implicating the base of the metacarpal bone of the thumb and in modern surgical works it is alluded to as Bennett's fracture. When he ceased active work in the University it was decided to perpetuate his memory by means of a suitable memorial. A large sum of money was contributed by his old pupils, a portion of which was set aside to found a money prize for the candidate who obtained the surgical travelling prize. With the remainder two medallions, representing Professor Bennett's profile, were struck; one has been placed in the surgical theatre of the medical school in which he lectured; the other occupies a conspicuous place in the hall of Sir Patrick Dun's Hospital. In addition to the medallions, dies were struck for a Bennett medal to be awarded to the student coming second in order of merit at the surgical travelling prize examination. The medal is of bronze. On one side Professor Bennett's head is seen in profile and the following inscription—"In Honorem Edward Hallaran Bennett, Prof. Chir., 1906." On the opposite side is represented the metacarpal bone of the thumb showing the fracture associated with his name and the inscription—"Viri In Fractis Ossibus Collocandis Solleritissimi."

As a friend Bennett endeared himself to all who knew him. Beneath a somewhat blunt exterior there lay a kindly disposition and a depth of geniality which few could fail to appreciate. He was a loyal colleague, and one with whom it was not merely a pleasure, but also an honour to be associated. He will long be remembered as a warm friend, a delightful companion, and an ornament to the surgical profession.

The funeral took place on Monday, June 24th, and was attended by a large and representative gathering Professor Bennett's late colleagues in the medical school of Trinity College and a large body of students in collegiate dress followed the *cortège* to Mount Jerome Cemetery. The President and members of Council of the Royal College of Surgeons, and the President and many of the Fellows of the Royal College of Physicians attended to pay the last tribute of respect to the memory of one for whom they entertained a genuine regard.

SPECIAL ARTICLE.

THE LATE ROBERT BARNES, M.D., F.R.C.P., F.R.C.S.Eng. (a)

By H. MACNAUGHTON-JONES, M.D.

It may be truthfully said of our late Honorary President, Dr. Robert Barnes, "Nullum quod tetigit non ornavit," and it is a proud boast of our Society that, from its inception, his name has been inseparably linked with its history. It was characteristic of Robert Barnes that he was ever on the side of progress and advance from the time that he began life as a general practitioner, up to his latest years. It is an interesting fact in his history that he was the son of the Founder of the Gardens of the Royal Botanical Society of London, and here there may have been a hereditary link that connected father and son in their love of nature and the natural sciences, as Robert Barnes was a Vice-President of the Meteorological Society and Fellow of the Linnean and Geographical Societies. The City of Norwich has the honour of having been his birthplace, as it has of being that of many other distinguished men in our profession. Having begun life in that best of all schools for preparation for devotion to a special study, that of a general practitioner, Barnes was one of those who waited not on opportunities, but created them; and therefore there was a good deal of struggle in his early professional days, both when he was studying in Paris in 1842, and after his return to London. As with many another worker he had to a great extent to rely on his pen. His acquaintance with languages began during his studies when at school at Bruges, and afterwards in Paris—a knowledge which was of material assistance to him in after life. His extensive practical acquaintance with obstetrics may be estimated by the mere recital of the various hospitals in the Metropolis in which he served—as obstetric physician to the London Hospital, St. Thomas's Hospital, and his own old hospital, St. George's, besides being consulting physician to the Royal Maternity Charity, the East London Hospital for Children, and the Hospital for Diseases of Women and Children, and the Seamen's Hospital.

(a) An address delivered at the British Gynæcological Society June 13th, 1907.

His reputation abroad was shown by the honours conferred on him by his election to various foreign societies, and the estimation in which he was held at home by his holding the Honorary Fellowship of the Royal College of Surgeons of England, the Honorary Fellowship of the College of Physicians of Ireland, and the Honorary Fellowship of the Royal Medical and Chirurgical Society, as well as of the Medical Society of London and the Obstetrical Society of Edinburgh. He was Honorary President of the Glasgow Obstetrical and Gynæcological Society, and Honorary President of three International Congresses of Obstetrics and Gynæcology—Bordeaux, Geneva, and Amsterdam. He was one of the original Fellows of the Obstetrical Society of London, and followed Henry Oldham as President in the year 1865, the first two occupants of the chair being Rigby and Tyler Smith.

In medical literature Barnes held much the same position in regard to his style of writing in obstetric medicine that Watson did in his "Principles and Practice of Physic." Clear in expression, leaving no ambiguity on the mind of the reader either as to his own opinion or the definite directions given regarding practice, yet withal in language simple but classical, we may truly say that his writings showed the man. The *Lancet* has paid a graceful tribute to the value of his contributions to, and his long association with that journal. His "System of Obstetric Medicine and Surgery," written in conjunction with his son, Dr. Fancourt Barnes, appeared at a time when gynæcology was emerging out of chaos, and passing from what we might term its colloid into the earlier stages of a crystalloid state, and though full of the most valuable clinical instruction, necessarily suffered from the rapid advances, especially of an operative nature, which practically made a new science of gynæcology in the years immediately succeeding its production.

Different has it been with his "Lectures on Obstetric Operations," of which Pajot, in his introduction to the French edition said: "The clearness of the style is perfect. . . . Clinical truths are sown over every page of this book. . . . Great questions in obstetrics are treated with accurate good sense . . . at each instant by some remark or other is revealed a superior mind ripened by having seen much and meditated much."

Having availed myself largely of these lectures, which appeared first in the same year that I obtained my University Chair, for which I had the honour to be recommended by the writer, I found them invaluable for teaching purposes, and I think that you will agree with me in the statement that no more concise, lucid and safe work on operative obstetrics has ever issued from an English pen. His name will ever be associated with the advocacy of the use of the long forceps, and the form of it which he devised, as with mechanical dilatation of the cervix in labour, and the management of placenta prævia.

In Great Britain there are some names which stand out as sign-posts marking the various stages in the progress of obstetrics, such as those of Smellie, Oulde, Chamberlain, Denman, Rigby, Simpson, McClintock, and Matthews Duncan, and the last of these is that of Barnes. He was one of those fortunate favourites of the gods for whom so great was their love that they endowed him with perpetual youth. Only last year he attended in the gardens founded by his father the meeting of the provincial Fellows of our Society called together to discuss with those of the Metropolis the scheme for amalgamation with the Obstetrical Society of London in the formation of the new section in the Royal Society of Medicine, and one of the last acts of our Council was to make one of our conditions for amalgamation that he should be elected an Honorary Fellow of the new society.

"Les dieux," says M. Jaccoud, "qui habitent l'Olympe boréal doivent à la céleste vertu des pommes d'or du Walhalla le mystérieux privilège d'échapper aux atteintes de l'age ; mais une condition absolue domine et commande cette apparente immortalité : l'usage de ces fruits inestimable doit etre quotidien ; s'il est un seul jour suspendu, le miracle cesse, et la sénilité conjurée reprend tous ses droits." (*a*)

After a lifetime of medical practice, at an age which few are permitted to reach, retaining health and faculties, he died in full mental vigour, having led a life :

Unwarped by bias, and from rancour free,
Above the trivial brawls that envy breeds;
His mind an index of a soul that soared
Outside the petty bonds of hostile creeds.
Through life his straight and even course he kept
His goal the truth ; and this the path he trod—
The highway Science marks for suffering's needs,
And Duty paves with stones rough hewn by God.

REVIEWS OF BOOKS.

LLOYD ON HAY FEVER (*b*).

THIS little book contains a clearly written account of the conditions known as hay fever and hay asthma. A brief *resume* of the opinions of leading writers on the subject discloses the belief that hay fever may be caused by a great variety of excitants other than pollen. The author discussed fully the action of pollen, of dust, and of temperature, to each of which he assigns a definite place in the ætiology of the disorder. Among predisposing causes he mentions the neurotic element, and quotes the interesting case in which an attack was induced by smelling an artificial flower. Another predisposing condition is that of adenoids. An interesting view of the pathology of hay fever is that which classes it among the neuroses for the reason that its principal manifestations are the result of a temporary arrest of vaso-motor control of the vessels of the nasal mucous membrane. Since Voltoline's clinical case of asthma was cured by the removal of a nasal polypus, the belief has become generally established that a certain percentage of cases of asthma are due to intra-nasal disease. The author is specially good and clear in dealing with the question of treatment, whether connected with some special pathological nasal condition or otherwise. He finishes by giving notes of a number of clinical cases and their practical treatment. Mr. Lloyd's little volume will be found of service to practitioners who are called upon to treat the troublesome minor ailment with which it deals.

(*a*) Discourse: "Un Salut à la rue Bonaparte." Académie de Médicine, Paris, 1902.

(*b*) "Hay Fever and Hay Asthma." By William Lloyd, M.R.C.S., Surgeon Ear and Throat Department, Kensington General Hospital &c. London: H. J. Glaisher. 1907.

WEBER ON MINERAL WATERS AND HEALTH RESORTS. (a)

The publication of a new and greatly enlarged edition of this well-known book of reference is sufficient evidence of the important position now occupied by physical therapeutics in modern treatment. In chronic and even in some acute maladies the question of environment is a large and important one, and it is becoming recognised more and more that the conditions of life, occupation, and surroundings in which a malady is engendered are not exactly the conditions favourable to recovery. For this, among other reasons, the question of "Where shall I send my patient?" is one often cropping up in the mind of the busy practitioner, and the possession of such a mass of information as is contained in this volume, upon the many possible places to which he may be advised to go, cannot fail to be of the greatest value. The ground covered is so extensive, and the number of health-resorts is so large, that the process of selection becomes more and more bewildering. Indeed, the time is not distant, surely, when more attention will be devoted to Balneology and Climatology in the medical curriculum, and an elementary knowledge of the subject become necessary before qualification. It is surely as important that a patient should be sent to the right health resort as that he should have the correct medicine prescribed for him, and when one has heard the maledictions heaped on the head of the unfortunate young practitioner who has sent his patient to the slushy discomforts of St. Moritz in April or October, or to the tropical heats of, say, Montreux in August, the appearance of a reliable book of reference such as this cannot fail to find a welcome. In looking at a book of reference of this sort, perhaps the best way of testing its value is to look up a few places one knows well, and to find out how the information given accords with one's own knowledge. Tested on these lines, the details given of many health stations of the best class, and of others comparatively insignificant, are found to be fairly accurate. During the last few years, a great deal of attention has been directed to our own health resorts, and it has repeatedly been pointed out that there are comparatively few advantages to be gained at a foreign spa which cannot be obtained just as well or better in our own country. When one considers the sea-crossing, the long and fatiguing railway journey, and the discomforts of most continental hotels it is obvious that it is only the invalid of the most robust order who should be sent so far from home; and yet one meets with English invalids at Carlsbad, Homburg, and Wiesbaden, and especially at Nauheim, in the most desperate condition, sent out, too, by "my London physician," and finding themselves in a crowded health resort, and submitted to the routine treatment of medical men, the most popular of whom at each resort are so overworked that they have not the time at their disposal to give the attention such cases demand. For these, at least, a home resort would be infinitely preferable, and, as the continental spas are described and recommended with such detail, it is disappointing to find that the home spas are but scantily noticed, and where they are alluded to it is, in many instances, but to damn them with faint praise. Take, for instance, Woodhall Spa (p. 265). The statement is made that it has much weaker brine than two other places; that it is *only* 40 feet above sea level, and that "though by many it would be called a dull place to stay at, others are likely to be well suited there."

Tunbridge Wells' Chaylbeate water is very poor in carbonic acid gas, and cannot be ranked with the waters of Spa in Belgium, Schwalbach in Germany, &c. Matlock Bath, which has during the last few years greatly increased its bathing facilities in connection with one of the three important warm springs in the country, is described as "less bracing" than some other places, and the properties of its waters hardly noticed. In reading through these Inland Spas, it would appear that nothing that could be advanced to their disparagement has been omitted, whereas in some of the smallest of the German or other Continental spas but little is said of their disadvantages, the statements of the Kur-verein being usually accepted and endorsed.

Again, in the "Localities Recommended for Various Complaints," the Riviera and Egypt, and Egypt and the Riviera, appear on nearly every page; Harrogate and Llandrindod Wells are mentioned once or twice, but nearly all the other British health resorts are conspicuous by their absence, while the German, Belgian, French, and Swiss "cure" places are freely recommended.

There is so much that is useful and of real value in this new edition that it is to be hoped that in the next one the advantages of our own health stations will be made more prominent, and that by this means some of the enormous sums taken abroad annually to the Continent may be diverted to them, so that they may add to their attractions, and become less "dull" and unpopular.

(a) "The Mineral Waters and Health Resorts of Europe." By Sir Hermann Weber, M.D., F.R.C.P., and F. Parkes Weber, M.D., F.R.C.P. London: Smith, Elder and Co. 1907.

THE ALCOHOL PROBLEM (a).

It is well that the much discussed and many-sided drink question should now be receiving that impartial and unprejudiced scientific study which only medical observers are in a position to afford. The problem is essentially a medico-sociological one, and all theories and measures of reform which neglect to recognise it as such must of necessity be lacking in the fundamental conception of the subject. Among recent works dealing with alcohol and alcoholism Dr. Sullivan's able monograph must be accorded a foremost place. It is written in a lucid and attractive style, its diction is that of the long experienced and thoroughly trained scientific observer, its matter is well arranged and is not lacking in originality and suggestiveness; in short, it is a serious and sensible contribution to a subject peculiarly intricate and perplexing, and abounding in difficulties and misunderstandings, which should be read and carefully analysed by every medical practitioner and all would-be reformers. Dr. Sullivan ably summarises the fundamental data of the drink question; presenting careful sections on the physiological action of alcohol, the pathology of chronic alcoholism, the social causes of intemperance, the relation of alcoholism to suicide, crime, insanity and human degeneration. The chief value of the work is that it definitely demonstrates that at least in this country intemperance as a social problem depends on the prevalence of industrial drinking. This is a conception which has received far too little consideration, and it may be hoped that Dr. Sullivan's able contribution will do much to direct measures of so-called temperance reform along rational lines. The appearance of this work is opportune, and it should do much to dissipate the prejudice and ignorance still existing among members of the medical and other professions, and occasionally finding expression in ludicrous and unscientific manifestos and other undesirable forms of publication.

Trinity College, Dublin.

During Trinity Term, 1907, Mr. Cecil Scaife passed (Part II.) in Public Health; and the following candidates passed the Final Medical Examination (Part II), (names arranged in order of merit): William Pearson, (passed on High Marks), Richard G. S. Gregg, Robert E. Wright, William A. R. Spong, Henry de C. Dillon, James G. M. Moloney, William E. M. Armstrong, Wilfrid J. Dunn, Thomas P. S. Eves, Henry P. Hart, Frederick Stevenson, Francis O'B. Kennedy, James D. K. Roche, Oliver St. J. Gogarty, James C. C. Hogan, Charles H. O'Rorke, Ernest T. Jameson, Joseph C. A. Ridgway, Edmond H. Sheehan, James R. Yourell, Archibald L. Robinson, Wallace D. Mitchell.

(a) "Alcoholism: A Chapter in Social Pathology." By W. C. Sullivan, M.D., Medical Officer in H.M. Prison Service. Pp. 214. London: James Nisbet and Co., Ltd., 1906. Price 3s. 6d. net.

DISEASES OF THE SKIN (*a*).

Dr. Meachen has endeavoured in this little book to render the nursing of skin cases more popular by diffusing more knowledge as to their nature. The book is primarily intended for nurses, consequently only the commoner forms of disease are described, and the general principles which underlie their management. We believe, however, that the book will be of considerable use to students beginning the study of dermatology and help them to acquire, what many of them are sadly deficient in, a general knowledge of the principles of the subject. The chapter on classification and the description of the different kinds of lesions is particularly useful in this connection, as is also the chapter on the principles of treatment. It would, we believe, have been an advantage had the author described a method of case taking in skin diseases and illustrated it by examples from some of the commoner forms, for it is in this respect that we have found students as a rule most deficient. Dermatology can only be learned in the clinic, but in order that the beginner may get the best advantage from the attendance at the clinic he must be able to observe and describe accurately the cases which he sees there. We recommend Dr. Meachen's book not only to nurses but also to students, and believe that a careful study of it will be of more advantage to them than many of the more pretentious works on dermatology.

FORMULAIRE FRANCAIS (*b*)

Each year this excellent annual grows in favour with both British and Continental physicians. The experience of many years has enabled the author to produce a book which is particularly suited for the requirements of the practitioner. All the new remedies are treated of with sufficient fulness both from the chemical and the therapeutic standpoints, and the untoward results of the use of the substance as well as its valuable properties are fairly told. There is no annual we prize more highly than M. H. Bocquillon-Limousin's dainty little volume.

OPERATIVE GYNÆCOLOGY (*c*).

The great work, "Operative Gynæcology," which Professor Kelly gave us nine years ago, has undergone a very careful revision. New chapters have been added, and some material found in the first edition has been omitted. Nevertheless, despite the fact of much additional matter, the work is more concise and explanatory, and has been thoroughly brought up to the standard that modern gynæcology requires. The illustrations which formed such a feature in the original edition retain their high grade of excellence, and while many have been left out as being perhaps unnecessary, a large number have been inserted which are admirably chosen and executed. In Chapter V. very full descriptions are given of the various methods of examining a patient. The author has, moreover, introduced a new method which is carried out by means of an instrument he has himself devised "for the purpose of measuring resistances in the abdominal wall, so as to differentiate between the firmer parts in relation to a tumour lying behind and the more yielding surrounding areas." This instrument he calls the Piezometer, and claims for it further a considerable value in detecting the amount of pressure necessary to produce pain in the appendical region as compared with the opposite side. There is an illustration of the instrument, and one showing its use in the latter capacity. Three new chapters are inserted at this stage dealing respectively with "Local and Palliative Treatment," "Menstruation and its Anomalies," and "Uterine Displacements and Their Treatment by Pessaries." The articles are short and the subjects far too sketchily written to be of great value. It is, however, of interest to note that Professor Kelly has a word to say on the pessary's behalf. The chapter dealing with repairs of perinæum and relaxed outlet is most explicit, and amply illustrated making each step in the operation perfectly clear. When we come to the chapters devoted to the affections of the urethra and bladder and the ureter, we find the author at his best. This portion has been for the most part rewritten, and the insertion of several new illustrations render it more valuable When we come to consider what we owe to Professor Kelly's work upon the bladder and the ureter, anything like criticism seems almost to savour of impertinence. A short chapter on X-rays as a means of detecting calculi is entirely new, and comes from the pen of Dr. F. H. Baetjer. The second volume contains most of the major operative work, and is in general a masterly exposition. It must be remembered, however, that many methods known to and recognised by all gynæcologists are not made mention of. This is because Professor Kelly describes "Operative Gynæcology" as it is seen by him to answer best, and, in spite of these omissions, his work stands as the first on the subject in the English language.

PLAGUE (*a*).

Some six or seven years ago Dr. Ishigami, of Osaka, published hurriedly, but under the supervision of Professor Kitasato, a little book on plague, intended to be of assistance to medical practitioners who were without any text-book on the disease in the Japanese language. This book has been translated, enlarged, and illustrated by Dr. Donald MacDonald, of Adelaide. It is very difficult to disentangle the original work of Dr. Ishigami from the additions of Dr. MacDonald. The process of doing so, indeed, appears to be the winnowing of wheat from the chaff. Dr. Ishigami's handbook, as far as we can judge, was excellent in its way—terse, clear, informative, and possibly, in the original, readable. He discusses the subject from every point of view—historical, clinical, pathological, epidemiological, and, as might be expected from a pupil of Kitasato, he is thoroughly scientific in his method of thought. The book, however, as Dr. Ishigami admits with all modesty, was hurriedly written, and by no means complete. Nevertheless, it would, if carefully translated into clear English, have been of considerable value and interest to English practitioners suddenly brought into contact with plague. As it is, however, we fear that Dr. MacDonald has defeated his purpose. In his attempt to make the work complete he has added a considerable mass of material, much of it valueless in itself, and nearly all out of place in a book with Dr. Ishigami's modest purpose. Moreover, although the book is not large, and is unpleasantly printed on bad paper, it is published at an exorbitant price. Dr. MacDonald's style is slovenly, and his technical terms are not to be trusted. We take at random one or two examples which could be equalled on nearly every page:—"The trachea is generally normal in most cases" (p. 24); "the stomach is often digested in cases that have expired some time" (p. 25); "the solitary glands are always more or less tumid. They are more so in the lower part of the intestine, which are sometimes the size of a pea. As in the case of typhus, Pyer's patches are, etc.," (*loc. cit.*) The reference is, of course, to typhoid. There are several charts exhibiting the course of the disease, and these are instructive. The other illustrations are most of them useless, and some offensive. Of the latter class are three "chromo-lithographic plates," which are supposed to depict cultures of bacteria. They are, apparently, impudent advertisements for a manufacturer of patent foods. We confess that we leave the book without discovering what the translator means by "pathological horticulture," or for what purpose he introduces quotations from Ruskin, Leigh Hunt, and Keats.

(*a*) "Skin Diseases: their Nursing and General Management." By G. Norman Meachen, M.D., Physician for Skin Diseases, Tottenham Hospital. London: The Scientific Press, Ltd. 8vo. Pp. 134.

(*b*) "Formulaire des Médicaments Nouveaux pour 1907." Par H. Bocquillon-Limousin, Docteur en Pharmacie, Pharmacien de 1st classe Laureat. Avec une introduction par Henri Huchard, Membre de l'Académie de Médecine, Medicin de l'hôpital Necker. Paris: Librairie J. B. Baillière et Fils. 1907.

(*c*) "Operative Gynæcology." By Howard A. Kelly, A.B., M.D., LL.D., F.R.C.S (Hon. Edinb.) With 11 plates and 703 original illustrations, for the most part by Max Brödel. Second Edition, revised and enlarged. London: Sidney Appleton. 1906

(*a*) "A Text-Book on Plague." By Tohiu Ishigami. Revised by Prof. Shibasaburo Kitasato. Translated, enlarged, and illustrated with Pathogenic Horticulture by Donald MacDonald, M.B. Adelaide Vardon and Pritchard. 1905. Pp. xx., 180.; Price 22s. 6d.

THE EDINBURGH MEDICAL JOURNAL (*a*).

This half-yearly volume, representative of the medical work and thought in Edinburgh, is well up to its own average, as far as the original articles it contains are concerned. It contains thirty papers in all dealing with medical, surgical, gynæcological, and other subjects, and in addition presents some very useful summaries of the advances that have been marked in various branches of medical science. Amongst these summaries we notice articles on such important subjects as heart block; chlorides in relation to œdema; superficial reflexes; thiosinnamine injections, and many others. The critical and complete nature of these summaries renders them a most important part of these volumes, and enables the reader with comparative ease to keep himself well in touch with modern research in almost every department of practical and theoretical medicine. We have always regarded them as the best of their kind to be found in English journals, and are glad to find their character maintained. The wonder is that no journals exist given up entirely to this class of work, which it must be remembered is very different from mere précis writing, in that concentration and criticism are combined. Numerous German journals of the kind exist, and are largely bought in this country. We venture to think that an English venture of the same kind would be a profitable investment in more ways than one, provided its literature selection was sufficiently cosmopolitan, and provided that some work and thought was put into its articles. Amongst the original articles one by Dr. Meikle on "The Persistence of Bacilli in the Throats of Convalescent Diphtheria Patients," as determined by an examination of 300 patients, is a most important one. In it he draws several important conclusions, amongst which we find (1) that the diphtheria bacilli present in the throats of convalescents are generally of diminished virulence; (2) that steady antiseptic treatment tends to still further diminish the persistence of such organisms; (3) that bacilli are generally absent after three weeks from the commencement of the illness. Two important therapeutical studies are also included, one on the use of "Formic Acid in the Treatment of Diphtheria," and another on the "Salicylate Treatment of Scarlatinal Nephritis"; while amongst the surgical papers is an important personal analysis of 46 cases of perforated gastric and duodenal ulcers operated upon. The volume, in fact, contains interesting matter for all medical readers, but it is unnecessary to refer directly to its further contents.

MEDICAL LATIN (*b*).

Mr. Bennett's book on "Medical and Pharmaceutical Latin" is intended to supply a sufficient knowledge of the Latin tongue for the purposes of writing and reading prescriptions. It is quite true, as the author points out, that the writing of a prescription in language understood by the patient has certain disadvantages, of which self-drugging is not the least. The writing of elegant prescriptions is, moreover, an art for which we have the greatest respect, but it is not, as many pharmacists seem to think, the final test of an educated physician. A man may be an excellent physician and a good citizen, and still be unable to write a prescription in sound Latin. The truth is that life is getting too crowded for the writing of elegant prescriptions; as, however, the employment of drugs is every year moving more into the background in rational therapeutics, the matter is not one of much moment. Mr. Bennett's book, however, is well adapted for its purpose. It contains not only the elements of Latin grammar, but a large collection of prescriptions in Latin and English by way of illustration, and several vocabularies containing all the words likely to be met with in pharmaceutics. The book will be found of much use to dispensers, and many medical men will be glad to have it for reference.

ELEMENTS OF PHYSICS (*a*).

The growing importance of the science of physics in the treatment of disease makes it imperative that medical students at the beginning of their studies should be well grounded in the different branches of this science. Mr. Page has written this book to supply a need he has experienced, a suitable text-book for students intending to enter for the examinations of the Conjoint Board and the Society of Apothecaries. The book is further intended "to bring into prominence those branches of physics which might be useful to the student in his future career."

A careful perusal of the work shows that Mr. Page's knowledge of the average student's needs has been turned to good account, with the consequence that a subject that is generally distasteful is presented in such a manner as to lose most of its terrors. The diagrams are excellent and free from unnecessary elaboration; the idea in keeping them simple and diagrammatic being "to encourage the student to reproduce them when describing the various instruments and methods." That the matter covers the requirements of the two syllabuses goes without saying, while the simplicity of letterpress and illustrations, will, we are confident, ensure the book a warm welcome from teachers and students.

LITERARY NOTES.

We learn that a circular has been issued to the members of the Medical Profession in Ireland and England asking for support for the Irish Language Fund, and pointing out that the promotion of the Irish language should specially appeal to the medical profession, not only on the ground of its great educational value, but also from the fact that a knowledge of Irish is of great advantage to any doctor practising in an Irish-speaking district. Subscriptions may be sent to the Hon. Sec. of the Medical Committee, 32 Lower Leeson Street, Dublin.

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The June number of the *Westminster Review* contains no less than three articles by medical men. Dr. James Baugh writes with information on one of the most interesting provinces of the Empire—French Canada. Dr. J. Haddon takes up the cudgels on behalf of vegetarianism. He thinks there is a close relation "between the nerves of the stomach and centres on which life seems to depend." He adds that physiology has not yet discovered where these centres are. Dr. John Knott belabours with his usual powers an unfortunate upholder of the doctrines of Christian Science.

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The late Mr. Richard Carmichael, having bequeathed to the Royal College of Surgeons, Ireland, a sum of money for the purpose of founding prizes for essays upon certain subjects specified by him, the President and Council give notice that, on the first Thursday in November, 1908, they will proceed to adjudge a prize of £120 for the best essay that may be presented to them in accordance with the following instructions prescribed by Mr. Carmichael:—(1) The state of the medical profession in its different departments of physic, surgery, and pharmacy, in Great Britain and Ireland, at the time of the writing of these prize essays. (2) The state of the hospitals and schools of medicine, surgery, and pharmacy. (3) The state and mode of examination, or of testing the qualifications of candidates of the different licensing colleges or corporations of medicine, surgery, and pharmacy. Under these heads the authors should make such suggestions as may occur to them respecting the improvement of the profession, with the view of rendering it more useful to the public, and a more respectable body than it is at present. In these

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(*a*) *The Edinburgh Medical Journal.* New Series. Vol. XX. 1906. Edinburgh and London: Young J. Pentland.

(*b*) "Medical and Pharmaceutical Latin for Students of Pharmacy and Medicine." By Reginald R. Bennett. With an Introduction by Henry G. Greenish, F.I.C., F.L.S. London: J. and A. Churchill. 1906. Pp. xii. and 442.

(*a*) "Elements of Physics for Medical Students." By Frederic James M. Page, B.Sc. (Lond.), F.I.C., A.R.S.M., Lecturer on Physics and Chemistry to the London Hospital Medical College, Examiner in Physics and Chemistry to the Society of Apothecaries of London. 1907. Price 5s. Pp. 288 and xvi., with a coloured frontispiece and 230 figures in the text. London: Cassell and Company, Ltd.

suggestions the authors must consider the preliminary and moral education of medical and surgical students, the mode of conducting their professional studies, and of testing the qualifications of candidates by the licensing bodies. Each essay is to be distinguished by a device or motto, and accompanied by a sealed packet, containing the name and address of the author, also distinguished by the same device or motto. The essays are to be lodged at the College on or before the first day of July, 1908. No essay shall exceed 65,000 words in length, and all quotations and extracts from any published work, pamphlet, or paper, shall be by reference merely to the volume and page on which the passage desired to be quoted is to be found. The President and Council will not consider themselves bound to award the prize should any of the essays not appear to them to possess sufficient merit. Fuller particulars will be found on reference to our advertisement columns.

NEW PREPARATIONS.

SOME SPECIALITIES BY PARKE, DAVIS & CO.

MESSRS. PARKE DAVIS have sent us specimens of various new preparations which bear the impress of careful and skilful pharmacy. Amongst them are tubes containing tablets of eucaine and adrenalin for use in solution as a local anæsthetic for tooth extraction and minor operations. There is a good cathartic compound "improved" tablet coated with chocolate, which should be efficient in its action. Another useful tablet is the triple glycero-phosphate.

Formidine is a brownish powder for internal use as an antiseptic alterative, and externally as an antiseptic dusting powder. Lastly, there is also an efficient saline laxative of excellent taste and efficiency. Altogether these preparations fully maintain the reputation of the firm by which they are issued.

"WELLCOME" BRAND ANÆSTHETICS.

IT is well known that chloroform is subject to decomposition by the action of air and ordinary daylight. In order to avoid deterioration from such influences, "Wellcome" Brand Chloroform is issued in hermetically-sealed amber-coloured glass tubes. "Wellcome" Brand Ether, S.G. ·720, which conforms to the requirements of the British Pharmacopœia for pure ether, is also issued in hermetically-sealed glass tubes. By this method perfectly fresh and chemically pure anæsthetics are always available. In both cases these tubes contain accurately measured quantities, and are convenient for charging graduated drop-bottles or those employed with inhalers. Both drugs are issued in tubes of 30 c.c. and 60 c.c. They are conveniently portable, since each tube is packed separately in a wooden box, so that there is little risk of breakage by accident.

MESSRS. BURROUGHS, WELLCOME & CO. have issued under the name of "Elixoid" Pine Tar Compound, a pleasantly flavoured fluid preparation containing "Pinol" tar, terpin hydrate, Virginian prune, balsam of tolu, and ipecacuanha. This combination is said to be effective in the treatment of affection of the respiratory organs, as its active components are excreted by the lungs, thereon exerting a slow, steady and continuous action. It is stated to allay pulmonary irritation and cough, and is of special service in chronic bronchitis and bronchorrhœa in doses of half to two drachms three or four times a day. Many antiseptics in common use have undesirable properties; their application causes local irritation, whilst general toxic symptoms may follow their absorption. The new preparations by the same firm includes "Nizine," a zinc salt of sulphanilic acid, a product which is antiseptic, readily soluble in water, and produces no irritation and no toxic effects. Even in strong solution it does not coagulate albumin. Its value is stated to be great in acute gonorrhœa, and to show a marked superiority over the salts of zinc hitherto in use. Urethral and vaginal injections of solutions of strength 2 to 6 grains to the ounce are said to have proved successful, while the treatment causes no scalding, smarting pain, or inflammatory swelling. Since no coagulum of albumin is formed, the solution reaches the gonococcus in the sub-mucous tissues. A strength of one grain to the ounce is employed in gonorrhœal ophthalmia, conjunctivitis and other eye affections, when an antiseptic and sedative application is required. "Soloid" Nizin, gr. 2, affords a ready and convenient means of preparing fresh solutions for injections and for eye-lotions.

"ALAXA" is an aromatic liquid preparation of cascara sagrada prepared also by Messrs. Burroughs, Wellcome & Co. It presents in a pleasant form the tonic laxative properties of the true bark in combination with stomachic and carminative principles. It is of agreeable flavour, which certainly cannot be said of ordinary fluid preparations of cascara sagrada, which are often unpleasant. "Alaxa" is said to be suitable for use in the treatment of the constipation of pregnancy, and appears to be convenient for that purpose, as it regulates the action of the bowels without producing irritation or griping. Each fluid drachm of "Alaxa" contains the equivalent of twenty-four minims of Liquid Extract of Cascara Sagrada B.P. The dose is, therefore, one to two fluid drachms, as may be required. It is well worthy of trial by medical practitioners.

To demonstrate the Spirochæta Pallida, Messrs. Burroughs and Wellcome put up in one "Soloid" Eosin and Methylene Azur, for use in the Giemas method. The Soloid is called Eosin Azur. To prepare a solution, one Soloid should be dissolved in 5 c.c. of pure methyl alcohol. A few drops are thus run on to the film and allowed to remain one or two minutes. Then double the volume of distilled water is dropped on to the film. After another five minutes staining, the film is washed in distilled water, dried in the air, and mounted in xylol balsam. The spircchætat will be found stained a pale reddish purple, while nuclear bodies are of an intense red.

Medical Man's Claim.

AT Camelford County Court on June 20th, before his Honour Judge Granger, Dr. Ernest J. Jerome, of Camelford, claimed £42 15s. 6d. from Mrs. Eliza Wilkinson, of Portsmouth Road, Esher, for medical attendance on her brother, Captain Harry Weatherby, deceased, late of Boscastle. Mr. C. H. Peter, for plaintiff, Mr. W. M. Wivell, for defendant.—Mr. Wivell mentioned that Dr. Jerome's fees for the ten years amounted to £115 3s., £72 7s. 6d. having been paid, and £42 15s. 6d. now claimed. As there was no written guarantee, he submitted that Mrs. Wilkinson was not responsible. The family regarded the charges now made as excessive. They had offered £25 in full settlement, but this Dr. Jerome had refused to accept. Judgment for plaintiff for the full amount claimed with costs.

The Treatment of Consumption.

A DEMONSTRATION of improved methods in the treatment of consumption was given at the Brompton Hospital Sanatorium on June 21st. Noticing the relapses which the poorer consumptive patients often undergo after leaving sanatoria, Dr. Paterson tried the experiment of modifying the treatment by training patients to do work, carefully graded to their powers, and discharging them when they had become hardened and accustomed to the work they would be called upon to do on their return. The results have been very satisfactory, as of the cases transferred from the Brompton Hospital to the sanatorium last year 110 were discharged with "total arrest" of all disease, 21 as "much improved," and 25 as "improved." Another encouraging circumstance is that 113 of these ex-patients are now following their ordinary occupations.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Subcutaneous Injury to the Pancreas.—Cowen (*British Medical Journal*, May 4th, 1907) reports the case of a man, aged 38, who while walking home at night stumbled and fell over a wooden railing, hitting his abdomen as he did so. The following morning he had great pain in the stomach and back, shooting up into the chest. The pain came on in paroxysms, and was accompanied by severe vomiting. On the fourth day the pain spread all over the abdomen, and he was admitted to the Southampton Hospital. On examination the patient looked extremely ill, and was very palid. The condition was looked upon as one of peritonitis, and exploration decided on. On opening the peritoneum liquid blood began to flow from all directions. There was much clot in the pelvis. The hand passed upwards over the posterior abdominal wall came across a bulging semi-fluid swelling above the navel, and blood was seen coming through a hole in the omentum, between the stomach and the transverse colon. It became apparent that the swelling was the lesser sac filled with clot and fluid blood. The opening in the omentum was enlarged by tearing, and the clot removed by handfuls. Dark liquid blood continually welled up from the region of the pancreas, obscuring everything, so that a view of the source of flow was impossible. It was obvious that the only thing to do was to trust to gauze pressure, and accordingly twelve yards of gauze was firmly packed against the pancreas and back of the lesser sac. The abdomen was rapidly closed, the gauze being brought out of the wound on a level with the hole in the gastro-colic omentum. On the following days there was a good deal of blood-stained discharge. The gauze plug was loose and easily removed on the 5th day after operation. The wound healed up fairly well, except for a sinus where the plug had been. From this was discharged daily 6 to 8 ounces of clear fluid, which was most irritating to the skin causing a very painful dermatitis. A specimen of the fluid was examined, and it was found to be pancreatic. The patient was discharged from the hospital wearing an abdominal belt, to which is fixed a bottle and tube to catch the juice and prevent skin irritation. When last seen, six months after the accident, the sinus was still discharging 3 or 4 ounces of fluid a day, but the patient was able to do his work. S.

The Operative Treatment of Fractures.—Arbuthnot Lane (*Brit. Med. Journ.*, May 4th, 1907) describes a case of fracture of junction of the upper and middle third of the femur in which union had taken place in bad position with 3¼ inches of shortening. The seat of fracture was exposed, and the bone sawn through in two oblique planes. Before making the section it was necessary to shell off masses of bone which surrounded the seat of fracture. The soft parts were stretched and formed little obstruction to reduction when sufficient force was applied. (The author has never seen any trouble arising from such stretching of the soft parts, and does not hesitate to use a sufficient force to bring it about.) Two stout steel plates were then screwed on to the opposing fragments, so that some of the screws perforated the oblique faces, which they held securely together. They were arranged vertically, and corresponded in position to the antero-lateral and postero-lateral aspects of the shaft. Convalescene was uneventful, and the shortening was reduced to one inch, which was compensated for very comfortably by an elevation in the boot of half an inch in height. Instances of malunion of fragments of the femur in fracture through the epiphyseal line of the head are very common. The fracture is very rarely recognised at the time the injury is sustained, as the soft blunt end of the neck of the femur produces no pain when the leg is moved, so much so that the patient will often walk about in comparative comfort, being only conscious of having strained the hip-joint somewhat. The mobile head becomes displaced in the cavity, so that its convexity looks inwards, backwards, and downwards, while the stump of the neck ascends to a variable extent, retaining its contact with the anterior and upper portion of the surface of the epiphyseal line. In proportion as the neck ascends, as the ilio-femoral ligament is relaxed, the femur rotates outwards and the stump of the neck projects forwards. This outward rotation is controlled solely by the resistance offered by the anterior ligament of the hip joint. Secure union is affected by an abundant callus with great rapidity. The patient suffers from two disabilities—an excessive outward rotation of the lower limb and a limitation in flexion of the hip joint. The author has never treated a recent case, but the operative procedure of such fractures united in bad position is as follows:—The front of the capsule is exposed, and the anterior ligament cleared and defined. If the stump of the neck is excessively prominent, as is usually the case, enough is taken away from it to allow of more or less complete range of flexion. The outward rotation of the shaft is overcome by lacing up the anterior ligament transversely to the length of its fibres by silver wire, so approximating its points of attachment till the range of rotation of the limb equals that of its fellow. All the patient further requires is the compensation for a very small amount of shortening by an elevator to render his locomotion comfortable and easy. S.

A New Method of Dealing with Cleft Palate.—Starr (*Canadian Journ. of Med. and Sur.*, June, 1907) points out that (1) tension along the line of the sutures, (2) sucking of the stitches by the patient, and (3) infection from the mouth, are often the cause of non-union along the line of closure in operations for cleft palate. To overcome the first two difficulties, the author introduces a piece of aluminium, sufficiently beaten out to make it pliable, through the lateral incisions and completely surrounding the flaps. When the muco-periosteal flaps are freed, and the edges of the cleft freshened, a piece of aluminium bent at an angle where it is to fold over the outer side of one flap is passed through one lateral incision. By passing a pair of forceps into the opposite lateral incision, the aluminium can be grasped and pulled down into the mouth cavity again. It is then carried across to the point at which it entered, and the excess cut off. The aluminium can be easily perforated at one or two points with a strong needle and tied with horsehair in order to prevent the free end scraping and irritating the tongue; or the free end can be turned up into the lateral incision again, and pinched with a pair of forceps. The aluminium can be left in for eight or nine days, when it is removed by cutting it close to the lateral incision. At the same time the stitches are removed. The author reports three cases, one of which was a child, æt. 14, who had a very wide cleft which had been pronounced incurable. Beside preventing tension on and sucking at the stitches, the aluminium splint prevents adhesion taking place between the muco-periosteum and the bone of the hard palate till union of the edges has occurred. To avoid infection of the mouth, it is sprayed with a solution of boric acid and 10 per cent. rectified spirit, which easily finds its way under the splint. The opsonic index should also be taken, and if it is low to the germs within the mouth, injections of vaccines should be administered a few days before the operation.

Intestinal Obstruction due to Persistence and Anomaly of the Urachus.—Fanoni (*Med. Record*, June 1st, 1907) reports the following case: Patient, æt. 25, had for two years occasional attacks of vomiting and constipation. When seen by the author he was suffering from intestinal obstruction requiring immediate operation. On opening the abdomen a piece of intestine, so large that it looked like an over-distended stomach, was found held between the anterior abdominal wall and a stout fibrous cord the size of the little finger. This cord started at the bladder, was free in the abdominal cavity, and passed two inches to the right side of the navel to a point one inch above the latter. Here it divided into three branches, which spread out in the shape of a fan. It had no connection with the liver. On microscopic examination after double ligature and removal, this cord turned out to be the urachus, and contained a centrally located lumen. On subsequently examining the bladder by the cystoscope the left ureter opening was found in the normal position, but about four times larger than normal. The ureteral catheter passed readily to the pelvis of the kidney and there was no evidence of narrowing. The right ureteral opening was normal in size, but there was some difficulty in finding it. Two months later intestinal obstruction again occurred, and it was found that a band of adhesions had formed between the omentum and the urachal stump, and that a loop of small intestine had been gradually constricted by this adhesion. The lumen of the gut was so narrowed at both ends of the loop that lateral anastomosis was necessary, but the loop was not removed. The patient made a good recovery. On histological examination, the stump of the urachus was found to be tubercular. S.

Chylous Cyst of the Thoracic Duct.—Biggar (*Cleveland Medical Journal*, May, 1907) reports the following case: Patient, æt. 38, a healthy farmer, had been diagnosed as a case of umbilical hernia. A tumour at the umbilicus had been first noticed six months before seen by the author, and had gradually increased to the size of a cocoanut. There was no pain or impairment of bowel functions. The diagnosis of hernia and intramural abscess was eliminated on account of the change of position of the neoplasm in different postures. On abdominal exploration, a round, smooth, and symmetrical tumour, six inches in diameter, was found attached to the mesentery of the jejunum by a pedicle and having a serous peritoneal covering. The tumour was cystic in character and distinctly fluctuating. During enucleation, while stripping off the peritoneal covering, the mass was punctured, and emitted a clear, milky, white fluid. This fluid on microscopic examination proved to be pure chyle. The tumour sac was trimmed off; the pedicle ligatured with the serous sac stitched to the peritoneum as in cholecystotomy, and the abdomen closed with a tubular drain. The patient had a normal course for three days, when suddenly there developed great distension, fæcal vomiting, and rapid, feeble pulse, and collapse. The wound was rapidly opened without anæsthesia to relieve possible bowel obstruction. The entire small intestine was found to be thickened, œdematous, dark bluish in colour, but with no apparent obstruction. No treatment was of any avail and the patient died within an hour. An autopsy showed autochthonous thrombosis of the superior mesenteric vein, and the site of the tumour to be at the receptaculum chyli. The remainder of the duct was normal. S.

A Method of Reducing Old Colles' Fractures.—McWilliams (*Med. Record*, May 25th, 1907) describes the following procedure to reduce old Colles' fractures. A large engineer's monkey-wrench is procured and the blades are well padded. The patient is anæsthetised and the blades so placed on the wrist that they are entirely proximally situated to the fracture line, the edge of the dorsal blade resting against the posteriorly projecting upper edge of the lower fragment. The blades are then screwed together so as to fairly tightly embrace the tissues; with the expenditure of a very little force, a re-fracture through the old fracture line may readily be produced by twisting the wrench so as to flex the lower fragment on the upper. There is no strain whatsoever brought upon the structures of the wrist itself, which consequently remains uninjured. The damage to the tendons is trifling and is soon recovered from. The after-treatment is similar to that which obtains in cases of fresh Colles' fractures. S.

When to Operate in Acute Appendicitis.—Richardson refers (*Northumberland and Durham Journ.*, March) to the cardinal symptoms, to which, during the early stages of the disease, great attention must be paid. These symptoms are: (1) The general appearance and expression; (2) the local tenderness, with or without rigidity, in the appendix area; (3) the temperature; (4) and the pulse. So long as all these cardinal symptoms continue to improve, the inflammation of the appendix is steadily subsiding, but if any one of these symptoms has not improved, or has got worse, the inflammation of the appendix is advancing. 1. The patient may look better, the local tenderness may be less acute, the temperature may be lower, but if the pulse has increased in frequency, recommend operation. 2. The patient may look better, the tenderness may be less acute, the pulse rate the same, but if the temperature has risen recommend operation. 3. The patient may look better, the temperature may be lower—perhaps normal; the pulse may not have become more rapid, but if the local tenderness has increased recommend operation. 4. The tenderness may be less, the pulse not more rapid, the temperature lower, but if the patient looks ill recommend operation. The so-called "thready pulse" must not be looked for. This is a late sign in general peritonitis, and occurs, as a rule, in cases beyond the help of surgery. It is well to remember that in all cases of recovering abdominal lesions the pulse rate steadily falls. G.

Ligature of the Renal Vessels for the Cure of Persistent Urinary Fistula.—M. Holt records a successful case (*Lancet*, June 8th, 1907) of a patient who had suffered from traumatic rupture of his left kidney. A large abscess had been opened in the loin after the injury, this opening continued to discharge pus and urine; an X-ray photo showed that several calculi were present in the kidney; an attempt was made to remove the kidney, but this failed owing to alarming hæmorrhage. Five calculi were removed, but urine continued to discharge from the wound. Five months later a second attempt was made, but this also had to be abandoned, as the peritoneum was inadvertently opened, and it was found impossible to define the limits of the kidney tissue. Three more calculi were removed, and again hæmorrhage was very profuse. Two further attempts to remove the kidney and cure the fistula, done at intervals of some months, both ended in failure, chiefly from alarming hæmorrhage. The author having tried nephrectomy, subcapsular nephrectomy, and morcellation, and being unable to carry out fully any of these methods, decided to ligature both renal artery and vein, for while experiments on animals show that in some cases it is sufficient to tie only artery or vein to prevent any further secretion from the kidney, yet in some cases this result did not at once follow, while in every case in which both vessels were ligatured immediate atrophy of the organ followed. Both renal artery and vein were accordingly tied through an abdominal incision, with the result that in four days time all discharge of urine ceased from the sinus, the sinus itself soon healed up, now at the time the author writes two years have elapsed and the patient remains in good health, the sinus keeping firmly closed. G.

Tortion of the Testis.—H. Rigby refers to the histories of forty-nine cases (*Lancet*, May 25th, 1907) of tortion of the testis, nine of which had been treated by the author. In all cases examined the congenital abnormalities present in all cases of tortion of the cord, whether the testis had fully descended or not were:—(1) The abnormal attachment of the common mesentery and vessels to the lower pole of the body of the t and globus minor, so that the testis is attached by a narrow stalk instead of by a broad band. (2) The elongation of the globus minor. (3) A capacious condition of the tunica vaginalis. The inversion which so commonly occurs most probably takes place before the twisting of the cord, for in the author's cases, when the twist was undone after the removal of the testis, the organ was still inverted, in cases that have been untwisted at operation, nothing has been said about altering the position of the testis; in cases untwisted without operation, a simple twist from right to left or from left to right, has been made and the symptoms at once relieved. Tortion of the partly descended testis should be treated by removal of the organ as soon as possible, the tunica vaginalis should be removed with the testis and the general peritoneal cavity shut off by a ligature, the internal ring is then closed by deep sutures, to prevent the occurrence of a hernia. In the fully descended testis the conditions are different, and if the case be seen early and a diagnosis made, an effort should be made to untwist the cord. In cases of acute tortion that cannot be untwisted, the case should be treated expectantly unless very urgent, as recovery is possible without marked atrophy, and if atrophy does occur, the patient is no worse off than if the testis had been removed. In cases of recurring tortion, if the testicle is in the inguinal canal, it should be cut down upon and either removed or an attempt made to place it in the scrotum, in either case the internal ring should be firmly closed. If the testis be in the scrotum it should be exposed and fixed by the removal of the parietal layer of the tunica vaginalis, as in the radical cure for hydrocele if a patent funicular process be present, it should be closed, and the internal ring sutured to prevent the occurrence of a hernia. G.

A Case of Hydrophobia.—J. Emans (*Postgraduate* June, 1907) says the incubation period of hydrophobia is from three weeks to five years, as a rule when symptoms begin to develop there are uncomfortable sensations at the seat of the bite, which may long since have healed. The patient becomes feverish, anxious and irritable, later on there is great thirst; but with these spasms on swallowing, followed by convulsive attacks, death from asphyxia comes on in from one to four days from the commencement of the symptoms. The mortality has been reduced by the Pasteur treatment from nearly 50 per cent. to less than 1 per cent. In the author's case the symptoms commenced with twitching of the lips, which soon spread to the throat, the patient, a boy æt 17, who had received a slight bite on the finger from a dog six months before, the wound never throughout his illness showed any signs of irritation. The least draught of air seemed to bring on the facial spasms, so that the boy refused to leave his room. Later on in the night he became so wild and noisy that he had to be removed to hospital, where his case was looked on as being one of bad hysteria. His temperature was found to be 106, he became during the night more wild, snapping at the attendants, two of whom were bitten. The boy died from asphyxia at four in the morning, less than four days from the first symptom. At the autopsy the brain was intensely congested. Inoculations showed it to be a true case of hydrophobia. G.

Cysticercus of the Iris.—Gradle (*Ophthalmic Record*, January, 1907) met the above rare condition in a boy, æt. 7. The iris was much inflamed and showed at the lower part a cyst-like growth. The cyst was transparent above, but below seemed to be occupied by a yellowish body. It was crossed by bands, measured about 4 mm. in length, and showed hub-like movements. Under chloroform most of the growth was removed, the rest was absorbed completely, and the boy recovered with excellent vision M.

Primary Glaucoma and Arterio-sclerosis and Renal Impermeability. — H. Joseph (*Gaz. des Hoptaux*, July 23rd, 1904) found evidence of arterio-sclerosis in eighteen cases of primary glaucoma which he studied clinically. The manifestations of arterio-sclerosis fall into two groups: (*a*) Those affecting the cardio-vascular system; and (*b*) those affecting the renal functions. In the first group the most frequent lesions involved the aortic orifice and the peripheral arteries. Sphymographic tracings showed exaggeration of arterial tension to be notable. Renal permeability was invariably diminished. Joseph thinks that these facts appear to give to arterio-sclerosis an important part in the ætiology of glaucoma, and that high arterial tension is one of the most potent factors in the production of glaucoma.—" Abstracted for the *Ophthalmoscope* by L. Gayard. M.

MEDICAL NEWS IN BRIEF.

The Bradford Police Surgeonships—A Deadlock.

In Bradford a very peculiar situation is in existence at the present time. Some of the more forward and younger medical practitioners have taken exception to the terms of the memorandum of the Chief Constable in connection with the advertisement for a chief surgeon at £120 per annum, three divisional medical officers at £50 per annum, and four sub-divisional officers at 10s. per man per annum. The doctors took exception to the inclusive nature of the stipends offered, to the repeated manner of using the words "Chief Constable" in connection with the appointments, and to the fact that no rate per policeman attended was considered in apportioning salaries. The Watch Committee have taken the view that, seeing that casualties in the city are already paid for by voucher at the rate of 5s. in the daytime and 10s. at night, and considering the signing of a name in a book once in twenty-four hours is a light matter, that the medical men are making a serious blunder. The British Medical Association through its local branch has called in all the applications. But as the assistant to the late police surgeon, Dr. S. Lodge, is still doing the work, the Watch Committee remains master of the situation. This will go on until July 31st, unless the Medical Association issues direct instructions withdrawing this medical man from doing the work, the dead-lock will obviously fail of its purpose.

Association of Scottish Medical Diplomates.

The third annual general meeting of the Association of Scottish Medical Diplomates was held on Wednesday, June 19th, at 11, Chandos Street, London, W. The revised laws of the Association submitted by the Council were discussed and duly approved. The Treasurer reported a satisfactory balance on the year's income. The retiring President Dr. C. Farrer, was appointed honorary Vice-President. of the Association. The meeting then elected unanimously the following officers for the year 1907–1908: President, David Walsh, M.D., Hon. Treasurer, Mr. Sydney Stephenson, F.R.C.S., Hon Secretary, Arthur Harries, M.D. Two new members were elected on the Council in the persons of Dr. Skene, Perth, and Mr. Charles Ryall.

Vital Statistics.

The deaths registered last week in the eighty great towns of the United Kingdom correspond to an annual rate of 13.1 per 1,000 of their aggregate population, which is estimated at 17,978,643 persons in the middle of this year. In the preceding three weeks the rates had been 14.9, 14.5, and 13.7; Measured by last week's mortality, the highest annual death-rates per 1,000 living were:—from all causes 25.8 in Dublin, 23.1 in Belfast, 18.7 in Glasgow, 18.0 in Liverpool, 18.7 in Stockton-on-Tees, 18.8 in Wigan, 19.6 in West Bromwich, 20.0 in Tynemouth, 20.4 in Sunderland, 22.0 in Middlesbrough, and 22.3 in Preston; from measles, 2.1 in Derby, 2.2 in Walsall, 2.3 in Bolton, 2.5 in Walthamstow, 2.6 in Middlesbrough, 3.3 in Gateshead, and 3.9 in Hanley; from diphtheria, 1.3 in Leyton; from whooping-cough, 1.3 in Leyton, 1.5 in Grimsby, 1.7 in St. Helens, and 2.0 in Stockton-on-Tees; from fever, 1.0 in Stockport; and from diarrhœa, 1.1 in Oldham. No death from small-pox was registered in any part of the United Kingdom

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

Auctor.—To answer your question would involve a great deal of historical research. The idea that plagues are visitations of Divine justice runs through most history—sacred and profane—but the rational view was taken at least as long ago as the time of Hippocrates. That great physician combated vigorously the supernatural view. In "De Libro Sacro" he declares himself opposed to the notion that some particular sicknesses were divine, or sent immediately from the Gods, and in "De Aëre, Locis, et Aquis," he likewise says that no diseases came more from the Gods than others, all coming from them, and yet all owning their proper natural causes; that the sun, cold, and winds are divine, and their changes, and influences on human bodies, are diligently to be considered by the physician. That such wise teaching should have been persistently overlooked must be attributed, we fear, to the superstitious self-interest of those who ought to keep men's minds in subjection.

Tablet.—Yes, there is no doubt that lead can be conveyed in ice-creams, though we do not remember having come across any specific instance in this country. Dr. Alessandro Baldoni, of Rome, has lately discovered an appreciable proportion of lead, on an average 0.69 milligrammes per 228 gramme of icecream. The samples were purchased from street vendors. He attributes the lead to alloy used in making the mixing vessels. The article on the subject will be found in the *Riforma Medica.*

Dr. P. R.—The origin of these things cannot be traced with satisfaction or certainty. There is a good deal to be said for Mr. George Bodington, surgeon, of Sutton Coldfield, being called the "Father of Open-air Treatment." His pamphlet—"An Essay on the Treatment and Cure of Pulmonary Consumption (on principles natural, rational, and successful), with suggestions for an improved plan of treatment of the disease amongst the lower classes of society; and a relation of several successful cases restored from the last stage of consumption to a good state of health"—is very rare. There is one copy in the library of the Birmingham Medical Institute.

Bane.—The hedgehog can eat without discomfort as much opium as a Chinaman can smoke in a fortnight, and can wash the meal down with as much prussic acid as would kill a regiment of soldiers. It is capable of swallowing arsenic with just as much relish as it eats cockroaches. It is quite immune to the venom of the snake.

Meetings of the Societies, Lectures, &c.

Wednesday, June 26th.

Society of Tropical Medicine and Hygiene (20 Hanover Square, W.).—8,30 p.m.: Address: The President (Sir Patrick Manson). Lantern Demonstration: Dr. Daniels.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. T. P. Legg: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. A. H. Tubby: Surgical Diseases of Children.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Thursday, June 27th.

Royal College of Physicians of London (Pall Mall East).—5 p.m.: Croonian Lecture:—Dr. W. J. R. Simpson: Plague.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. J. Berry: The Treatment of Hip Disease.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting). Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m.: Special Demonstration of Medical Cases (Dr. Auld).

Hospital for Sick Children (Great Ormond Street, London).—4 p.m.: Lecture:—Dr. Garrod: Diabetes in Children.

Friday, June 28th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Dr. D. Grant: Clinique. (Ear.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—9.30 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

National Hospital for the Paralysed and Epileptic (Queen Square, Bloomsbury).—3.30 p.m.: Clinical Lecture:—Dr. F. Buzzar: Acute Poliomyelitis.

Central London Throat and Ear Hospital (Gray's Inn Road, W.C.).—3.45 p.m.: Demonstration: Dr. Abercrombie: Nose and Accessory Sinuses.

Vacancies.

London County Asylum, Claybury.—Junior Assistant Medical Officer. Salary, £150 per annum. Applications to H. F. Keene, Clerk of the Asylums Committee. (See advt.)

Newcastle-on-Tyne, Dispensary.—Visiting Medical Assistant. Must be doubly qualified and registered, and be prepared to remain at least one year. Salary £160 for the first year, and £180 afterwards. Applications to the Honorary Secretary.

Egypt.—Sub-Inspector of Ophthalmic Hospitals. Salary £500 a year, with two months' salary in lieu of travelling expenses to and from England. The appointment is for two years, during which three months' leave on full pay will be allowed. Applications will be received in London up to July 7th by A. F. MacCallan, Esq., 32 Bedford Gardens, Kensington, W.

Stockport Union.—Resident Assistant Medical Officer. Salary commencing at £130 per annum, with furnished apartments, rations, etc. Applications to Charles F. Johnson, Clerk to the Guardians.

Corporation of Sheffield.—Junior Assistant Medical Officer to the Fever Hospitals. Salary £130 per annum, with board, lodging, and washing. Applications to H. Sayer, Town Clerk, Sheffield.

Leeds Union.—Assistant Medical Officer. Salary £100 per annum, with board, washing, apartments, and attendance. Particulars of the Medical Superintendent at the Union Infirmary, Beckett Street.

Edmonton Union.—Assistant Medical Officer at the Workhouse, Upper Edmonton. Salary £180 per annum. Application forms of F. Shelton, Clerk, White Hart Lane, Tottenham.

Tunbridge Wells General Hospital.—House Surgeon. Immediate applications to the Secretary, at the General Hospital.

Carmarthenshire Infirmary.—Resident Medical Officer. Salary £100 per annum, with furnished apartments, board, attendance, etc. Applications to Howell Howell, Secretary.

Appointments.

Drury, G. H., M.B., M.S. Ed., Medical Officer and Public Vaccinator for the Fifth District of the Wells (Somerset) Union.

Fanning, J. J., L.R.C.P. and S. Edin., L.F.P.S. Glasg., Certifying Surgeon for the Birr District of King's County.

Geddie, David Watson, M.A., M.B., C.M. Aberd., Anæsthetist to the Royal Sick Children's Hospital, Aberdeen.

Lyon, T. M. M., M.D. Edin., Certifying Surgeon under the Factory and Workshop Act for the Mid-Calder District of Edinburgh.

Peddie, C., L.R.C.P. and S. Edin., L.F.P.S. Glasg., Certifying Surgeon for the Withnell District of the county of Lancaster.

Porteous, Herbert Llewellyn, L.R.C.P. Lond., M.R.C.S., District Medical Officer of the Stroud Union, Gloucester.

Richards, John, M.B., F.R.C.S. Edin., Medical Superintendent of the Joint Counties Asylum, Carmarthen.

Spaight, Henry William, L.R.C.P., L.R.C.S., L.M. Irel., District Medical Officer for the Helston Union, Cornwall.

Willcox, W. H., M.D. Lond. M.R.C.P. Lond., Physician to Outpatients at St. Mary's Hospital, Paddington.

Births.

Eager.—On June 18th, at "Abingdon," Durban Road, Watford, the wife of Mervyn Eager, M.R.C.S.Eng., of a daughter.

Gunning.—On June 13th, at 7 St. Michael's Road, Bedford, the wife of Lieut.-Col. R. C. Gunning, R.A.M.C. (retired), of a son.

Howkins.—On June 18th, at Milverton, Yardley, Worcestershire, the wife of Cyril Howkins, M.R.C.S., L.D.S., of a daughter.

Nimmo.—On June 20th, at 119 King's Terrace, Southsea, the wife of Staff Surgeon Frank H. Nimmo, R.N., H.M.S. Essex, of a daughter.

Marriages.

Bent—Ransom.—On June 19th, at St. Mary's Church, Balham, Sidney C. H. Bent, M.D.(Brux), M.R.C.S., L.R.C.P.(Lond.), third son of the late John F. V. Bent, M.D., to Ellen Muriel, only daughter of the late Thomas R. Ransom and Mrs. Ransom, Upper Tooting.

Bliss—Chitty.—On June 19th, at All Saints' Church, Highgate, Norman Cleaver, third son of Edwin Bliss, of Highgate, to Edith Goldney, elder daughter of A. Goldney Chitty, M.R.C.S., L.R.C.P., of Highgate.

Gillespie—Fynn.—On June 19th, at St. Mark's Church, Southampton, Thomas Gillespie, M.B., B.C. (Cantab.), second son of Thomas Gillespie, J.P., of Morpeth, Northumberland, to Josephine Eva, second daughter of Arthur F Fynn, of Bassett, Hampshire.

Smith—Greenwell.—On June 15th, at All Saints' Church, Gosforth, Newcastle-on-Tyne, Charles W. Smith, M.B.Lond., of Hillsborough, Sheffield, to Ruby, third daughter of the late Rev. Wm. Greenwell, M.A., late Vicar of Horton, Northumberland.

Deaths.

Lacey.—On June 8th, at Rangoon, of heart failure, William W. Lacey, M.R.C.S., L.R.C.P., of Castlepark House, Exmouth, aged 44.

Wilson.—On June 22nd, at Laxfield, Suffolk, in her 88th year, Caroline, widow of Robert R. Carley, M.R.C.S., of Laxfield.

IRISH POOR-LAW AND LUNACY INTELLIGENCE,

Being the Weekly Supplement of the "Medical Press and Circular."

WEDNESDAY, MARCH 13TH, 1907.

Notice to Correspondents.

Poor Law Medical Officers and other subscribers to The Medical Press and Circular are invited to make use of the facilities provided by the Management of the Journal for obtaining information on all matters connected with the Poor-Law Medical Service or the Medical Profession generally in Ireland.

The Editor will be glad at all times to receive letters or marked copies of newspapers dealing with matters of medical interest. All communications must be addressed to the Office of the Journal 18 Nassau-street, Dublin, and should be delivered not later than Saturday morning to ensure attention in the issue of the following week.

CONTENTS.

	PAGE
EVENTS OF THE WEEK	2
CASTLEREA UNION	3
IRISH WORKHOUSE ASSOCIATION	3
FEVER IN ARDNAREE	4
A CLARE MAGISTRATE ON MEDICAL FEES ..	4

"MEDICAL PRESS AND CIRCULAR," 18 Nassau Street, DUBLIN.

LOCUM TENENS REGISTRY.

MEDICAL OFFICERS—LOCUM TENENS.—Medical Officers seeking temporary substitutes are requested to make application to the Locum Tenens' Registrar, Dublin Office of the "MEDICAL PRESS," 18 Nassau-street, Dublin.

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EVENTS OF THE WEEK.

The cost of the *Journal of the Irish Medical Association* has exercised the minds of the more thoughtful of the members and attracted the attention of the Council; its abolition as useless has been discussed; but the number for March suggests the possibility that its existence may be a grave danger to the Association. In the February number the following resolution of the South Tipperary branch was published;—"That the dispute in connection with the engagement of an assistant at surgical operations in the Clogheen Workhouse Hospital should be referred to the Council of the Irish Medical Association." At the meeting of the Council on January 31st, on the motion of Dr. Hennessy, this resolution was discussed and adjudicated on. The Association is empowered to arbitrate in disputes between individual members of the profession *when such arbitration may be requested;* and by a by-law of 11th November, 1902, the Council is authorised to appoint one or more arbitrators either from their own body or from among the members of the Association, or otherwise, for the settlement of professional difficulties and disputes in which any member desiring assistance may be concerned. No arbitration can take place unless both contending parties agree to it, and to submit to the decision of the arbitrators. In the present case only one of the parties demanded the interference of the Council, the others refused to accept it, and therefore the Council had no right to discuss and decide the case at all. The Honorary Secretary of the Association is supposed to know the power of the Council and the rules and regulations of the Association; and it was obviously his duty to advise the Council that it was acting *ultra vires*. Whether, as he states, in his capacity of editor of the *Journal*, "it is well, however, when such disputes do arise that there should be such a tribunal as the Council to refer them to." is a matter of opinion—not of fact; if such cases, with all their details and with the editor's comments, are to be published and disseminated broadcast in the *Journal*, then we think it would be anything but well that there should be such a tribunal established. The *Journal* instead will become a dangerous and disruptive force if the proceedings of the Council in arbitration cases and the letters written by the contending parties are to be published. The object of arbitration in professional disputes is to put an end to disagreements and to restore harmony, not to spread abroad throughout the Association, and far beyond it, the details of quarrels, and the winged words men may write or utter in the heat of the contest. That does not tend to peace and renewal of friendship. Nor can there be any excuse for the amazing indiscretion of the editor's utterances in his notes on the Council meeting. Whatever his own personal opinion may be, he has no right, as editor of the *Journal* of the Association, to take a particular view or adopt praise or censure. Very properly the chairman ruled at the meeting, "I cannot allow personalities to be discussed. We must only consider the principle." Yet in the face of that ruling the editor of the *Journal* writes an article mainly personal, and certainly likely to be most damaging to the Association.

The deaths registered in the Dublin area for the week ending 2nd inst. represented an annual death rate of 30.4 per 1,000 of the population. The rates in other capital cities, according to the latest returns, are:—London, 18.4; Edinburgh, 17.4; Calcutta, 39.1: Paris, 31.2; Brussels, 21.1; Amsterdam, 21.4; Copenhagen, 18.9; Stockholm, 13.3; Christiania, 20.8; St. Petersburg, 30.9; Berlin, 16.4; Vienna, 21.2; Rome, 25.7. Beside Dublin the following cities in the Registrar-General's list present rates exceeding 20:—Glasgow, 22; Calcutta, 39.1; Bombay, 39.3; Madras, 38.2; Paris, 31.2; Brussels, 21.1; Amsterdam, 21.4; Christiania, 20.8; St. Petersburg, 30.9; Morocco, 33.1; Breslau, 24.1; Vienna, 21.2; Buda-Pesth, 24.1; Prague, 23; Trieste, 34.6; Rome, 25.7; Venice, 24.3; Boston, 22.6. The following towns in Ireland present for the month ending 2nd inst. rates of 20 or over per annum per 1,000:—Armagh, 30.9; Ballymena, 31.1; Belfast, 26.3; Clonmel, 26.9; Cork, 25.2; Drogheda, 25.6; Dundalk, 27.9; Galway, 25.3; Kilkenny, 27; Limerick, 20.9; Lurgan, 29.9; Newry, 20; Newtownards, 21.5; Portadown, 22; Sligo, 20.4; Tralee, 31.7; Waterford, 35.1; Wexford, 36.2.

The Belfast Health Commission began its sittings on the 5th inst. Among the witnesses examined have been the Registrar-General, the Chief Clerk to the Corporation, the Chairman of the Public Health Committee (Dr. King-Kerr), the Medical Officer of Health (Dr. Bailie).

The Kerry County Council have unanimously resolved to join with the counties of Limerick and Clare for the purpose of establishing a sanatorium for consumptives.

Some alarm was raised in the neighbourhood of Charleville a few weeks ago by the deaths of two patients in whose cases some of the symptoms of cerebro-spinal fever were present. That matter has been inquired into by Dr. Brown, Local Government Board Inspector, and he agrees with the medical men in attendance, Drs. Cremin and Connery, in thinking that the disease was not cerebro-spinal fever in either case.

At the meeting of the Galway Board of Guardians on the 27th ultimo Dr. O'Brien was elected medical officer of the Aran Dispensary District, by a large majority. Dr. Cusack, the other candidate, is a young man with the record of a distinguished career at the Queen's College, Galway. We congratulate him on his escape from having his professional life ruined by exile and isolation in these remote islands.

Whilst Dr. Wilson, Medical Officer of the Enniskillen Workhouse, was on holidays he was called in by his substitute, Dr. Betty, to assist at two operations in the infirmary. For these services, Dr. Wilson sent in a claim for two guineas, which the Guardians declined to pay until directed by the Local Government Board. This Board have now written to say that they did not consider the medical officer entitled to receive any extra remuneration under the circumstances. If this contention be well founded, we might, in all seriousness, ask the question :—"When is a holiday not a holiday ?" We think, however, that the Local Government Board is quite wrong in this decision. While on leave, the Guardians had no claim on the services of Dr. Wilson, and when they called on him, through their agent, Dr. Betty, they are responsible for his fee. We hope that the Irish Medical Association will take the matter up on behalf of Dr .Wilson.

The Clogher Board of Guardians have requested the Local Government Board to hold a sworn inquiry in connection with the medical treatment of Edward Boyle, William Parson, and George Giles, all of whom have been treated in the workhouse. It was in relation to the treatment of Boyle that the cause of action for libel arose which Dr. Ross is taking against a guardian named Donnelly. Both litigants express themselves satisfied with the action of the Guardians, and Dr. Ross is most anxious that the inquiry should be held.

Dr. Browne, Dispensary Medical Officer, Ballynahinch, in the Downpatrick Union, having been certified unfit for duty by Dr. Tate, owing to an attack of influenza, the relieving officer reported that he had been obliged to retain the services of Dr. Hamilton, who refused to act for less than £1 1s. per diem. The Guardians scale only allows £3 3s per week, but Dr. Hamilton resolutely refused to accept this. Some members of the board suggested that they should get a doctor from Belfast, but it was feared that they could not get one to come for less than a guinea ; so that they ultimately decided to leave the matter in the hands of the relieving officer, as they admitted that the doctors had them in a fix.

Dr. L. Kidd, Enniskillen, has written to the Irvinestown Guardians with reference to his fee of £5 5s., for performing a difficult operation in the infirmary, respectfully declining to modify his charge. It was not until after due consideration, and in order to save correspondence and trouble, that he asked for the very moderate fee of £5 5s., a sum substantially less than he would be justified in claiming. He pointed out that it was not for assisting at, but for performing a surgical operation, that he charged the fee It was decided to pay the amount, subject to the sanction of the Local Government Board.

Dr. R. T. Hayes has been elected Medical Officer of Balrothery Workhouse.

Dr. Corcoran has been elected medical officer of the Ballinrobe District. There were two other candidates. The election took place amid wild disorder, and the board had to adjourn for half an hour to allow the boardroom to be cleared.

We regret to note the death of Dr. John Nolan, who had been resident medical officer of the Limerick Workhouse for over twenty years.

CASTLEREA UNION.

The medical officers of the Castlerea Union have again applied to the Guardians asking for the adoption of a graded scale of salaries. The following passage occurs in their letter to the board :—

"Under recent Acts of Parliament and late rules and regulations of the Local Government Board, increased particularity in performance of duties, and largely added new duties, with still inadequate or no remuneration, have been placed on the shoulders of the unfortunate Poor Law Medical Officers. Notwithstanding all this, at present your medical officers receive in wages a lesser sum than they received thirty-five years ago, and further, to-day you enjoy the services of two medical officers at a lesser salary than you paid one medical officer twenty-five years ago for the joint appointment. You, yourselves, know that this is not just ; that it is cruel and ungenerous in the face of the acknowledged increase in the necessary expense of present day living, and of labour generally. You would not dream of getting a labourer to work now for the wages he received thirty or forty years ago ; neither would you get the domestic servant, the mechanic, the architect, the engineer, yet it is reserved for the unfortunate medical officer, who is the sole dependence of the general community in their corporal afflictions, and who is ever, in the interest and for the protection of the public, at danger's post, in endemics and epidemics, no matter how virulent and dangerous to his own and to his family's lives, to work for wage that neither affords the means of living or of efficiently discharging his important and onerous duties.

Gentlemen, you pay, *in toto*, in salaries to your medical staff, £510 per annum. Half of this is recouped from Government Consolidated Fund, and more than a fourth is recouped under the Equivalent Grant, so that the rates of the entire Union is responsible for something like £100 to the entire salaries."

The communication was marked "received," Mr. Patrick Webb, interjecting, "throw it in the waste paper basket."

IRISH WORKHOUSE ASSOCIATION.

The annual general meeting of the Irish Workhouse Association was held last week in the Mansion House. Mr. Charles Eason presided.

Speeches were delivered by the Chairman, Mrs. Haslam, Miss Armstrong, Rev. Father Finlay, Mrs. Foran, Mr. Hugh Law, M.P. ; Miss Rose Barrett, Dr. M'Walter, Mr. A. W. Samuels, Miss Welply, and Rev. J. D. Osborne.

The following resolutions, among others, were adopted :—

"That this meeting begs respectfully to urge on the Government to take the Report of the Viceregal Commission on Poor Law Reform into their immediate consideration, with a view to prompt action to carry out its recommendations."

"That this meeting urges on all members of the Irish Workhouse Association to take every opportunity, public and private, of directing attention to the Report, and that it be an instruction to the Executive Committee to promote the discussion of the Report at Conferences of Poor Law reformers and representatives of the public bodies concerned."

"That this Association thinks that in any legislation carrying out the recommendations of the Commission provision should be made to secure the continued and adequate representation of women on Boards of Guardians."

Mrs. Rushton said she had been requested by Lady Aberdeen to announce that a meeting of the Women's National Health Association of Ireland would be held at the Royal College of Physicians on Wednesday, the 13th inst.

FEVER IN ARDNAREE.

At a recent meeting of the Ballina District Council, a circular letter from the Local Government Board was read calling attention to the prevailing outbreak of cerebro-spinal fever, and the urgent necessity for sanitary precautions being taken.

Notwithstanding outbreaks of typhus, diphtheria, and febrile diseases, the following extract from their discussion on the circular shows how completely callous the members are:—

Mr. Muffney—The sanitary officers will bother their heads very much about it. Some four or five years ago we had several applications to put in new sewerage for Ardnaree, as there was an immense number of houses without water closets or connections; and since that sewerage was carried out at considerable expense never a single water closet was erected.

Mr. Joynt—There was one.

At a subsequent meeting, reporting on a case of fever in Ardnaree, Dr. Macaulay attributed the outbreak to insanitary surroundings and shortage of water.

Mr. Muffney—We made a new sewer there, and there never was a connection made to any house.

Mr. Walsh—Bring the law of compulsion to bear on them. It speaks very badly for the town to see an outbreak of fever in it at this time of year. Every man in Ardnaree should be compelled to get a *water closet irrespective of politics.*

Mr. Chambers—Ah, there is no politics in water closets.

Mr. Walsh—Well, if there is not there is some favouritism in regard to the matter.

It is not to be wondered at that under these circumstances fever should be prevalent in Ballina.

A CLARE MAGISTRATE ON MEDICAL FEES.

The usual weekly meeting of the Ennistymon board of guardians was held on Tuesday, 5th inst., at which Mr. M. Leyden, J.P., presided.

A resolution was adopted at the previous meeting requesting the local magistrates, in the committal of lunatics to the asylum, not to certify for more than one guinea to medical officers for the examination of lunatics, and Mr. H. B. Harris, to whom a copy of the resolution was sent, replied that he never signed a certificate in lunacy cases for more than 21s., because he considered it the easiest-earned money a doctor received, and because, also, he considered it would be an abuse of a magistrate's privilege to give more, unless under very extraordinary and exceptional circumstances. He wished they could control the medical profession so as to compel all medical men to accept, in town and country, a fee of 2s. 6d. for a visit to a doctor's own house, 5s. for a visit of two miles distance, and 10s. for a distance under five miles. As to operations, their charges were exorbitant and should be reduced, in cases where the patients were not wealthy and very well off. The State should give a contribution towards operation fees in certain cases, because very useful lives were lost owing to humble persons not being able to pay the fees insisted upon, and in other cases people even delaying calling in a doctor owing to the excessive fees, until it was too late.

Mr. H. B. Harris is evidently a "very harbitrary gent."

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Being the Weekly Supplement of the "Medical Press and Circular"

WEDNESDAY, MARCH 6TH, 1907

Notice to Correspondents.

Poor Law Medical Officers and other subscribers to THE MEDICAL PRESS AND CIRCULAR are invited to make use of the facilities provided by the Management of the Journal for obtaining information on all matters connected with the Poor-Law Medical Service or the Medical Profession generally in Ireland.

The Editor will be glad at all times to receive letters or marked copies of newspapers dealing with matters of medical interest. All communications must be addressed to the Office of the Journal 18 Nassau-street, Dublin, and should be delivered not later than Saturday morning to ensure attention in the issue of the following week.

CONTENTS.

	PAGE
EVENTS OF THE WEEK	2
IRISH POOR LAW REFORM	3
INCREASE OF INSANITY IN COUNTY WEXFORD	3
LIMAVADY UNION	3
UNION MEDICAL CONTRACTS	3
BALLINASLOE DISTRICT ASYLUM	4
SLIGO DISTRICT ASYLUM	4

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EVENTS OF THE WEEK.

THE deaths registered in the Dublin area in the week ending 23rd ult. represented an annual death-rate of 27.9 per 1,000 of the population. The rates in other capital cities, according to the latest returns are:—London, 17.1; Edinburgh, 18; Calcutta, 35.8; Paris, 26.6; Brussels, 18.6; Amsterdam, 20.4; Copenhagen, 16.9; Stockholm, 15.5; Christiania, 18.7; St. Petersburgh, 31; Berlin, 16.4; Vienna, 19.3; Rome, 24.1. The following cities in the Registrar-General's list, besides Dublin, have rates exceeding 20:—Glasgow, 20.3; Calcutta, 35.8; Bombay, 33.5; Madras, 34.5; Paris, 26.6; Amsterdam, 20.4; St. Petersburg, 31; Moscow, 32; Breslau, 23.7; Buda-Pesth, 23.9; Trieste, 34.6; Rome, 24.1; Venice, 23.4; Philadelphia, 22.4; Boston, 20.7. The following towns in Ireland present, for the month ending 23rd ult., annual rates exceeding 20:—Armagh, 29.2; Ballymena, 26.3; Belfast, 24.3; Clonmel, 25.6; Cork, 25.7; Drogheda, 26.6; Dundalk, 27.9; Galway, 20.4; Kilkenny, 33.2; Lurgan, 31; Newry, 21; Newtownards, 22.9; Portadown, 20.7; Tralee, 22.5; Waterford, 34.6; Wexford, 32.7.

The total number of notified cases of cerebro-spinal fever in Belfast at time of going to press has been 118, with 70 deaths. The Lisburn Guardians, in view of the spread of the epidemic, have ordered the schools in Dunmurry, which are contiguous to the city boundaries, to be disinfected. They further agreed to have the tramps disinfected on admission to the workhouse, in presence of the Medical Officer. Dr. MacKenzie respectfully declined to inspect such operations, as it did not come within his duties, without extra remuneration, and it was arranged that the Clerk wire to the Local Government Board to ascertain what was the Medical Officer's duty in a case of this kind. We should strongly advise Dr. Mackenzie to have nothing to do with forcible disinfection of tramps, or anybody else, or he may find himself let in for an action for assault. Guardians have no power to disinfect anyone.

In a letter to the *Freeman's Journal* of 27th ult., Dr. M'Walter defends the Dublin Corporation against charges of carelessness with regard to the health of the city. He says—"It is well known that the Dublin death-rate is high because of the large infant mortality." This is a mistake. The high death-rate is principally due to tuberculosis and diseases of the respiratory tract. As a matter of fact Dublin contrasts not unfavourably, as regards infant mortality, with many other towns in the Kingdom.

The Lisburn Board of Guardians had under consideration, at a recent meeting, the advisability of appointing a midwife for the district of Ballylesson, in support of which a deputation of ladies had appeared before the Board a fortnight previously. The appointment had been recommended by Dr. Clibborn, the Local Government Board Inspector; but, before making it, the Guardians requested the opinion of the Medical Officer of the district, Dr. Gavin Orr. This gentleman accordingly wrote to the Board, but gave such a lukewarm opinion in favour of the appointment that the Guardians considered themselves justified in refusing to saddle the ratepayers with any increased expenditure. The district comprises 11,961 acres, with a population of 4,296, in 1901, and there are about 84 births annually. We should imagine that the services of a skilled midwife would be found most useful; nay more, would be absolutely necessary, in such a district, and we cannot appreciate the considerations which prevent a medical officer from expressing his opinion firmly in favour of the appointment. We hope the time is not far distant when every dispensary district in Ireland will be provided with a fully-trained midwfe, so that every lying-in woman may have the attention and skill necessary to carry her through her hour of trial to perfect recovery.

The Irvinestown Guardians spent a considerable time discussing an application from Dr. L. Kidd for a fee of £5 5s. for performing an operation in the infirmary. They ultimately passed a resolution asking Dr. Kidd to be satisfied with a smaller fee. Some of the Guardians, as well as the Clerk, semed to think that the scale of fees drawn up under the Dispensary Regulations, should also apply to fees for operations in the infirmary, and consultations with the workhouse doctor. This, however, is not the case, and the Medical officer of a Workhouse has full liberty to call in whomsoever he will to assist him.

The Belfast Guardians have come to the conclusion that there is no necessity for two fever hospitals in the union, and have directed the medical officers to send all cases of infectious disease to Purdysburn. The average weekly number at present in the workhouse fever hospital reaches almost 100, including, during the past week, two cases of cerebro-spinal fever. It will be interesting to watch the result of this procedure.

The following officers of the Leinster Branch of the British Medical Association have been elected for the ensuing year:—President—John Lentaigne, F.R.C.S. President-Elect—J. Wallace Boyce, M.B. Vice-Presidents—F. W. Kidd, M.D., Sir William Smyly, M.D. County Representative of Branch on Irish Committee—J. M. Kenny, M.B., Granard. Hon. Secretary and Treasurer—Professor White, Royal College of Surgeons, Dublin.

Mr. Birrell last week received in private Sir Arthur Chance and Dr. Donnelly, who attended as a deputation from the Irish Medical Association to complain of limitations recently placed by the Irish Local Government Board upon the mode of selecting candidates for medical Poor Law appointments, especially with reference to their vaccination qualifications. Mr. Birrell promised to consider the points brought before him.

We quote below extracts from a highly interesting report on the increase of insanity in the County Wexford, presented by Dr. Thomas Drapes to the Committee of the Enniscorthy District Asylum. Dr. Drapes places most stress on defective education and alcoholism as causes of insanity, whereas he considers tea-drinking of little importance.

IRISH POOR LAW REFORM.

The annual meeting of the Leinster branch of the British Medical Association was held in the Royal College of Physicians, Dublin, last week, Surgeon Lentaigne, President, occupied the chair.

The President, in delivering his address, devoted himself to the report of the Viceregal Commission on Poor Law Reform in Ireland, and expressed his concurrence with the majority of the recommendations set forth in it. What mostly concerned medical men was the re-organisation of the county and workhouse hospitals, the very valuable suggestions as to the treatment of the sick, and especially of tuberculosis, the proposed regulations for the accommodation of the insane, of epileptics, and of the aged and infirm, and the formation of what had been rather unfortunately called a State Medical Service. The latter designation was a bad one, and the service should be called national or civil. With regard to the reorganisation of hospitals, a much-needed reform was proposed. All county and workhouse hospitals were to be brought into a county hospital system with the county infirmary as the central institution. At least a minimum standard of efficiency was to be secured by inspection. The recommendations in the report for the accommodation and treatment of patients suffering from tuberculosis were most valuable. It was important that some system of arranging for the suitable employment of the convalescent cases should be introduced. In conclusion, Dr. Lentaigne said that of all the recommendations in the report the best and most important, from their point of view, was that for a State, or as it should be called, a National Medical Service. That scheme was, he believed, the keystone on which the entire fabric of reform depended.

On the motion of Dr. Conolly Norman a resolution was adopted congratulating the members of the Viceregal Commission on their excellent report, and expressing approval of the suggestion that the entire Medical Poor Law Service should be formed into a National Service; and the opinion that the Imperial Treasury should provide the funds necessary for the payment of the members of the service, that the service should be entered by competitive examination, and that the members of the National Service should have a voice in selecting a due proportion of the members of the Central Board of Control.

INCREASE OF INSANITY IN CO. WEXFORD.

Dr. Thomas Drapes, M.B., R.M.S., of Enniscorthy District Asylum, has issued a special report dealing with the increase of insanity in County Wexford during the decade ending 1903. Discussing causes and conditions, he says:—"Insanity in those who work their brains hardest—such as statesmen, eminent professional men, and others, who have to endure a high degree of mental strain—is comparatively rare. The rural and uneducated class contribute the highest quota. In the matter of education the County Wexford compares unfavourably with the rest of Ireland generally, and still more markedly with the other counties of the same province. Wexford has a ratio of insane to population considerably higher than the average for all Ireland, and without wishing to dogmatise on the subject, I am inclined to think that there may be some connection between the two facts revealed by the Census returns. Undoubtedly, better education would, at any rate, tend in the long run to develop a higher standard of mental stability, and, probably, *pari passu*, a robuster constitution in the structure of the brain, which would thus be less liable to break down under strain.

The cases in which drink was an assignable cause, primary or contributory, increased from 121 in the first decade to 213 in the last; a rise of 76 per cent. They formed 16 per cent. of admissions in the earlier period, and 23.6 per cent. in the second; an increase of 47.5 per cent. This is not to be wondered at, when we take into consideration the enormous amount of money spent on drink, which, in the County Wexford alone, amounts to £400,000 per annum, and to the unscrupulous action of the licensing authorities in the reckless and indiscriminate multiplication of publichouses with the connivance of the State, thus increasing largely the facilities for the formation of drinking habits among the population, an evil which is bringing about deplorable results.

Tea drinking has been regarded by some as a predisposing, if not a directly exciting cause of insanity, but to my mind this view is based on wholly insufficient grounds."

LIMAVADY UNION.

At a recent meeting of the Limavady Guardians the Clerk said he had written to Dr. Lane, Medical Officer of the Bellarena Dispensary District, informing him that at the last meeting of the board Miss Martin had alleged that he had unduly delayed visiting a child who had died in the fever hospital on the 8th from diphtheria. Miss Martin had stated that a medical relief ticket had been left at his residence on the 5th, and that he did not attend to the child till the following day. He had received a letter from Dr. Lane offering an explanation on the matter. The doctor stated that on Tuesday, the 5th, he left home at 6.40 a.m. to visit a patient at Benone. On returning he was taken to Bellarena to see a second case, and from there proceeded to his dispensary. He reached home about 6.20 p.m., and then he found a ticket issued by Mrs. Gibson, Broighter, which had been left during his absence. No message was left as to the nature of the illness or otherwise, and the messenger was informed the hour he left home, where he was and the probable time of his return, and had the case been an urgent one the messenger could easily have taken the ticket to the dispensary, or else intercepted him on his return home. He (the doctor) entered the ticket on his list for the following morning. He went out that night again about 7.45 p.m., and returned at 10 p.m., and during his absence an uncle of the boy's called to inquire if the ticket had been left. The uncle then stated that the boy was suffering from a sore throat, and left a message asking him to call that night or early the following day. He attended the case the first thing next morning. The doctor further said he would like to add that the case was not urgent when he saw it, and it was the seventh day of illness.

The Chairman—I think the doctor's explanation is fairly satisfactory.

Miss Martin—I do not think so. The doctor should have gone the first night.

Mr. Guthrie—I think if there was any carelessness it was on the part of those who left the ticket.

Mr. O'Loane said if the case was urgent the ticket should have been marked so.

The Guardians decided to accept the doctor's explanation as satisfactory.

UNION MEDICAL CONTRACTS.

The Local Government Board have written to the various Boards of Guardians with regard to the taking of tenders for medicines and medical and surgical appliances for the following year.

The Board drew attention to Article 10 which is as follows:—"Recoupment from the Local Government Taxation (Ireland) Act, will not be allowed in any case where the Guardians accept a tender other than the lowest tender received by them for the supply of drugs or other articles contained in the prescribed lists, unless the Local Government Board, on application being made to them for that purpose, approve of the acceptance of the tender." The Board also expressed the wish to be understood that recoupment cannot be allowed in any case where the Guardians have accepted a tender other than the lowest, unless it can be clearly shown to the satisfaction of the Board that there are good and sufficient reasons for acting otherwise. They would not, of course, expect the Guardians to accept the lowest tender where the party tendering had previously proved unsatisfactory in any Union in Ireland, nor where the balance of convenience and speedy delivery was in favour of a firm whose tender was slightly above the lowest tender. In any case where it is considered that convenience and promptness of delivery justify the Guardians accepting a tender other than the lowest, detailed evidence on the point will be expected by the Board.

The reference to "convenience and promptness of delivery" seems to suggest that the Local Government Board will not this year raise objection to a preference being given to Irish firms.

BALLINASLOE DISTRICT ASYLUM.

At the monthly meeting of the Committee, Dr. Kirwan, Resident Medical Superintendent of the Asylum, reported that the health of the Asylum for the last month had not been so good. There had been several fresh cases of enteric fever and influenza, and two deaths had occurred from enteric. The sewerage was bad, and he was having several alterations made.

The Aughrim Hurling Club wrote recommending Mr. P. Carey for the position of an Asylum Attendant.

Mr. P. J. Kelly said they would not be dictated to.

Dr. Kirwan stated the application would come up at next Committee meeting, so the mattter was dropped.

The connection between hurling and lunacy, and how a hurling club is in a position to judge of the fitness of a member to take charge of the insane, is not very clear. Possibly, the members of the Aughrim Club desire to have a friend in court in cases of cracked heads.

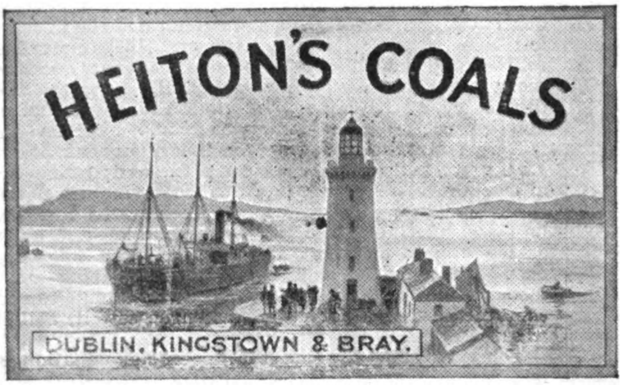
SLIGO DISTRICT ASYLUM.

At the monthly meeting of the Committee, the Resident Medical Superintendent submitted a statement relative to chronic harmless lunatics. There are at present in the asylum 73 chronic harmless lunatics who are capable of doing some work. Out of the 73 only 12 are under 40 years of age. With regard to the question of such patients being taken out by their friends, it must be borne in mind that because patients are quiet and do some work in the asylum, it by no means follows that they therefore will remain quiet and contnue to work if taken out of the asylum. Out of the 73 patients referred to 20 have been discharged at one time or another—13 once, 5 twice, and 2 three times. It must also be borne in mind that many persons who become insane develop a dislike to some of their immediate relatives—*i.e.* those with whom they have been living. To discharge patients in care of such relatives would be only to provoke a relapse. In regard to the particular case referred to by Father Flynn, I have not included him in the return. He has been an inmate for over ten years. He labours under the delusion that someone sucks his blood at night; sometimes he accuses an inmate, and at other times an attendant.

The Chairman said he knew of a case where one of the inmates went into the yard and cut a pound of steak off a live cow's leg, and then cooked it.

Rev. Mr. Flynn—The Chairman's barbacue.

The Committee made a minute that they would consider applications at the next meeting of the Board from respectable farmers and others who are desirous of employing or hiring out discharged patients as farm labourers, wages offered to such labourers to be approved of by the committee.



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SUMMARY OF CONTENTS.

	PAGE
Editorial Notes and Comments	693
Leading Articles	694
Current Topics	695
Personal	697
Clinical Lecture	698
Original Papers	702
Clinical Records	704
Operating Theatres	705
Transactions of Societies	706
Correspondence : Foreign and Special	708
Correspondence : Home	709
Letters to the Editor	710
Obituary	710
Special Article : The Late Robert Barnes, M.D., F.R.C.P., F R.C.S., Eng.	711
Reviews of Books	712
Weekly Summary of Medical Literature	716
Medical News in Brief	718
Notices to Correspondents ; Weekly Diary &c.	720

FOR FULL TABLE OF CONTENTS SEE NEXT PAGE.

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Table of Contents.

PAGE
NOTES AND COMMENTS:—
Principles of Provident Medical Association 693
Doctors and Alcohol 693
Science and the Indian Government 694
Sir Frederick Treves and the Public 694
LEADING ARTICLES:—
The Medical Inspection of School Children 694
CURRENT TOPICS:—
Tuberculosis in London 695
The Queen's Nurses 695
Identification by Palate 695
The Teaching of Physiology .. 696
The Anti-Vivisectionist "Expert" 696
Straw and Strawberries 696
A Royal Commission on Cancer .. 696
Administration of Anæsthetics .. 697
Dugong Oil as Medicine 697
PERSONAL 697
CLINICAL LECTURE:—
"Disorders of Micturition in Women. (Being the second of two lectures delivered at Guy's Hospital). By Peter Horrocks, M.D.Lond., F.R.C.P. 698
ORIGINAL PAPERS:—
The Value of the Widal Reaction in the Diagnosis of Typhoid Fever as ascertained by its use on 230 occasions. By W. James Wilson, B.A., M.B., D.P.H. Camb. 702
Conservative Surgery in Abdominal Operations. By C. B. Keetley, F.R.C.S. 704
CLINICAL RECORDS:—
Three Cases of Acute Pneumonia. By S. J. Ross, M.D. 704
PAGE
OPERATING THEATRES:—
St. Thomas's Hospital.—Case of Tuberculosis of the Occipital Lobe 705
TRANSACTIONS OF SOCIETIES:—
British Gynæcological Society:—
Death of the Honorary President, Dr. Robert Barnes 706
The Modern Treatment of General General Peritonitis 706
Society for the Study of Disease in Children:—
Acute Rheumatism in Childhood 707
Cerebro-Spinal Meningitis .. 708
Contraction of the Tendo Achillis 708
CORRESPONDENCE—FOREIGN:—
Germany:—
The Late Professor Von Bergmann 708
Calculus of a Horseshoe Kidney 708
Primary Carcinoma of the Vermiform Appendix .. 708
Hæmorrhage from Varices of the Œsophagus 708
Austria:—
Exostosis and Chondroma .. 709
Syphilis Maligna Præcox .. 709
Disinfection 709
Puerperal Therapy 709
CORRESPONDENCE—HOME:—
Belfast:—
The Treatment of Consumption 709
Cerebro-Spinal Meningitis .. 709
Typhus Fever in Newry.. .. 709
Ulster Medical Society 709
LETTERS TO THE EDITOR:—
Physiology and Practice 710
Quackery and Practice by Companies 710
PAGE
OBITUARY 710
SPECIAL ARTICLES:—
The late Robert Barnes, M.D., F.R.C.P., F.R.C.S.Eng... .. 711
REVIEWS OF BOOKS:—
Lloyd on Hay Fever 712
Weber on Mineral Waters and Health Resorts 713
The Alcohol Problem 713
Diseases of the Skin 714
Formulaire Francais 714
Operative Gynæcology 714
LITERARY NOTES 715
The Edinburgh Medical Journal .. 715
Medical Latin 715
WEEKLY SUMMARY OF MEDICAL LITERATURE:—
Subcutaneous Injury to the Pancreas 717
The Operative Treatment of Fractures 717
A New Method of Dealing with Cleft Palate 717
Ligature of the Renal Vessels for the Cure of Persistent Urinary Fistula 718
Tortion of the Testis 718
When to Operate in Acute Appendicitis 718
Intestinal Obstruction Due to Persistence and Anomaly of the Urachus 718
Chylous Cyst of the Thoracic Duct
A Method of Reducing Old Colles' Fractures 718
Primary Glaucoma and Arterio-sclerosis and Renal Impermeability 719
Cysticercus of the Iris 719
A Case of Hydrophobia 719
MEDICAL NEWS IN BRIEF 719
NOTICES TO CORRESPONDENTS, WEEKLY DIARY, LECTURES, MEETINGS, VACANCIES, BIRTHS, MARRIAGES AND DEATHS, &c... .. 720

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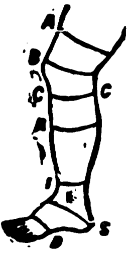

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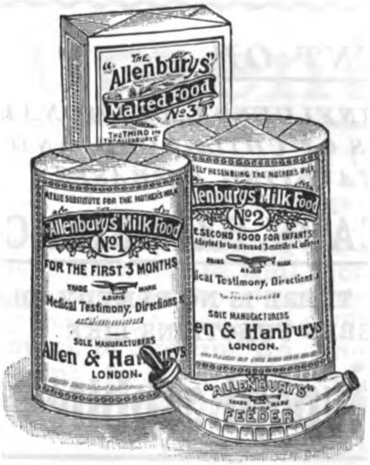
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Chloride of Sodium	29·047
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Carbonate of Manganese	0·429
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APOTHECARIES HALL, IRELAND.

The Examination for the License in Medicine, Surgery, Midwifery and Pharmacy, will commence on Monday, July 15th, 1907, at the Hall, 40 Mary Srreet, Dublin.

All entries should be lodged with the Registrar at least 14 days previously.

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The next Examination for the CERTIFICATE IN PSYCHOLOGICAL MEDICINE of the above Association will be held in :—

London ... ... Bethlem Hospital
Glasgow ... ... Gartnloch Asylum
Dublin ... ... Richmond Asylum

on THURSDAY, JULY 11th, 1907, at 10 a.m.

The next Examination for the GASKELL PRIZE will take place at London ... ... Bethlem Hospital. on THURSDAY and FRIDAY, JULY 11th and 12th, 1907, at 10 a.m.

Candidates intending to present themselves for either of the above Examinations, should give 14 days' notice to the Registrar (Dr. Alfred Miller), Warwick County Asylum, Hatton, near Warwick, from whom any other particulars may be obtained.

Last day for receiving Essays for the Bronze Medal and £10, FRIDAY, JULY 12th.

THE HOSPITAL FOR SICK CHILDREN
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A HOUSE SURGEON is required on July 10th, 1907.

Candidates are invited to send in their applications, addressed to the Secretary before 12 o'clock on Wednesday, July 3rd, 1907, with not more than three testimonials *given specially for the purpose*, and also evidence of their having held a responsible Hospital appointment.

The appointment is made for six months. Salary £20, washing allowance £2 10s., with board and residence in the Hospital.

Candidates must be unmarried, and possess a legal qualification to practice. They will be required to attend before the Joint Committees at their meeting on Thursday, July 4th, 1907, at 5 p.m. precisely.

Forms of application to be obtained of the Secretary.

By order of the Committee of Management,
June 11th, 1907. STEWART JOHNSON, Secretary.

ROYAL COLLEGE OF SURGEONS
IN IRELAND.
CARMICHAEL PRIZE ESSAY.

The late Richard Carmichael, Esq., having bequeathed to the College a sum of money for the purpose of founding Prizes for Essays upon certain subjects specified by him, the President and Council hereby give notice that, on the first Thursday in November in the year 1908, they will proceed to adjudge a prize of One Hundred and Twenty Pounds for the best Essay that may be presented to them in accordance with the following instructions prescribed by Mr. Carmichael.

1st. "The state of the Medical Profession in its different departments of Physic, Surgery, and Pharmacy, in Great Britain and Ireland, at the time of the writing of these Prize Essays."

2nd. "The state of the Hospitals and Schools of Medicine, Surgery, and Pharmacy."

3rd. "The state and mode of examination, or of testing the qualifications of Candidates of the different Licensing Colleges or Corporations of Medicine, Surgery, and Pharmacy."

"Under these heads the authors will be pleased to make such suggestions as may occur to them respecting the improvement of the profession, with the view of rendering it more useful to the public, and a more respectable body than it is at present. In these suggestions the authors will be pleased to consider the preliminary and moral education of Medical and Surgical Students, as well as the mode of conducting their professional studies."

"In considering the third head, or mode of testing the qualifications of candidates by the licensing bodies, the authors will please to consider the most practical mode of rendering the examination as demonstrative as possible—*i.e.*, in Anatomy, by having the dead subject placed before the candidate; in Chemistry, Botany, and Pharmacy, specimens of minerals, plants, and pharmaceutical preparations placed before him; and in the practice of Physic and Surgery, the candidate to be placed before the patients in the wards of an hospital as the testator is certain that this will afford the most certain and only true mode of ascertaining the qualifications of candidates."

Each Essay is to be distinguished by a device or motto, and accompanied by a sealed packet, containing the name and address of the author, also distinguished by the same device or motto. The Essays are to be lodged at the College on or before the first day of July, 1908.

No Essay shall exceed 65,000 words in length, and all quotations and extracts from any published work, pamphlet or paper, shall be by reference merely to the volume and page on which the passage desired to be quoted is to be found.

The President and Council will not consider themselves bound to award the Prizes should any of the Essays not appear to them to possess sufficient merit.

By order of the Council,
JOHN BARTON, F.R.C.S.,
Secretary of the Council.
Dublin, June 19, 1907.

POOR-LAW MEDICAL OFFICERS—LOCUM TENENS.—Medical Officers seeking temporary substitutes, or practitioners willing to act as such, are requested to make application to the Locum Tenens' Registrar, Dublin Office of the Medical Press 18 Nassau Street, Dublin.

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INDIAN MEDICAL SERVICE.

INDIA OFFICE, LONDON,
28th May, 1907.

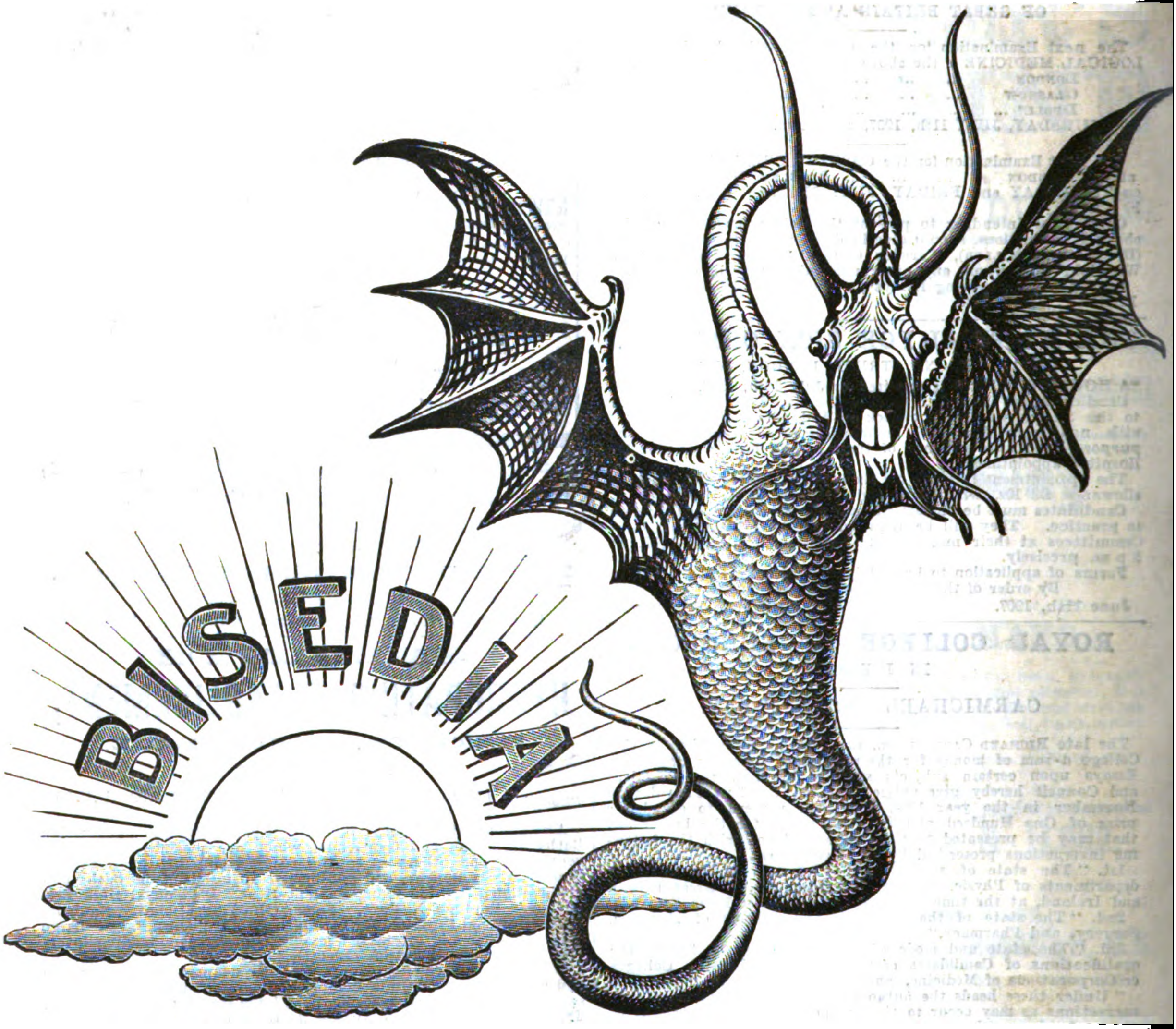
An examination for not less than 11 Commissions in the Indian Medical Service will be held in London on Tuesday the 23rd July, 1907, and the four following days. Particulars regarding pay, promotion, &c., in the Service, and the necessary forms for application, can be obtained from the Military Secretary, India Office, London, S.W. The applications, duly filled up and accompanied by the required certificates, must reach this office on or before the 9th July, 1907.

E. STEDMAN, General.

LONDON COUNTY ASYLUM,
CLAYBURY, WOODFORD BRIDGE, ESSEX.

A Junior Assistant Medical Officer is required at the above-named Asylum. Salary £150 a year, with board, furnished apartments, and washing. Age not to exceed 35 years. Candidates must be single men and duly registered and qualified to practise both in medicine and surgery in England. Forms of application can be obtained at the office of the Committee, where such forms, duly filled up and accompanied by copies only of not more than three recent testimonials, are to be delivered by 12 noon on Wednesday, 3rd JULY, 1907. Selected candidates will be invited to appear before the Sub-Committee of the Asylum. The person appointed will be required to pass a medical examination.

H. F. KEENE,
Clerk of the Asylums Committee.
Asylums Committee Office, 6 Waterloo Place, S.W.
21st June, 1907.



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